Living Well with Long-term Conditions and Chronic Pain

THE TALKING THERAPIES UK SELF-HELP SERIES



Living Well with Long-term Conditions and Chronic Pain

An eight-module programme for the psychological and behavioural dimensions of living with chronic pain, fatigue, and other long-term physical health conditions, covering the biopsychosocial model, pacing, cognitive patterns, acceptance and values-based action, mood and sleep, communication around invisible illness, and a personal flare-up plan

A self-help workbook · 8 modules · about 8 weeks

TALKING THERAPIES UK

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First edition, 2026.

This workbook accompanies the Living Well with Long-term Conditions and Chronic Pain programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 6. This printing was set on 15 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this workbook

Living with a long-term physical health condition is one of the more sustained challenges an adult life can present. Whether the condition is chronic pain that has not resolved with treatment, a long-term illness like multiple sclerosis or rheumatoid arthritis, a fatigue syndrome that has reshaped what is possible in a day, an inflammatory or autoimmune condition that flares unpredictably, or a metabolic or cardiovascular condition that requires ongoing management, the territory shares enough common psychological ground that a single programme can address most of it. The body has become unreliable in some specific way, the management is ongoing rather than time-limited, and the rest of life has had to reshape itself around that reality. This eight-module programme works with the dimensions of long-term illness that medicine alone does not always reach: the relationship between the mind and the body, the activity patterns that either calm or aggravate the condition, the cognitive patterns that amplify suffering beyond what the underlying condition produces, the acceptance work that allows a meaningful life to be built within the condition rather than waiting for the condition to be cured, the mood and sleep cycles that interact with the physical symptoms, the relational challenges of invisible illness, and the planning that keeps you steady through flares and setbacks. A non-negotiable framing first. The programme sits alongside the medical management of your underlying condition; it does not replace it, and it is not based on any premise that your physical symptoms are psychological or that you could think your way out of the underlying illness. Long-term conditions are physical realities. The psychological work is about the layer that grows up around the condition: the suffering that adds to the underlying difficulty, the patterns that amplify symptoms, the loss of meaningful activity that comes from withdrawing from life, and the relationship with the condition itself. The biopsychosocial model. The framework underpinning the programme is the biopsychosocial model of illness, which understands the experience of a long-term condition as the product of biological factors (the underlying disease process), psychological factors (cognition, emotion, behaviour, attention), and social factors (relationships, work, support, environment). Each layer influences the others; intervention at any layer can change the whole system. The programme works at the psychological and social layers, with the biological layer remaining the responsibility of your medical team. The cognitive patterns that amplify suffering. Across long-term conditions, certain cognitive patterns reliably make the experience worse: catastrophising about the meaning of symptoms (‘this means the disease is getting worse’), fear-avoidance beliefs that reduce activity below what the condition actually requires, all-or-nothing thinking that swings between pushing through and complete rest, and the comparison with a previous self that no longer exists. The cognitive modules teach you to identify these patterns and apply the same evidence-testing approach used elsewhere in CBT, calibrated specifically for chronic-illness cognition. Pacing and activity management. The single most evidence-supported behavioural intervention across long-term conditions is pacing: the disciplined matching of activity to capacity, with deliberate alternation between activity and rest based on a planned schedule rather than on how you feel in the moment. Pacing is counterintuitive (it often involves doing less on good days and more on bad days than you would naturally choose), and learning to pace properly is a skill that takes time to develop. The programme dedicates substantial time to pacing, including the specific protocols developed for chronic pain, fatigue

