Associated Features

Research with nationally representative samples of the U.S. population has found that sedative, hypnotic, or anxiolytic use disorder is often associated with other substance use disorders (e.g., alcohol, cannabis, opioid, stimulant use disorders). Sedatives are often used to alleviate the unwanted effects of these other substances. With repeated use of the sedative, hypnotic, or anxiolytic, tolerance develops to the sedative effects, and a progressively higher dose is used. However, tolerance to brain stem depressant effects develops much more slowly, and as the individual takes more substance to achieve euphoria or other desired effects, there may be a sudden onset of respiratory depression and hypotension, which may result in death. Intense or repeated sedative, hypnotic, or anxiolytic intoxication may be associated with severe depression that although temporary can lead to suicide attempt and suicide.

Prevalence

The 12-month prevalence of DSM-IV sedative, hypnotic, or anxiolytic use disorder in the United States is estimated to be 0.3% among adolescents ages 12–17 years and adults age 18 years and older, and this prevalence has remained stable nationally despite increases in rates of prescription of these medications. Rates of DSM-IV sedative, hypnotic, or anxiolytic use disorder in the United States have not been shown to vary consistently by gender, but data from other countries have generally found higher rates among girls and women than boys and men. The 12-month prevalence of DSM-IV sedative, hypnotic, or anxiolytic use disorder in the United States decreases as a function of age and is greatest among individuals ages 18–29 years (0.5%) and lowest among individuals 65 years and older (0.04%).

Twelve-month prevalence of sedative, hypnotic, or anxiolytic use, misuse (e.g., use without a prescription), or disorder varies across U.S. ethnoracial groups. For instance, 12-month prevalence estimates for sedative, hypnotic, or anxiolytic misuse across ethnoracial groups range from 0.6% to 2.5% for adolescents ages 12–17 years and 0.7% to 10.1% for adults.

Development and Course

The usual course of sedative, hypnotic, or anxiolytic use disorder involves individuals in their teens or 20s who escalate their occasional use of sedative, hypnotic, or anxiolytic agents to the point at which they develop problems that meet criteria for a diagnosis. This pattern may be especially likely among individuals who have other substance use disorders (e.g., alcohol, opioids, stimulants). An initial pattern of intermittent use socially (e.g., at parties) can lead to daily use and high levels of tolerance. Once this occurs, an increasing level of interpersonal difficulties can be expected, as well as increasingly severe episodes of cognitive dysfunction and physiological withdrawal.

The second and less frequently observed clinical course begins with an individual who originally obtained the medication by prescription from a physician, usually for the treatment of anxiety, insomnia, or somatic complaints. As either tolerance or a need for higher doses of the medication develops, there is a gradual increase in the dose and frequency of self-administration. The individual is likely to continue to justify use on the basis of original anxiety or insomnia symptoms, but substance-seeking behavior becomes more prominent, and the individual may seek out multiple physicians to obtain sufficient supplies of the medication. Tolerance can reach high levels, and withdrawal (including seizures and withdrawal delirium) may occur.

As with many substance use disorders, sedative, hypnotic, or anxiolytic use disorder generally has an onset during adolescence or early adult life. Although the risk for misuse and use disorder decreases with age after about age 30, side effects associated with psychoactive substances may increase as individuals age. In particular, cognitive impairment increases as a side effect with age, and the metabolism of sedatives, hypnotics, or anxio-

lytics decreases with age among older individuals. Both acute and chronic toxic effects of these substances, especially effects on cognition, memory, and motor coordination, are likely to increase with age as a consequence of pharmacodynamic and pharmacokinetic age-related changes. Individuals with major neurocognitive disorder are more likely to develop intoxication and impaired physiological functioning at lower doses. Because sedatives, hypnotics, and anxiolytics are often used in combination with other psychoactive substances, it can be difficult to ascertain whether the functional consequences are attributable to a single substance (e.g., sedative) or to the use of multiple substances.

