SOMATIC SYMPTOM AND RELATED DISORDERS

Psychological Factors Affecting Other Medical Conditions

PFAOMC

DSM-5-TR 316 | ICD-10-CM F54

A documented medical condition whose course, treatment, or risk profile is measurably worsened by psychological or behavioral factors.

PREVALENCE	TYPICAL ONSET	SETTING	IMPACT
Common; rarely coded	Any age; follows medical dx	C-L psychiatry, primary care	Worse adherence and outcomes

CLINICAL PICTURE

- A real, documented medical condition is present, and the psychological contribution is an aggravating factor rather than the origin of the symptoms.
- Typical examples include denial that delays presentation in myocardial infarction, anxiety that worsens asthma, and stress-triggered arrhythmia or Takotsubo syndrome.
- Behavioral pathways dominate in practice: missed dialysis sessions, insulin omission, unfilled prescriptions, continued smoking, and skipped oncology follow-up.
- This is the mirror image of somatic symptom disorder, where preoccupation is excessive; here the medical illness is objectively present and being made worse.
- The diagnosis earns its place by making the psychological contribution visible, billable, and communicable to the treating medical team.
- Severity ranges from mild, meaning increased risk, to extreme, meaning immediate life-threatening consequences such as refusing emergency treatment.

DIAGNOSTIC CRITERIA AT A GLANCE

- A medical symptom or condition other than a mental disorder is present, which is the mandatory anchor for the entire diagnosis.
- Psychological or behavioral factors adversely affect it in one of four ways, and only one pathway needs to be demonstrated for the diagnosis.
- Those pathways are influencing course, interfering with treatment, adding a well-established health risk, or precipitating symptoms through physiological mechanisms.
- The factors are not better explained by another mental disorder such as major depression, panic disorder, or PTSD, which are coded instead when criteria are met.
- Severity is specified as mild, moderate, severe, or extreme, and distress caused merely by having the illness is coded as adjustment disorder instead.

NEUROBIOLOGY & PHYSIOLOGY

- Sustained HPA axis activation with elevated cortisol impairs glycemic control, delays wound healing, and suppresses cell-mediated immune competence.
- Sympathetic overdrive raises blood pressure, heart rate, and platelet aggregation, providing the substrate for stress-precipitated acute coronary events.
- Catecholamine surge underlies Takotsubo cardiomyopathy, the clearest demonstration that acute emotional stress can produce reversible myocardial injury.
- Inflammatory signaling through IL-6, TNF-alpha, and CRP links chronic stress and depression to atherosclerosis, insulin resistance, and worse prognosis.
- Vagal withdrawal with reduced heart rate variability independently predicts cardiac mortality and tracks depression severity in post-infarction cohorts.
- Sleep disruption and cumulative allostatic load translate chronic psychosocial stress into measurable metabolic, cardiovascular, and immune dysregulation.

PSYCHOLOGICAL MECHANISMS

- Illness representations covering identity, timeline, cause, control, and consequences predict adherence and outcome better than objective disease severity.
- Low self-efficacy and an external health locus of control reduce self-management behaviors across diabetes, heart failure, and COPD populations.
- Denial can be adaptive in the acute phase but becomes lethal when it postpones emergency presentation or drives discontinuation of essential treatment.
- Type D personality, combining negative affectivity with social inhibition, is associated with poorer cardiac outcomes and lower rehabilitation uptake.
- Medical mistrust rooted in prior mistreatment, stigma, and discrimination is a psychological factor that clinicians frequently misread as noncompliance.

DIFFERENTIAL & COMORBIDITY

- Adjustment disorder covers emotional symptoms arising in response to the illness, whereas this diagnosis requires the psychology to be worsening the illness.
- When criteria for major depression, generalized anxiety, panic disorder, or PTSD are fully met, code that disorder rather than this residual category.
- Somatic symptom disorder and illness anxiety disorder involve disproportionate symptom preoccupation, not documented aggravation of verified disease.
- Substance use disorders, delirium, and cognitive impairment can each impair medical self-management and should be excluded before this code is applied.
- Depression, anxiety, and cognitive disorders commonly coexist with the target medical illness and independently worsen adherence and mortality.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- There is no pharmacotherapy for the code itself; treat the identified comorbid disorder with agents selected for the specific medical context.
- **Sertraline** has the strongest post-infarction safety data and, with escitalopram, carries the lowest interaction burden in medically complex patients.
- Check QTc before and during **citalopram** above 20 mg in older or cardiac patients, and avoid tricyclics after myocardial infarction.
- Screen CYP450 interactions with warfarin, tamoxifen, immunosuppressants, and antiretrovirals before adding any antidepressant to a complex regimen.
- Reduce starting doses in renal or hepatic impairment and titrate slowly, since side effects in this population reinforce nonadherence quickly.

PSYCHOTHERAPY

- **Motivational interviewing** is the highest-yield intervention for adherence, ambivalence, and health behavior change across chronic disease populations.
- **CBT** adapted for chronic illness targets catastrophic illness beliefs, activity avoidance, and sleep, and CBT-I addresses the insomnia that amplifies everything.
- **ACT** helps patients pursue valued activity alongside irreversible disease, and outperforms symptom-elimination framing in chronic pain and disability.
- Brief problem-solving therapy and stress management fit the short visit structure of medical clinics and can be delivered by embedded staff.
- Couples and family sessions matter when the partner controls diet, medication, or transport, which is common in heart failure and diabetes care.

ADJUNCT & SUPPORTIVE

- **Collaborative care** with an embedded behavioral health manager improves both mood and medical outcomes, as shown in the IMPACT and TEAMcare trials.
- Cardiac rehabilitation, pulmonary rehabilitation, and structured diabetes self-management education combine exercise, education, and behavior change.
- Monitor with the **PHQ-9** and **GAD-7** alongside disease-specific markers such as HbA1c, refill records, and pill counts to make change visible.
- Address social drivers directly, since medication cost, transport, food insecurity, and health literacy explain much of what is labeled nonadherence.
- Communicate the mechanism to the medical team in writing, naming the specific behavior and the specific outcome it is degrading.

CLINICAL PEARLS

- The medical illness is real; the psychology is what is making it worse.
- Distress about being ill is adjustment disorder. Behavior that worsens the illness is this code.
- Collaborative care improves the mood and the HbA1c; referral out usually improves neither.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Glassman, A. H., O'Connor, C. M., Califf, R. M., Swedberg, K., Schwartz, P., Bigger, J. T., Jr., Krishnan, K. R. R., van Zyl, L. T., Swenson, J. R., Finkel, M. S., Landau, C., Shapiro, P. A., Pepine, C. J., Mardekian, J., Harrison, W. M., Barton, D., & McIvor, M. (2002). Sertraline treatment of major depression in patients with acute MI or unstable angina. *JAMA, 288*(6), 701-709. https://doi.org/10.1001/jama.288.6.701

Katon, W. J., Lin, E. H. B., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., Peterson, D., Rutter, C. M., McGregor, M., & McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine, 363*(27), 2611-2620. https://doi.org/10.1056/NEJMoa1003955

Levenson, J. L. (Ed.). (2019). *The American Psychiatric Association Publishing textbook of psychosomatic medicine and consultation-liaison psychiatry* (3rd ed.). American Psychiatric Association Publishing.

National Institute for Health and Care Excellence. (2009). *Depression in adults with a chronic physical health problem: Recognition and management* (NICE Guideline CG91). https://www.nice.org.uk/guidance/cg91

National Institute of Mental Health. (n.d.). *Chronic illness and mental health: Recognizing and treating depression*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

NOTE

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