**An Introduction to Medically Unexplained Physical Symptoms (MUPS)**

**What are MUPS?**

Medically Unexplained Physical Symptoms (MUPS) is a broad umbrella category used to describe any constellation of symptoms or impairment that is not fully accounted for by medical evidence or an organic cause, such as disease or damage in the body. This broad category covers a variety of somatoform disorders and complaints that are frequently seen in the hospital setting, including conversion disorder, pain disorder, somatization disorder, and more generic somatic complaints not substantial enough to qualify for a clinical diagnosis. MUPS can include, but are not limited to, any of the following symptoms:

* Seizure-like events
* Paralysis of one or more limbs
* Inability to walk, speak, hear, taste, etc.
* Muscle spasms or weakness
* Chronic fatigue
* Loss of memory or cognitive abilities
* Chronic headaches
* Stomach pain
* Urinary retention or constipation

We conceptualize these symptoms as multifactorial, and avoid dichotomizing between “medical” or “psychological” as MUPS are equally both at any given time. MUPS essentially occur when the brain and body get in a pattern of communicating that is incorrect or ineffective. Neurons can begin misfiring and sending “wrong” messages of pain or dysfunction. This can occur after an illness or injury and can continue happening despite the illness or injury no longer being present. It can also occur as a result of conditioning in the body, sensitization to pain or sensations, underlying psychiatric symptoms, life stressors, or a disruption in routine and scheduling.

**How MUPS Patients Present in the Hospital:**

MUPS families tend to present in the hospital setting with significant fear, confusion, and worry about their child’s distressing physical symptoms. They are admitted to the hospital and their medical team may run a variety tests (often extensive and expensive!) which either come back negative or with minor abnormalities that do not fully explain the symptoms. When this happens doctors can feel at a loss as to do what to do next. Unfortunately, the most frequent scenario is that the medical team relays the following message to the family: “The tests are normal and reassuring and so we now know that it’s your child’s body’s way of dealing with stress or anxiety, and we’ll have our psych team come to talk to you about that”.

There are many problems with this, but we’ll discuss a few of the main ones here.

* **First**, we’ve learned that parents are not actually reassured when they hear that tests are “normal”. In fact, many of them tell us that it would be better if it were cancer or some other severe illness. Parents feel they are only being told what it *isn’t*, and not what it *is*, and are concerned that their child has a very serious illness that the doctors are missing or are not taking seriously.
* **Second**, parents do not like to feel that they are being handed off to “psych”. They have been invested in a medical diagnosis up to this point, and to hear that “it’s not medical” and that now the psych team will step in to help can be very upsetting. Parents can feel that providers are sending the message that “it’s all in my kid’s head” when this happens.
* **Third,** and perhaps most importantly, an explanation that focuses on stress, anxiety, or psychological problems may or may not be true for every patient. In fact, many patients presenting with MUPS do not have an underlying psychiatric concern. It may also be the case that any anxiety, stress, or depression present is in fact *caused by* the distressing physical symptoms rather than the other way around. Thus, a purely psychological explanation can be further frustrating and confusing for families when they do not identify with being stressed or anxious.

Because of these mishaps in communication and a general misunderstanding of MUPS, by the time the CL team sees these families they are often upset and defensive. They may not be in a good place emotionally to accept a diagnosis that is not purely medical, and are likely to be very guarded toward behavioral health. In this state, recommendations our team makes might not be considered and families can end up discharged home feeling that the hospital “got it wrong”. They are more likely than many other disorder types to return to the hospital, require patient relations interventions, seek out other doctors or diagnostic tests, and revisit medical clinics and emergency departments in the search for an acceptable answer.

**Effecting Changes in the Hospital for MUPS Care**

What we know about MUPS patients from research and experience highlights a dire need for hospitals to have a standardized approach to care that showcases a cohesive and holistic case conceptualization with good communication at every stage of care. While this is true for all patients, it is particularly true of those with MUPS—the wrong language can spoil a family’s investment in our treatment plan. We have to identify ways for all teams involved to use consistent language from the very beginning of the admission up until discharge planning.

In addition to improving our language and standardizing what is said across teams and team members, we need to work toward having a holistic treatment approach throughout the patient’s hospital stay. Most notably, we need to avoid the “hand off” from medical to psychiatric teams, because MUPS are not purely a psychological problem. Ideally, the primary team will introduce a holistic conceptualization from the beginning of admission, involve multidisciplinary teams for consults early on, stay involved in helping the family to understand and integrate all of the information they are receiving, and include multidisciplinary goals and recommendations in the discharge paperwork.

**How Can the Consult Team Support Changes**

The CL team is uniquely situated to provide excellent support in implementing quality improvement changes in the hospital. The following are suggestions for improving conceptualization and treatment of MUPS in the hospital setting.

* Hold in-services at resident conferences, team rounds, and grand rounds
* Provide teams with handouts and clear talking points to use with families and encourage them to use them as early as possible in the admission process (i.e., the MUPS diagram)
* Meet with teams for frequent “check ins” to support, reinforce, model, and role play how to have MUPS conversations with families
* Provide case based consultation: Make behavioral health team members available to go with medical teams to have difficult conversations with families, be willing to talk with team members often and discuss their thoughts and feelings about specific cases, help with problem solving, etc.
* Attend multidisciplinary rounds (like Rehab rounds on Tuesdays) to reinforce a good conceptualization of MUPS patients and advocate for quality care, answer questions, etc.
* Be available to meet with these patients frequently (daily) in order to support rapid functional improvement in the hospital setting.
* Facilitate disposition/discharge planning with the team. Follow-up with outpatient treatment providers who may not be as familiar with MUPS and support them in providing quality services to the patient and family upon discharge

**MUPS Treatment Plans Should Include:**