Deliberate intoxication to achieve a "high" is most likely to be observed in teenagers and individuals in their 20s. Problems associated with sedatives, hypnotics, or anxiolytics are also seen in individuals in their 40s and older who escalate the dose of prescribed medications. In older individuals, intoxication can resemble a progressive major neurocognitive disorder.

Risk and Prognostic Factors

Temperamental. Impulsivity and novelty seeking are individual temperaments that relate to the propensity to develop a substance use disorder but may themselves be genetically determined. Personality disorders can also increase the risk of sedative, hypnotic, or anxiolytic misuse or use disorder.

Environmental. Because sedatives, hypnotics, or anxiolytics are all medications, a key risk factor relates to availability of the substances, both through an individual's own prescriptions and from prescriptions dispensed to family and friends. In the United States, the historical patterns of sedative, hypnotic, or anxiolytic misuse relate to broad prescribing patterns. For instance, a marked decrease in prescription of barbiturates was associated with an increase in benzodiazepine prescriptions. Peer factors may relate to genetic predisposition in terms of how individuals select their environment. Other individuals at heightened risk might include those with alcohol use disorder who may receive repeated prescriptions in response to their complaints of alcohol-related anxiety or insomnia.

Genetic and physiological. As with other substance use disorders, the risk for sedative, hypnotic, or anxiolytic use disorder has been found in U.S.-based twin registry studies to be related to individual, family, peer, social, and environmental factors. Within these domains, genetic factors play a particularly important role both directly and indirectly. Overall, across development, genetic factors seem to play a larger role in the onset of sedative, hypnotic, or anxiolytic use disorder as individuals age through puberty into adult life.

Course modifiers. In nationally representative U.S. studies, early onset of use is associated with greater likelihood for developing a sedative, hypnotic, or anxiolytic use disorder.

Culture-Related Diagnostic Issues

Prescription patterns (and availability) of this class of substances vary across countries and populations, which may lead to variations in prevalence of sedative, hypnotic, or anxiolytic use disorder. In the United States, use of benzodiazepines has been more frequently reported by non-Latinx Whites than Latinx or African Americans. However, risk of the disorder may vary within populations exposed to these substances. For example, the 12-month prevalence of DSM-IV benzodiazepine use disorder among U.S. individuals who used benzodiazepines was higher among African Americans (3.0%) and non-Latinx "others" (2.6%) than among non-Latinx Whites (1.3%).

Sex- and Gender-Related Diagnostic Issues

Although estimates from individual studies vary, there appear to be no gender differences in the prevalence of sedative, hypnotic, or anxiolytic use disorder.

Diagnostic Markers

Almost all sedative, hypnotic, or anxiolytic substances can be identified through laboratory evaluations of urine or blood (the latter of which can quantify the amounts of these agents in the body). Urine test results are likely to remain positive for up to approximately 1 week after the use of long-acting substances, such as diazepam or flurazepam.

Association With Suicidal Thoughts or Behavior

U.S. epidemiological studies show that hypnotics are associated with suicide, but it is unclear if this association is attributable to underlying psychiatric conditions such as depression and insomnia, which are themselves risk factors for suicide.

Functional Consequences of Sedative, Hypnotic, or Anxiolytic Use Disorder

The social and interpersonal consequences of sedative, hypnotic, or anxiolytic use disorder mimic those of alcohol in terms of the potential for disinhibited behavior. Accidents, interpersonal difficulties, and interference with work or school performance are common outcomes. The disinhibiting effects of these agents, like alcohol, may potentially contribute to overly aggressive behavior and arguments or fights, with subsequent interpersonal and legal problems. Physical examination is likely to reveal evidence of a mild decrease in most aspects of autonomic nervous system functioning, including a slower pulse, a slightly decreased respiratory rate, and a slight drop in blood pressure (most likely to occur with postural changes).

Acute intoxication can result in accidental injuries and automobile accidents. There may be consequences of trauma (e.g., internal bleeding, a subdural hematoma) from accidents that occur while intoxicated. For elderly individuals, even short-term use of these sedating medications at prescribed doses may be associated with an increased risk for cognitive problems and falls. The association of sedative, hypnotic, or anxiolytic medications with increased risk of major neurocognitive disorder remains unclear.