syndromes, and inflammatory conditions. Acceptance and meaningful action. Some aspects of a long-term condition cannot be changed and trying to change them produces only frustration and exhaustion. Acceptance and Commitment Therapy (ACT), particularly in the form developed by Lance McCracken and colleagues for chronic pain, teaches a different relationship with the unchangeable parts: not resignation, but a willingness to carry the difficulty alongside meaningful action towards what matters. The acceptance modules are not about pretending the condition is not difficult; they are about building a life that has room for both the condition and the things that give life meaning. The mood, sleep, and symptom triangle. Long-term conditions interact with mood and sleep in characteristic ways: poor sleep amplifies pain and fatigue, low mood amplifies symptom focus, anxiety amplifies the threat-reading of bodily sensation, and the resulting symptom amplification damages mood and sleep further. The programme works explicitly with this triangle, applying the relevant CBT-I and CBT-D techniques calibrated for the specific challenge of doing this work alongside an active physical condition. Invisible illness and the social challenge. Many long-term conditions are largely invisible from the outside: people who do not have your condition cannot see the fatigue, the pain, or the cognitive symptoms, and tend to underestimate them or misattribute them. The relational modules work with the specific challenges of invisible illness, including the conversations that have to happen with family, friends, employers, and clinicians. Flares and setback planning. Long-term conditions typically have a flare-and-recovery pattern, and one of the most useful pieces of work is the setback plan: knowing in advance what your specific flare looks like, what works for you at each stage of a flare, what does not work despite the temptation to do it, and how to recover the trajectory after the flare resolves. Who this is for and what it is not. The programme is suitable for adults living with a diagnosed long-term physical condition who are receiving appropriate medical management and who want psychological work alongside that care. It is grounded in the cognitive-behavioural model of chronic pain (Turk, Gatchel, Williams), acceptance and commitment therapy adapted for chronic pain (McCracken), the Stanford Chronic Disease Self-Management Programme (Lorig and colleagues), and the NICE clinical guideline on chronic pain (NG193). It is suitable for self-directed work at NHS Talking Therapies Step 2 equivalent. It is not a substitute for specialist pain management services or condition-specific psychological services where these are indicated. If your physical condition has not been adequately diagnosed and managed, that is the priority rather than this programme. If you are in crisis, please contact Samaritans on 116 123, text SHOUT to 85258, or NHS 111 option 2.

This workbook is the written form of the Living Well with Long-term Conditions and Chronic Pain programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module’s teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you

reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- By the end of this module you will:
- Understand the biopsychosocial model of long-term illness and why every long-term condition has psychological and behavioural dimensions alongside its physical ones
- Recognise the important distinction between pain and suffering, and between the disease process and the wider life impact of living with it
- Know what self-management means in the context of medical care, and why the two work better together than separately
- Have set three concrete goals for what you want this programme to change
- Understand the difference between acute and chronic pain at the level of the underlying physiology
- Know what central sensitisation is and how it explains why chronic pain often outlasts the original injury
- Recognise the role of the brain in producing the pain experience, without this being the same as saying the pain is not real
- Understand why some interventions that work for acute pain do not work for chronic pain, and what the implications are for self-management
- Recognise the boom-bust pattern in your own activity and symptom history

PART 1

Understanding Long-term Conditions and Chronic Pain

The biopsychosocial model, the difference between pain and suffering, and what self-management actually means alongside medical care

CHAPTER 1

Welcome to the programme

This is an eight-module programme for the psychological and behavioural dimensions of living with a long-term physical health condition. The programme is designed to be useful across a wide range of conditions: chronic pain (back pain that has not resolved, headaches that have become persistent, joint pain that has outlasted its expected healing time), fatigue syndromes (chronic fatigue syndrome and ME, post-viral fatigue), autoimmune and inflammatory conditions (rheumatoid arthritis, lupus, inflammatory bowel disease, multiple sclerosis, psoriasis, fibromyalgia), and the metabolic and cardiovascular conditions that require sustained self-management (type 1 and 2 diabetes, COPD, heart failure, hypertension). The programme cannot replace the medical care that any of these conditions requires; what it does is work on the dimensions of living with the condition that medicine alone does not always reach, and that often determine how much suffering a given condition produces in a given life.

The starting premise of the programme is that there are two related but distinct kinds of difficulty in any long-term condition. The first is the underlying disease process: the inflammation, the nerve signal, the tissue damage, the metabolic dysregulation. This is what your medical team manages with medication, procedures, and the wider clinical care. The second is the psychological and behavioural envelope around the disease process: how you think about it, how you respond to it, what you do with the energy you have, how you communicate about it with the people around you, what you grieve and what you accept, what you continue to invest in despite it, and how steady you stay through flares and setbacks. The two interact constantly. The disease process shapes the envelope, and the envelope shapes how the disease process is experienced. Programmes like this one are about the envelope, on the principle that even where the disease process cannot be cured, the envelope can be substantially improved, and the improvement in the envelope often changes the felt experience of the disease itself.

