Living Well with Long-term Conditions and Chronic Pain: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Living Well with Long-term Conditions and Chronic Pain: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

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

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 5. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

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How to use this guide

This guide is for qualified practitioners who support clients through the Living Well with Long-term Conditions and Chronic Pain programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: the biopsychosocial model, the distinction between pain and suffering, what is known about chronic pain, how the eight modules are built, and the practitioner's part
- Chapter 2, What the research shows: how common mental health problems are alongside long-term conditions, the risk of suicide in chronic pain, the evidence for psychological therapies, acceptance and commitment therapy, self-management and pacing, and the national guidance

CHAPTER 1

The model behind the programme

A programme that sits beside medical care

The programme's description begins with what it calls a non-negotiable framing, and the practitioner should hold to it in every contact. The programme sits alongside the medical management of the client's condition and does not replace it, and it is not based on any premise that the client's physical symptoms are psychological. Many clients with chronic pain or fatigue have been told, or have heard, that their condition is "all in the head", and some will come to the first contact expecting to be told so again. The work is on the layer that grows up around a real condition: the suffering that adds to it, the patterns that amplify symptoms, the life that has narrowed, and the relationship with the condition itself.

The biopsychosocial model

Module 1 teaches the biopsychosocial model, which Engel (1977) proposed as an alternative to a purely biomedical account of illness. The experience of a long-term condition is shaped by three layers that influence each other continuously: the biological (the disease process, inflammation, the pain pathways, medication), the psychological (beliefs, emotions, attention, coping, mood) and the social (relationships, work, family roles, support, the law and the workplace). In chronic pain the model is now the most widely accepted framework for understanding and treating the

condition (Gatchel et al., 2007). Its practical value for the practitioner is twofold. It explains why psychological work helps a physical condition without implying that the condition is psychological, and it gives the client back an active part, since how they think about the condition, what they do with their capacity and how they talk about it to others all affect how it goes.

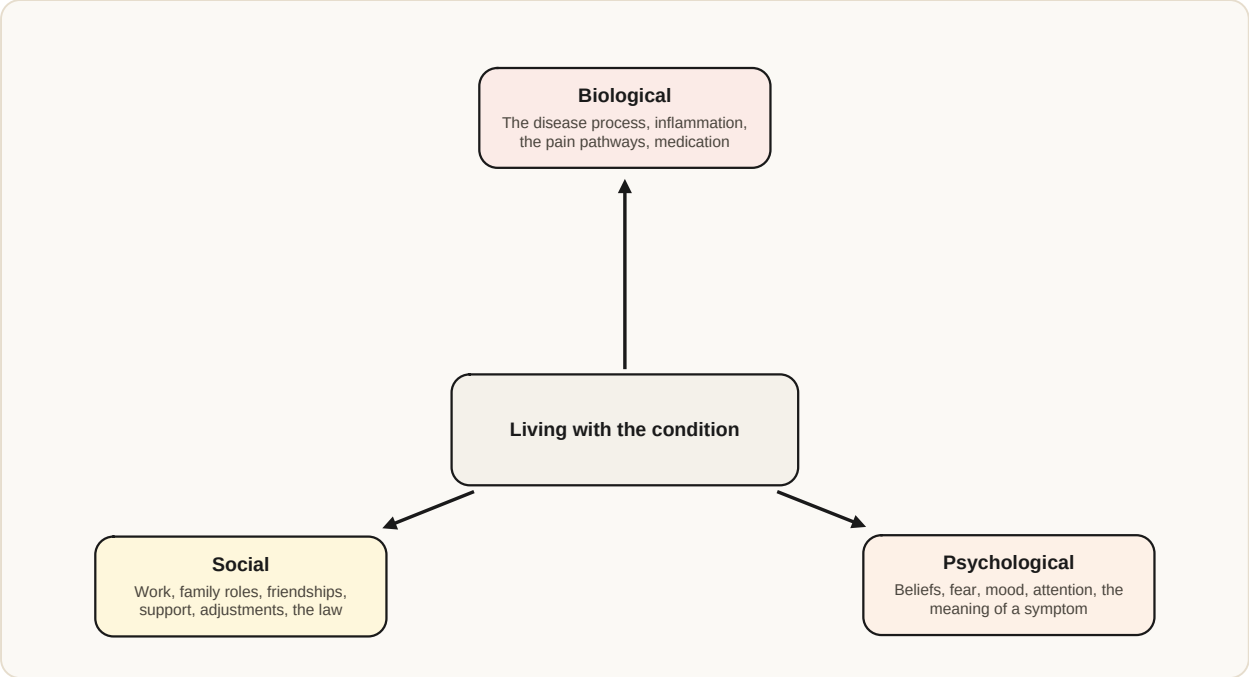


FIGURE 1.1 Three layers of a long-term condition
Module 1 teaches the biopsychosocial model: the experience of a long-term condition is shaped by biological, psychological and social layers that influence each other continuously. The medical team works on the first; the programme works on the second and third, alongside medical care and never instead of it.

Pain and suffering

The second idea of module 1 is the distinction between the symptom and the suffering around it, which the programme traces to Cassell (1982). Cassell argued that suffering is experienced by persons rather than merely by bodies, that it can include physical pain but is not limited to it, and that relieving suffering and curing disease are twin obligations of medicine. The programme asks each client an honest question: of the difficulty they are living with, how much is the symptom itself and how much the fear, grief, limitation, isolation and loss of identity around it? Its three illustrations (Margaret, who has had ME/CFS for fourteen years; David, who has had low back pain for nine; and Aisha, who has Crohn's disease) answer it differently, and all three find a large layer of suffering they had been treating as part of the symptom.