At high doses, sedative, hypnotic, or anxiolytic substances can be lethal, particularly when mixed with other central nervous system depressants, such as opioids or alcohol, although the lethal dosage varies considerably among the specific substances. Intravenous use of these substances can result in medical complications related to the use of contaminated needles (e.g., hepatitis, HIV).

Accidental or deliberate overdoses, similar to those observed for alcohol use disorder or repeated alcohol intoxication, can occur. Overdoses may be associated with a deterioration in vital signs that signals an impending medical emergency (e.g., respiratory arrest from barbiturates). In contrast to their wide margin of safety when used alone, benzodiazepines taken in combination with opioids and alcohol can be particularly dangerous, and accidental overdoses are reported commonly in U.S. data. Accidental overdoses have also been reported in individuals who deliberately misuse barbiturates and other nonbenzodiazepine sedatives (e.g., methaqualone), but because these agents are much less available than the benzodiazepines, the frequency of overdosing is low in most settings.

Differential Diagnosis

Sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; and sedative-, hypnotic-, or anxiolytic-induced mental disorders. Sedative, hypnotic, or anxiolytic use disorder is differentiated from sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; and sedative-, hypnotic-, or anxiolytic-induced mental disorders (e.g., sedative-, hypnotic-, or anxiolytic-induced depressive disorder) in that sedative, hypnotic, or anxiolytic use disorder describes a problematic pattern

of sedative, hypnotic, or anxiolytic use that involves impaired control over such use; social impairment attributable to this use; risky sedative, hypnotic, or anxiolytic use (e.g., driving while intoxicated); and pharmacological symptoms (the development of tolerance or withdrawal); whereas sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; and sedative-, hypnotic-, or anxiolytic-induced mental disorders describe psychiatric syndromes that occur in the context of heavy use. Sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; and sedative-, hypnotic-, or anxiolytic-induced mental disorders occur frequently in individuals with sedative, hypnotic, or anxiolytic use disorder. In such cases, a diagnosis of sedative, hypnotic, or anxiolytic intoxication; sedative, hypnotic, or anxiolytic withdrawal; or a sedative-, hypnotic-, or anxiolytic-induced mental disorder should be given in addition to a diagnosis of sedative, hypnotic, and anxiolytic use disorder, the presence of which is indicated in the diagnostic code.

Other medical conditions. The slurred speech, incoordination, and other associated features characteristic of sedative, hypnotic, or anxiolytic intoxication could be the result of another medical condition (e.g., multiple sclerosis) or of a prior head trauma (e.g., a subdural hematoma).

Alcohol use disorder. Sedative, hypnotic, or anxiolytic use disorder must be differentiated from alcohol use disorder. The differential diagnosis is determined mostly through clinical history, although liver damage and other potential signs of chronic alcohol toxicity (e.g., cardiomyopathy) can also be more suggestive of alcohol use disorder than of sedative, hypnotic, or anxiolytic use disorder.

Clinically appropriate use of sedative, hypnotic, or anxiolytic medications. Individuals may continue to take benzodiazepine medication according to a physician's direction for a legitimate medical indication over extended periods of time. Even if physiological signs of tolerance or withdrawal are manifested, many of these individuals do not develop symptoms that meet the criteria for sedative, hypnotic, or anxiolytic use disorder because they are not preoccupied with obtaining the substance and its use does not interfere with their performance of usual social or occupational roles.

Comorbidity

Nonmedical use of sedative, hypnotic, or anxiolytic agents is associated with alcohol use disorder, tobacco use disorder, and, generally, illicit drug use. There may also be an overlap between sedative, hypnotic, or anxiolytic use disorder and antisocial personality disorder; depressive, bipolar, and anxiety disorders; and other substance use disorders, such as alcohol use disorder and illicit drug use disorders. Antisocial behavior and antisocial personality disorder are especially associated with sedative, hypnotic, or anxiolytic use disorder when the substances are obtained illegally. Comorbidity with other substance use disorders and other psychiatric disorders increases the risk of transition from sedative, hypnotic, or anxiolytic use to use disorder and decreases the probability of remission.