The clinical literature is clear that this kind of work makes a real difference. Across multiple randomised controlled trials and systematic reviews, structured psychological and behavioural programmes for long-term conditions produce measurable improvements in symptom levels, in

functional capacity, in mood, and in quality of life, and the magnitude of the improvement is often comparable to the magnitude produced by medical interventions. The most consistent finding across this literature is that the people who engage seriously with self-management work, in addition to their medical care, do better in almost every measurable way than the people who rely on medical care alone.

This first module sets out the framework: the biopsychosocial model, the distinction between pain and suffering, and what self-management is and is not. Modules two through seven build the working content. Module two covers the body and the pain system, with particular attention to why chronic pain often does not behave like the acute pain most people are familiar with. Module three covers pacing and the boom-bust cycle, which is the single most useful behavioural skill in long-term conditions and is often the part where the largest early gains come from. Module four covers cognitive strategies. Module five covers acceptance and values-based action. Module six covers the mood and sleep cycles that interact with the physical symptoms. Module seven covers communication around invisible illness. Module eight closes by helping you build a personal flare-up plan and recognises when stepping up to specialist support is the right move.

A note on what this programme is and is not. It is a self-management programme for long-term conditions that are medically under assessment and care. It is not a substitute for medical investigation of new or undiagnosed symptoms, for the medical management of your underlying condition, or for specialist care of severe presentations. If you have unexplained symptoms that have not yet been assessed by a doctor, the right first step is your GP, not a self-help programme. If your condition is currently unstable, in active flare, or causing significant distress at the level of daily functioning, the programme can still be useful but should sit alongside specialist care rather than instead of it.

CHAPTER 2

The biopsychosocial model of illness

The biopsychosocial model was articulated in 1977 by the American psychiatrist George Engel as a deliberate alternative to the biomedical model that had dominated clinical thinking for most of the twentieth century. The biomedical model treats illness as a disturbance in the physical body, to be diagnosed and treated through physical interventions, with the patient's psychology and social context relegated to the side. The model worked well for acute medical conditions (the broken bone, the bacterial infection) but performed poorly for chronic conditions, where the same underlying disease produced very different outcomes in different people, and where treatment focused exclusively on the physical level often produced disappointing results.

Engel's biopsychosocial model holds that illness is shaped by three interacting layers: the biological layer (genetics, physiology, tissue, organ systems, biochemistry), the psychological layer (thoughts, emotions, beliefs, coping styles, attention, mood), and the social layer (relationships, work, family roles, support, environment, the wider context the person is embedded in). The three layers are not separate domains; they continually shape each other. A pain signal is a biological event, but its felt intensity is shaped by what the person thinks the pain means, by their mood, by whether they are alone or with someone, by whether they have slept, and by whether the workplace context permits accommodations or punishes weakness. The social context of relentless work pressure shapes the psychological state of stress, which shapes the biological levels of cortisol, which shape the inflammatory processes that may underlie a flare of an autoimmune condition. The arrows go in every direction.

The biopsychosocial model matters for two practical reasons. The first is that it provides the rationale for psychological and behavioural interventions in physical conditions: not because the condition is all in your head (which is what people sometimes hear when they are referred to a psychologist for chronic pain), but because the condition has psychological and behavioural dimensions in addition to its physical ones, and intervening at the psychological and behavioural level produces real improvements in the condition itself. The second is that it gives the patient room to operate. In the biomedical model, the patient is largely passive, waiting for medical interventions to fix the problem. In the biopsychosocial model, the patient has a substantial active role: how they think about the illness, what they do with their available capacity, how they respond to flares, how they communicate with their support system, and what they invest in alongside the illness all measurably affect the trajectory.

A NOTE

Psychological and behavioural dimensions are not optional add-ons to a real medical condition. They are part of the condition itself, and the evidence is consistent that addressing them produces measurable improvements in symptom levels and quality of life. Working on the envelope is not a sign that you are failing to be properly medical about your illness; it is a sign that you are taking the condition as seriously as it deserves.

