SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

Sedative, Hypnotic, or Anxiolytic Use Disorder

SHAUD

DSM-5-TR 304.10/305.40 | ICD-10-CM F13.10, F13.20

Problematic benzodiazepine, Z-drug, or barbiturate use with dose escalation and a withdrawal syndrome that can be lethal.

12-MONTH PREVALENCE	TYPICAL ONSET	HIGHEST-RISK GROUP	COURSE
~0.3-1% (US adults)	Any age; often iatrogenic	Adults 65+; most prescribed	Chronic; protracted taper

CLINICAL PICTURE

- Dose escalation, early refill requests, and multiple prescribers, typically beginning with legitimate treatment of anxiety or insomnia.
- Intoxication resembles alcohol with slurred speech, ataxia, nystagmus, disinhibition, and anterograde amnesia, but without any odor.
- Interdose withdrawal on short-acting agents such as **alprazolam** produces rebound anxiety that patients interpret as worsening illness.
- Withdrawal includes tremor, insomnia, autonomic hyperactivity, perceptual distortion, and seizures, and can be fatal if stopped abruptly.
- Older adults present with falls, hip fractures, confusion, and apparent cognitive decline that partially reverses after a careful taper.
- Co-use with opioids or alcohol is common and multiplies respiratory depression, sedation, and overall overdose mortality risk.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires at least 2 of 11 criteria within a 12-month period, with severity graded mild 2-3, moderate 4-5, or severe 6 or more.
- Tolerance and withdrawal are excluded from the count when the medication is taken as prescribed under appropriate medical supervision.
- Physiologic dependence alone in a properly monitored patient does not establish the diagnosis, since impaired control must also be present.
- Sedative withdrawal is a separate diagnosis requiring 2 or more characteristic symptoms within hours to days of cessation or dose reduction.
- The class spans benzodiazepines, Z-drugs, barbiturates, carbamates, and most prescription sleep and anxiolytic medications.

NEUROBIOLOGY & PHYSIOLOGY

- Benzodiazepines act as positive allosteric modulators at **GABA-A** receptors, increasing the frequency of chloride channel opening.
- Z-drugs such as **zolpidem** bind preferentially to alpha1-containing subunits, favoring sedation and amnesia over anxiolysis.
- Chronic exposure downregulates GABA-A receptors and upregulates glutamatergic tone, producing rebound hyperexcitability on cessation.
- Barbiturates directly open the chloride channel, which explains their far narrower therapeutic index and their lethality in overdose.
- Kindling from repeated withdrawal episodes escalates seizure risk over time, closely mirroring the pattern observed with alcohol.
- Long-term use is associated with impaired attention, visuospatial ability, and psychomotor speed, with partial recovery after cessation.

PSYCHOLOGICAL MECHANISMS

- Rapid symptom relief teaches immediate avoidance of anxiety, blocking the extinction learning that exposure-based therapy depends on.
- Patients attribute all symptom relief to the medication and develop low self-efficacy for tolerating anxiety without taking it.
- Fear of withdrawal, rather than craving for euphoria, is usually the central obstacle to starting and completing a taper.
- Iatrogenic origin creates an alliance problem, since patients often feel blamed for a dependence that a clinician initiated.
- Catastrophic interpretation of ordinary bodily sensations during taper drives dose reinstatement, and cognitive work reduces this risk.

DIFFERENTIAL & COMORBIDITY

- Differentiate from primary anxiety, panic, and insomnia disorders that were never adequately treated with first-line therapies.
- Rule out alcohol use disorder, which shares cross-tolerance with sedatives and requires simultaneous management during withdrawal.
- Comorbid opioid use disorder is common and raises fatal overdose risk, prompting the FDA boxed warning update issued in 2020.
- Screen for depression, PTSD, and personality pathology, all of which predict taper difficulty, dropout, and later reinstatement.
- In older adults evaluate falls, delirium, and driving safety, since benzodiazepines appear on the **Beers Criteria** avoid list.

Treatment

EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- Convert to a long-acting agent such as **diazepam** or **clonazepam**, then taper roughly 5% to 10% of the dose every 2 to 4 weeks.
- Slow the taper markedly near the end and let the patient help set the pace, since abrupt discontinuation risks seizures and delirium.
- **Flumazenil** is contraindicated in chronic users because reversal can precipitate refractory seizures in the overdose setting.
- Adjuncts with some support include **gabapentin**, **pregabalin**, and **melatonin** for taper-related insomnia and anxiety.
- Treat the underlying disorder concurrently with an **SSRI** or **SNRI**, allowing 4 to 8 weeks for the full therapeutic effect.

PSYCHOTHERAPY

- **CBT** delivered during the taper roughly doubles successful discontinuation compared with taper alone at 12-month follow-up.
- **CBT-I** should replace hypnotic medication as first-line insomnia treatment either before or alongside the taper itself.
- Interoceptive exposure and panic-focused **CBT** rebuild tolerance for the very sensations the medication had been suppressing.
- **Motivational interviewing** addresses ambivalence when a patient is satisfied with a medication the clinician wants discontinued.
- Personalized written taper letters from prescribers, as tested in the EMPOWER trial, produce discontinuation without therapy contact.

ADJUNCT & SUPPORTIVE

- Set a collaborative and flexible taper schedule in writing, since unilateral or forced tapers drive illicit acquisition and harm.
- Prescribe **naloxone** whenever opioids are co-prescribed, and consolidate prescribing to a single clinician and single pharmacy.
- Address sleep hygiene, exercise, and caffeine intake, and warn patients that rebound insomnia peaks in the first one to two weeks.
- Use **ASAM** criteria: inpatient withdrawal management is indicated for high doses, seizure history, or significant polysubstance use.
- Monitor with prescription drug monitoring programs, urine testing, and validated anxiety and sleep outcome measures over time.

CLINICAL PEARLS

- Sedative withdrawal, like alcohol withdrawal, can kill; never stop it abruptly.
- Flumazenil is contraindicated in chronic users; it precipitates seizures.
- Taper about 5% to 10% every 2 to 4 weeks and slow further near the end.

References

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NOTE

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