Sedative, Hypnotic, or Anxiolytic Intoxication

Diagnostic Criteria

A. Recent use of a sedative, hypnotic, or anxiolytic.
B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment) that developed during, or shortly after, sedative, hypnotic, or anxiolytic use.

C. One (or more) of the following signs or symptoms developing during, or shortly after, sedative, hypnotic, or anxiolytic use:
   1. Slurred speech.
   2. Incoordination.
   3. Unsteady gait.
   4. Nystagmus.
   5. Impairment in cognition (e.g., attention, memory).
   6. Stupor or coma.

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.

Coding note: The ICD-10-CM code depends on whether there is a comorbid sedative, hypnotic, or anxiolytic use disorder. If a mild sedative, hypnotic, or anxiolytic use disorder is comorbid, the ICD-10-CM code is **F13.120,** and if a moderate or severe sedative, hypnotic, or anxiolytic use disorder is comorbid, the ICD-10-CM code is **F13.220.** If there is no comorbid sedative, hypnotic, or anxiolytic use disorder, then the ICD-10-CM code is **F13.920.**

Note: For information on Development and Course; Risk and Prognostic Factors; Culture-Related Diagnostic Issues; Diagnostic Markers; Functional Consequences of Sedative, Hypnotic, or Anxiolytic Intoxication; and Comorbidity, see the corresponding sections in Sedative, Hypnotic, or Anxiolytic Use Disorder.

Diagnostic Features

The essential feature of sedative, hypnotic, or anxiolytic intoxication is the presence of clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment, impaired social or occupational functioning) that develop during, or shortly after, use of a sedative, hypnotic, or anxiolytic (Criteria A and B). As with other brain depressants, such as alcohol, these behaviors may be accompanied by slurred speech, incoordination (at levels that can interfere with driving abilities and with performing usual activities to the point of causing falls or automobile accidents), an unsteady gait, nystagmus, impairment in cognition (e.g., attentional or memory problems), and stupor or coma (Criterion C). Memory impairment is a prominent feature of sedative, hypnotic, or anxiolytic intoxication and is most often characterized by an anterograde amnesia that resembles "alcoholic blackouts," which can be disturbing to the individual. The symptoms must not be attributable to another medical condition and are not better explained by another mental disorder (Criterion D). Intoxication may occur in individuals who are receiving these substances by prescription, are borrowing the medication from friends or relatives, or are deliberately taking the substance to achieve intoxication. Because sedatives, hypnotics, and anxiolytics are often used in combination with other psychoactive substances, it can be difficult to ascertain whether the functional consequences are attributable to a sedative, hypnotic, or anxiolytic or to the use of multiple substances.

Associated Features

Associated features include taking more medication than prescribed, taking multiple different medications, or mixing sedative, hypnotic, or anxiolytic agents with alcohol, which can markedly increase the effects of these agents.

Prevalence

The prevalence of sedative, hypnotic, or anxiolytic intoxication in the general population is unknown. However, it is probable that most nonmedical users of sedatives, hypnotics,

or anxiolytics would at some time have signs or symptoms that meet criteria for sedative, hypnotic, or anxiolytic intoxication; if so, then the prevalence of nonmedical sedative, hypnotic, or anxiolytic use in the general population may be similar to the prevalence of sedative, hypnotic, or anxiolytic intoxication. For example, in 2018, tranquilizers or sedative were used nonmedically in the United States by 2.4% of individuals age 12 or older and 4.9% of those ages 18–25.

Differential Diagnosis

Alcohol use disorder. Because the clinical presentations may be identical, distinguishing sedative, hypnotic, or anxiolytic intoxication from alcohol use disorder requires evidence for recent ingestion of sedative, hypnotic, or anxiolytic medications by self-report, informant report, or toxicological testing. Many individuals who misuse sedatives, hypnotics, or anxiolytics may also misuse alcohol and other substances, and so multiple intoxication diagnoses are possible.