CHAPTER 3

Pain and suffering: an important distinction

One of the most useful conceptual distinctions in the chronic-pain and long-term-condition literature is between pain and suffering, and between the analogous symptom and the wider life impact of the symptom. The distinction is associated with the work of Eric Cassell, the American physician whose 1982 paper The Nature of Suffering and the Goals of Medicine made the case that medicine had been over-focused on the underlying physical signal and under-focused on the wider experience of being unwell, and the distinction has since become foundational in chronic-pain work.

Pain (or any symptom) is the bodily signal: the nerve firing, the inflammatory response, the fatigue, the breathlessness, the joint stiffness. The pain is real, it has a physical basis, and to varying degrees it is responsive to medical management. Suffering, by contrast, is the wider human experience of living with the pain: the meaning the person attaches to it, the limitations it imposes, the felt sense that life has been narrowed by it, the grief over what is no longer possible, the fear of what might come next, the social isolation that often accompanies it, the identity changes that follow from living differently. Two people with similar levels of underlying pain can have very different levels of suffering, and the difference is in the envelope around the pain rather than in the pain itself.

The clinical importance of the distinction is that the medical management of the underlying pain is often partial. Chronic pain frequently does not respond to medication the way acute pain does. Long-term conditions often have a residual symptom burden that medical management cannot fully eliminate. The disease process is what it is, and what medicine can do for it has limits. The suffering, however, is often meaningfully responsive to psychological and behavioural intervention, and a common aim of work like this programme is to reduce disability and distress associated with symptoms. People often find that the same underlying pain is much more bearable when the suffering around it has been reduced, and reductions in distress and threat can improve perceived pain and day-to-day function, even when the underlying symptom intensity changes only modestly.

This is not the same as saying that the pain is not real or that it can be willed away. The pain is real, the disease is real, the symptoms are real. What is being said is that the experience of pain is shaped by more than the pain signal alone, and the parts of the experience that are not the pain signal are responsive to work, even when the pain signal is not.

A second related distinction. Acute pain is the body's signal that something is wrong and needs attention; it serves a useful protective function, and the appropriate response is to attend to it, rest, and let healing happen. Chronic pain is pain that has outlasted the period of useful protective function and has become its own condition, which may involve changes in the nervous system and can be maintained by multiple factors. In many people, ongoing tissue pathology and nociception may still contribute, but the protective response is no longer the sole driver and needs a different overall approach. The two require different responses. The protective behaviours that are appropriate for acute pain (rest, avoidance of activity, vigilant attention to the pain) are often counterproductive for chronic pain, where they can contribute to deconditioning, increased pain

sensitivity, and worsening function. Module 2 covers the physiology of this in more detail, but the practical point lands here: if you are responding to chronic pain with the strategies that worked for acute pain, the strategies are part of why the chronic pain is not improving.

A NOTE

A useful question. Of the difficulty you are presently experiencing with your condition, how much is the underlying pain or symptom, and how much is the suffering around it (the meaning, the fear, the limitation, the grief, the loss of identity, the isolation)? Honest answers to this question are often surprising and tend to point at where the most gains are available.

Three adults living with different chronic conditions, each asked the pain-versus-suffering question by their practitioner at the start of this programme. The answers illustrate how the pattern presents in different conditions and where the gains are usually available.

Margaret, sixty-two, ME/CFS for fourteen years. She thinks about the question carefully. Her honest answer: the underlying fatigue is perhaps thirty per cent of her difficulty. The suffering around it is the other seventy per cent. The suffering includes the loss of the active life she had built before the illness, the embarrassment of explaining the condition to people who do not believe it is real, the financial pressure of having had to reduce her work, the slow erosion of friendships with people who do not understand why she cannot do what she used to do, the grief about not being the kind of grandmother she had imagined being, the anger at the years that have been organised around the illness, and the loneliness of being substantially housebound for stretches. She had not made this distinction explicitly before. She notices, with some surprise, that the seventy per cent is the part that might be most amenable to the work of this programme. The thirty per cent that is the fatigue itself she will continue to manage with her existing pacing strategies. The seventy per cent that is the suffering she had been treating as inseparable from the fatigue is in fact a separate domain that has its own interventions.