Alcohol intoxication. Alcohol intoxication may be distinguished from sedative, hypnotic, or anxiolytic intoxication by the smell of alcohol on the breath. Otherwise, the features of the two disorders may be similar.

Sedative-, hypnotic-, or anxiolytic-induced mental disorders. Sedative, hypnotic, or anxiolytic intoxication is distinguished from sedative-, hypnotic-, or anxiolytic-induced mental disorders (e.g., sedative-, hypnotic-, or anxiolytic-induced anxiety disorder, with onset during withdrawal) because the symptoms (e.g., anxiety) in the latter disorders are in excess of those usually associated with sedative, hypnotic, or anxiolytic intoxication; predominate in the clinical presentation; and are severe enough to warrant clinical attention.

Neurocognitive disorders. In situations of cognitive impairment, traumatic brain injury, and delirium from other causes, sedatives, hypnotics, or anxiolytics may be intoxicating at quite low dosages. The differential diagnosis in these complex settings is based on the predominant syndrome. An additional diagnosis of sedative, hypnotic, or anxiolytic intoxication may be appropriate even if the substance has been ingested at a low dosage in the setting of these other (or similar) co-occurring conditions.

Comorbidity

Given the typical overlap of sedative, hypnotic, or anxiolytic intoxication with sedative, hypnotic, or anxiolytic use disorder, see "Comorbidity" under Sedative, Hypnotic, or Anxiolytic Use Disorder for more details about co-occurring conditions that are likely to be encountered.

Sedative, Hypnotic, or Anxiolytic Withdrawal

Diagnostic Criteria

A. Cessation of (or reduction in) sedative, hypnotic, or anxiolytic use that has been prolonged.

B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) sedative, hypnotic, or anxiolytic use described in Criterion A:

   1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm).
   2. Hand tremor.

3. Insomnia.
4. Nausea or vomiting.
5. Transient visual, tactile, or auditory hallucinations or illusions.
6. Psychomotor agitation.
7. Anxiety.
8. Grand mal seizures.

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 if:

With perceptual disturbances: This specifier may be noted when 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 sedative, hypnotic, or anxiolytic use disorder and whether or not there are perceptual disturbances.

For sedative, hypnotic, or anxiolytic withdrawal, without perceptual disturbances: If a mild sedative, hypnotic, or anxiolytic use disorder is comorbid, the ICD-10-CM code is **F13.130**, and if a moderate or severe sedative, hypnotic, or anxiolytic use disorder is comorbid, the ICD-10-CM code is **F13.230**. If there is no comorbid sedative, hypnotic, or anxiolytic use disorder (e.g., in a patient taking sedatives, hypnotics, or anxiolytics solely under appropriate medical supervision), then the ICD-10-CM code is **F13.930**.

For sedative, hypnotic, or anxiolytic withdrawal, with perceptual disturbances: If a mild sedative, hypnotic, or anxiolytic use disorder is comorbid, the ICD-10-CM code is **F13.132**, and if a moderate or severe sedative, hypnotic, or anxiolytic use disorder is comorbid, the ICD-10-CM code is **F13.232**. If there is no comorbid sedative, hypnotic, or anxiolytic use disorder (e.g., in a patient taking sedatives, hypnotics, or anxiolytics solely under appropriate medical supervision), then the ICD-10-CM code is **F13.932**.

Note: For information on Development and Course; Risk and Prognostic Factors; Culture-Related Diagnostic Issues; Functional Consequences of Sedative, Hypnotic, or Anxiolytic Withdrawal; and Comorbidity, see the corresponding sections in Sedative, Hypnotic, or Anxiolytic Use Disorder.

Diagnostic Features

The essential feature of sedative, hypnotic, or anxiolytic withdrawal is the presence of a characteristic syndrome that develops after a marked decrease in or cessation of intake after several weeks or more of regular use (Criteria A and B). This withdrawal syndrome is characterized by two or more symptoms (similar to alcohol withdrawal) that include autonomic hyperactivity (e.g., increases in heart rate, respiratory rate, blood pressure, or body temperature, along with sweating); a tremor of the hands; insomnia; nausea, sometimes accompanied by vomiting; anxiety; and psychomotor agitation. A grand mal seizure may occur in perhaps as many as 20%–30% of individuals undergoing untreated withdrawal from these substances. In severe withdrawal, visual, tactile, or auditory hallucinations or illusions can occur but are usually in the context of a withdrawal delirium. If the individual's reality testing is intact (i.e., knows the substance is causing the hallucinations) and the illusions occur in a clear sensorium, the specifier "with perceptual disturbances"

can be noted. When hallucinations occur in the absence of intact reality testing, a diagnosis of substance/medication-induced psychotic disorder should be considered. The 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 (e.g., alcohol withdrawal, generalized anxiety disorder) (Criterion D). Relief of withdrawal symptoms with administration of any sedative-hypnotic agent would support a diagnosis of sedative, hypnotic, or anxiolytic withdrawal.

Associated Features

The timing and severity of the withdrawal syndrome will differ depending on the specific substance and its pharmacokinetics and pharmacodynamics. For example, withdrawal from shorter-acting substances that are rapidly absorbed and that have no active metabolites (e.g., triazolam) can begin within hours after the substance is stopped; withdrawal from substances with long-acting metabolites (e.g., diazepam) may not begin for 1–2 days or longer. The withdrawal syndrome produced by substances in this class may be characterized by the development of a delirium that can be life-threatening. There may be evidence of tolerance and withdrawal in the absence of a diagnosis of a benzodiazepine use disorder in an individual who has abruptly discontinued benzodiazepines that were taken for long periods of time at prescribed and therapeutic doses.

The time course of the withdrawal syndrome is generally predicted by the half-life of the substance. Medications whose actions typically last about 10 hours or less (e.g., lorazepam, oxazepam, temazepam) produce withdrawal symptoms within 6–8 hours of decreasing blood levels that peak in intensity on the second day and improve markedly by the fourth or fifth day. For substances with longer half-lives (e.g., diazepam), symptoms may not develop for more than 1 week, peak in intensity during the second week, and decrease markedly during the third or fourth week. There may be additional longer-term symptoms at a much lower level of intensity that persist for several months.

The longer the substance has been taken and the higher the dosages used, the more likely there will be severe withdrawal. However, withdrawal has been reported with as little as 15 mg of diazepam (or its equivalent in other benzodiazepines) when taken daily for several months. Doses of approximately 40 mg of diazepam (or its equivalent) daily are more likely to produce clinically relevant withdrawal symptoms, and even higher doses (e.g., 100 mg of diazepam) are more likely to be followed by withdrawal seizures or delirium. Sedative, hypnotic, or anxiolytic withdrawal delirium is characterized by disturbances in consciousness and cognition, with visual, tactile, or auditory hallucinations. When present, sedative, hypnotic, or anxiolytic withdrawal delirium should be diagnosed instead of withdrawal.

Prevalence

The prevalence of sedative, hypnotic, or anxiolytic withdrawal is unknown.

Diagnostic Markers

Seizures and autonomic instability in the setting of a history of prolonged exposure to sedative, hypnotic, or anxiolytic medications suggest a high likelihood of sedative, hypnotic, or anxiolytic withdrawal.

Differential Diagnosis

Other medical conditions. The symptoms of sedative, hypnotic, or anxiolytic withdrawal may be mimicked by other medical conditions (e.g., hypoglycemia, diabetic ketoacidosis). If seizures are a feature of the sedative, hypnotic, or anxiolytic withdrawal, the

differential diagnosis includes the various causes of seizures (e.g., infections, head injury, poisonings).

Essential tremor. Essential tremor, a neurological condition that frequently runs in families, may erroneously suggest the tremulousness associated with sedative, hypnotic, or anxiolytic withdrawal.