David, fifty-five, chronic lower back pain for nine years. He hesitates over the question. He has been told by previous practitioners that he is catastrophising and he is wary of any framework that might minimise his physical pain. The practitioner clarifies that the question is not about whether the pain is real (it is) or whether the pain matters (it does) but about the distinction between the sensation and the layers of meaning and limitation around it. David tries again. His honest answer: the sensation itself is perhaps forty per cent of his difficulty. The other sixty per cent is the fear of further injury, the avoidance of activities that he has been told are bad for his back but which he is not sure actually are, the impact on his marriage from his sustained low mood, the loss of his previous identity as a competent active man, the constant low-level worry about the future, and the irritation with himself for being unable to manage. He notices that the sixty per cent has been growing relative to the forty per cent over the years; the physical pain has been roughly stable but the suffering around it has been increasing as the limitations have accumulated.

Aisha, thirty-eight, Crohn's disease for six years. Her answer is different in shape. The physical symptoms come and go with flares and remissions; in a flare, the physical experience is perhaps eighty per cent of the difficulty and the suffering around it twenty per cent. In a quiescent period, the proportions reverse: the suffering (the constant vigilance about whether a flare is starting, the planning of every outing around toilet access, the embarrassment of having to explain absences

at work, the impact on her relationship with her young children who do not fully understand why mummy is sometimes too tired to play) becomes the dominant part. The condition itself is variable in a way that the others are not; her honest answer is that the work of this programme will be more useful in the quiescent periods, where the suffering layer is dominant, than in the acute flares where the physical management is the priority.

What the three answers share. All three have a significant suffering component that they had not been explicitly working with. All three have been responding to the suffering as if it were the same thing as the symptom, which means the strategies that work for symptoms have been being applied to suffering and have not been working. The suffering layer is what the psychological, behavioural, and relational work of this programme is designed to address. The symptom layer remains the work of the medical team and of the person's existing self-management strategies.

What the answers do not mean. The suffering layer is not in any sense less real than the symptom layer. Suffering is not weakness; it is the lived experience of the meaning and limitation that the condition has produced. The work on the suffering layer is not about positive thinking or about minimising the condition. It is about applying psychological skills to a domain that is amenable to them, in the same way the medical team applies medical skills to the domain that is amenable to those. The two layers need different interventions; the gains from intervening in the right layer are substantial.

WORKSHEET

Sort each feature into the biopsychosocial layer it belongs to

Before setting your three concrete goals for the programme, sort twelve features of life with a long-term condition by which of Engel's three layers each one represents. Engel's biopsychosocial model is the central conceptual framework of M1 because it provides the rationale for psychological and behavioural interventions in physical conditions. The illness is shaped by the three layers continuously, with arrows running in every direction between them, and recognising which layer a given feature belongs to is what allows the work to be directed at the layer where the most gain is available rather than concentrated at only the biological layer where medical management has its limits.

Biological is the physical-body layer: genetics, physiology, tissue, organ systems, biochemistry, the disease process itself, inflammation, the pain signal at the nerve level. Psychological is the inner-experience layer: thoughts, beliefs, emotions, coping styles, attention, mood, the meaning the person attaches to the symptom, the felt experience of the condition. Social is the wider-context layer: relationships, work, family roles, support networks, environment, the workplace context, the cultural attitudes that shape what is and is not accommodated.

The groups: A Biological layer B Psychological layer C Social layer

Write the letter of the group each item belongs to in its box.

☐ 1. The inflammatory process in the joints that produces the underlying pain signal and the morning stiffness that most directly responds to the disease-modifying medication my rheumatologist has prescribed

☐ 2. The belief that any movement that produces pain must be damaging my body, which has built up across the past two years and which has been driving the avoidance pattern I have noticed