Alcohol withdrawal. Alcohol withdrawal produces a syndrome very similar to that of sedative, hypnotic, or anxiolytic withdrawal. The differential diagnosis is determined mostly through clinical history, although liver damage and other potential signs of chronic alcohol toxicity (e.g., cardiomyopathy) can also be more suggestive of alcohol withdrawal than of sedative, hypnotic, or anxiolytic withdrawal.

Sedative-, hypnotic-, or anxiolytic-induced mental disorders. Sedative, hypnotic, or anxiolytic withdrawal is distinguished from sedative-, hypnotic-, or anxiolytic-induced mental disorders (e.g., sedative-, hypnotic-, or anxiolytic-induced anxiety disorder, with onset during withdrawal) because the symptoms (e.g., anxiety) in the latter disorders are in excess of those usually associated with sedative, hypnotic, or anxiolytic withdrawal; predominate in the clinical presentation; and are severe enough to warrant clinical attention.

Anxiety disorders. Recurrence or worsening of an underlying anxiety disorder produces a syndrome similar to sedative, hypnotic, or anxiolytic withdrawal, although the most extreme manifestations of withdrawal, such as delirium tremens or true seizures, are not symptoms of any anxiety disorder. Withdrawal would be suspected with an abrupt reduction in the dosage of a sedative, hypnotic, or anxiolytic medication. When a taper is under way, distinguishing the withdrawal syndrome from the underlying anxiety disorder can be difficult. As with alcohol, lingering withdrawal symptoms (e.g., anxiety, moodiness, trouble sleeping) can be mistaken for independent anxiety or depressive disorders (e.g., generalized anxiety disorder).

Comorbidity

Given the typical overlap of sedative, hypnotic, or anxiolytic withdrawal with sedative, hypnotic, or anxiolytic use disorder, see "Comorbidity" under Sedative, Hypnotic, or Anxiolytic Use Disorder for more details about co-occurring conditions that are likely to be encountered.

Sedative-, Hypnotic-, or Anxiolytic-Induced Mental Disorders

The following sedative-, hypnotic-, or anxiolytic-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): sedative-, hypnotic-, or anxiolytic-induced psychotic disorder ("Schizophrenia Spectrum and Other Psychotic Disorders"); sedative-, hypnotic-, or anxiolytic-induced bipolar and related disorder ("Bipolar and Related Disorders"); sedative-, hypnotic-, or anxiolytic-induced depressive disorder ("Depressive Disorders"); sedative-, hypnotic-, or anxiolytic-induced anxiety disorder ("Anxiety Disorders"); sedative-, hypnotic-, or anxiolytic-induced sleep disorder ("Sleep-Wake Disorders"); sedative-, hypnotic-, or anxiolytic-induced sexual dysfunction ("Sexual Dysfunctions"); and sedative-, hypnotic-, or anxiolytic-induced major or mild neurocognitive disorder ("Neurocognitive Disorders"). For sedative, hypnotic, or anxiolytic intoxication delirium; sedative, hypnotic, or anxiolytic withdrawal delirium; and delirium induced by sedatives, hypnotics, or anxiolytics taken as prescribed, see the

criteria and discussion of delirium in the chapter "Neurocognitive Disorders." These sedative-, hypnotic-, or anxiolytic-induced mental disorders are diagnosed instead of sedative, hypnotic, or anxiolytic intoxication or sedative, hypnotic, or anxiolytic withdrawal only when the symptoms are sufficiently severe to warrant independent clinical attention.

Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

F13.99

This category applies to presentations in which symptoms characteristic of a sedative-, hypnotic-, or anxiolytic-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 sedative-, hypnotic-, or anxiolytic-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

Stimulant-Related Disorders

Stimulant Use Disorder
Stimulant Intoxication
Stimulant Withdrawal
Stimulant-Induced Mental Disorders
Unspecified Stimulant-Related Disorder

Stimulant Use Disorder

Diagnostic Criteria

A. A pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
   1. The stimulant 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 stimulant use.
   3. A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
   4. Craving, or a strong desire or urge to use the stimulant.
   5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
   6. Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
   7. Important social, occupational, or recreational activities are given up or reduced because of stimulant use.