- [ ] 3. The workplace culture at my office where presenteeism is unspoken policy, where taking proper sick days is treated as weakness, and where the accommodations I would benefit from feel difficult to request
- [ ] 4. The autoimmune process producing the fatigue and the inflammatory markers that show up in my blood work, the physiological substrate of the condition that the medical team monitors directly
- [ ] 5. The persistent low mood that has been with me across the past several months alongside the physical symptoms, with the felt sense that the future is going to be harder than the present
- [ ] 6. The partnership where my husband has taken on more of the household across the past year, the practical redistribution of load that is one of the more common consequences of chronic illness
- [ ] 7. The peripheral and central sensitisation processes in my pain pathways that have developed across years of sustained activation, the neuroplastic changes that Module 2 covers in detail
- [ ] 8. The catastrophic interpretations that fire when I notice a new symptom, the cognitive amplification that turns a small concern into a much larger imagined scenario across the next few hours
- [ ] 9. The two friendships that have quietly faded across the past two years as the condition has reshaped what I can offer socially, and the new connections with other people who have long-term conditions that have formed in their place
- [ ] 10. The medication I take three times a day, the dosing schedule worked out with my consultant, and the side effects that the team is helping me work through
- [ ] 11. The shame that arrives when I have to decline a social invitation for the third time in a row, the felt-quality of internal judgement that is independent of how the person actually responded
- [ ] 12. The Equality Act protections that apply to my condition as a protected disability and the reasonable-adjustments duty that my employer has under the law, which I have not yet fully explored

The answers are at the back of the book.

WORKSHEET

Set three goals for the programme

Take fifteen minutes to set three concrete goals for what you want this programme to change. Goals work better when they are specific to your life with the condition, achievable within an eight-module timeframe, and within your influence. Vague goals (“feel better”) are harder to measure than specific ones (“go for a fifteen-minute walk three times a week without triggering a flare”, “have one honest conversation with my partner about the limitations my condition is putting on us”, “return to one activity I used to do that I have stopped doing because of the pain”).

Set three goals. The good ones are specific, observable, time-bounded, and within your influence. They do not have to be ambitious; small concrete goals that you actually achieve build momentum better than large abstract ones that drift, particularly when capacity is fluctuating.

Goal 1

How I will know I am making progress on Goal 1

Goal 2

How I will know I am making progress on Goal 2

Goal 3

How I will know I am making progress on Goal 3

CHAPTER 4

Closing Module 1

You have a working framework for thinking about your condition (the biopsychosocial model), an important distinction (pain versus suffering, the symptom versus the suffering around the symptom), and three concrete goals for what this programme should change.

Looking ahead

Module 2 covers the body and the pain system. Chronic pain in particular often behaves differently from the acute pain most people are familiar with, and understanding the physiology behind chronic pain (peripheral and central sensitisation, neuroplasticity, the role of the brain in producing the pain experience) is foundational for the rest of the work. The same physiological framework largely applies to chronic fatigue and to the symptom experience of inflammatory and autoimmune conditions, although the specific mechanisms differ.

Practice for the week ahead

Between now and Module 2, notice without judgement what your day looks like in terms of activity, rest, pain or symptom levels, mood, and sleep. The aim is observation, not problem-solving. The data you collect will inform the work in the next module and especially in Module 3 on pacing.

CHECK-IN

Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3

8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total: _____ Date: _____

Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.

If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.

The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.

CHECK-IN

Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.

CHECK-IN

General wellbeing check-in (CORE-10)

And a short general wellbeing questionnaire, which captures overall distress in a way that suits this programme's territory particularly well.

This check-in uses the CORE-10 (Clinical Outcomes in Routine Evaluation). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.

WORKSHEET

Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.

PART 2

The Body and the Pain System

Why chronic pain is different from acute pain, the role of central sensitisation, and what this means for treatment and self-management

CHAPTER 5

Why pain physiology matters in self-management

Most people's working understanding of pain is built on their experience of acute pain: a cut, a sprain, a broken bone, the post-operative period, a bad headache. Acute pain is the body's signal that something is wrong and needs attention. The mechanism is well-understood: tissue damage activates pain receptors in the affected area, signals travel up the spinal cord to the brain, the brain registers the pain, and as the tissue heals the signal reduces and the pain fades. The system works beautifully and serves an important protective function. Acute pain is also straightforwardly responsive to medical management: anti-inflammatories reduce inflammation, opioids dampen the signal at receptor level, immobilisation protects the healing tissue, and the underlying problem usually resolves on its own timeline.

Chronic pain is a different phenomenon. It is pain that has outlasted the period of useful protective function, that often does not correspond cleanly to ongoing tissue damage in the way acute pain does, and that frequently does not respond to the same interventions that work for acute pain. The contemporary pain neuroscience literature has substantially revised the older view that chronic pain is acute pain that has not gone away; the more accurate view is that chronic pain is the pain system itself becoming a condition, with mechanisms that are partly distinct from the original injury or insult that started the process.

The distinction matters because it changes what self-management is for. If chronic pain is acute pain that has not gone away, the appropriate response is to keep treating it like acute pain (rest, avoidance of activity, increasing medication, waiting for the underlying problem to resolve) and to wait for the underlying tissue damage to be identified and fixed. If chronic pain is the pain system itself becoming a condition, the appropriate response is different: gradual reactivation, attention to the broader factors that are amplifying the signal (mood, sleep, stress, central nervous system reactivity), and acceptance that complete resolution may not be the realistic goal. Most chronic-pain self-management is built on the second view, which is consistent with the contemporary research and which produces measurably better outcomes than the first view.

This module covers the basic physiology in plain language. The same broad framework applies, with adjustments, to chronic fatigue, to the symptom experience of inflammatory and autoimmune

conditions, and to the interaction between mood and physical symptoms across long-term conditions more generally. Understanding the physiology is foundational for the pacing work in Module 3 and the cognitive and acceptance work in Modules 4 and 5.

CHAPTER 6

Peripheral and central sensitisation

The pain system has two main components: the peripheral component (the nerve fibres and receptors in the affected tissue, and the spinal cord pathways that carry the signal up to the brain) and the central component (the brain itself, which receives the signal, interprets it, and produces the conscious experience of pain). Both components can change over time in response to sustained activation, and the changes are part of what produces chronic pain.

Peripheral sensitisation is when the pain receptors and nerve fibres in the affected area become more easily activated. The threshold at which a stimulus produces a pain signal drops, and the intensity of the signal for a given stimulus rises. The mechanism is well-understood at the cellular level: sustained activation of pain pathways changes the chemistry at the nerve endings, recruits additional receptors to the cell membrane, and makes the system more reactive. Practically, peripheral sensitisation means that an activity that did not produce pain three months ago now produces pain, and a movement that produced mild pain six months ago now produces severe pain. The tissue itself has not changed substantially; the sensitivity of the local pain pathways has increased.

Central sensitisation is the analogous process in the central nervous system. When pain signals have been arriving at the spinal cord and brain for a sustained period, the central pathways themselves become more reactive. The amplification gain on the system is turned up. Signals that would previously have been registered as innocuous (a light touch, a mild pressure, a movement that should be neutral) start to be registered as painful. The phenomenon is called allodynia: pain in response to a stimulus that should not be painful. A related phenomenon is hyperalgesia: increased pain in response to a stimulus that is genuinely painful but should not be as painful as it is felt to be. Both are markers of central sensitisation.

A useful analogy is the sensitivity setting on a smoke alarm. A smoke alarm at a moderate sensitivity setting will fire when there is actual smoke. The same alarm at a maximum sensitivity setting will fire when there is steam from a kettle, dust, or even just temperature changes. The alarm is doing the same thing in both cases (detecting potential threats to fire safety), but the threshold has changed, and the change is not in the kitchen but in the alarm. Central sensitisation is the pain system's threshold being turned up, often as a result of sustained activation, and the consequence is that the system is producing pain in response to stimuli that would not previously have produced pain.

A NOTE

Central sensitisation does not mean the pain is imaginary. The pain is real and the underlying neural activity is measurable. What it does mean is that the relationship between the underlying tissue and the pain experience has become looser than it was in the acute phase, and that the standard interventions for acute pain (which target the tissue) often do not work because the problem is not primarily in the tissue any more.

A practical implication. If chronic pain is partly a sensitisation phenomenon, the appropriate response includes things that turn the sensitivity down rather than just things that target the tissue. Sleep, stress reduction, mood management, gradual reconditioning, and the cognitive and acceptance work in later modules are not soft interventions added on top of real medicine; they are interventions that target the actual mechanism that is producing the persistent pain. This is one of the more important conceptual reframes in the chronic-pain literature, and it changes what self-management work is doing.

The end of the sample

This is a free sample of “Living Well with Long-term Conditions and Chronic Pain”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

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