The module states this carefully, and the practitioner should keep to its wording. The suffering is described as often meaningfully responsive to psychological and behavioural work, whose common aim is to reduce the disability and distress associated with symptoms; reductions in distress and threat can improve perceived pain and day-to-day function even when the underlying symptom changes only modestly. Chronic pain is described as pain that has outlasted its protective function and may involve changes in the nervous system, while ongoing tissue changes and pain signals from the body may still contribute in many people. That is the accurate position, and it matters: the practitioner never tells a client that their pain has no physical cause.

What is known about chronic pain

Module 2 explains the physiology in plain language. Sustained activation can make the nerve endings at the site of pain more easily triggered (peripheral sensitisation) and can increase the responsiveness of the spinal cord and brain (central sensitisation), so that a light touch can hurt (allodynia) and a painful stimulus can hurt more than it should (hyperalgesia). Woolf (2011) describes central sensitisation as an amplification of neural signalling within the central nervous system that produces pain hypersensitivity, and as a contributor to pain in a range of conditions, including the inflammatory arthritides. The module adds the role of the brain in producing the experience of pain from all the information available to it, including beliefs, expectations, mood, sleep and context. Teaching people about the biology of their pain in this way has a substantial research literature behind it, reviewed by Moseley and Butler (2015).

How the programme works

The programme draws on cognitive behavioural approaches to chronic pain, on acceptance and commitment therapy as McCracken and colleagues adapted it for chronic pain (McCracken and Vowles, 2014), on the self-management tradition of the Stanford programme (Lorig et al., 1999), and on NICE's guideline on chronic pain. Module 1 sets out the framework and asks for three goals. Module 2 covers the pain system, module 3 pacing and the boom-bust cycle, and module 4 the thinking patterns most active in chronic illness, with a thought record. Module 5 turns to acceptance and values-based action, module 6 to the cycle of mood, sleep and symptoms, and module 7 to the relational work of invisible illness, including the spoons model and asking for adjustments at work. Module 8 builds a flare-up plan and sets out when to step up.

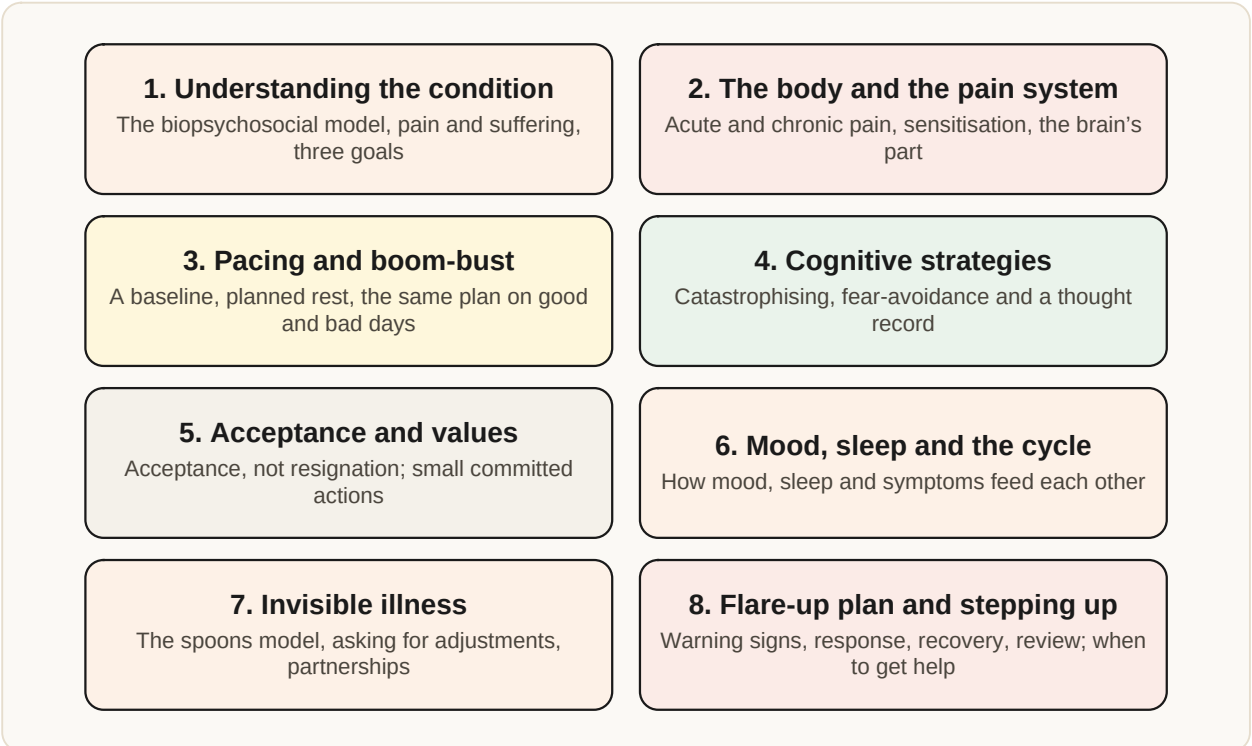


FIGURE 1.2 The eight modules and what each works on
The programme moves from understanding to skills to a plan: a framework for the condition and the pain system first, then pacing, thinking, acceptance and values, the cycles of mood and sleep, the relationships around the condition, and finally a flare-up plan with clear points for stepping up.

How the modules are built

Each module has an introduction, two or three teaching sections, a sorting exercise, a practical worksheet, a closing summary and the reflection “Taking this forward”. The sorting exercises carry much of the teaching, and their answers and reasons print in this guide. The check-ins come in modules 1, 4 and 8: the PHQ-9, the Work and Social Adjustment Scale and the CORE-10 in module 1, and the PHQ-9, GAD-7, WSAS and CORE-10 in modules 4 and 8. Take the GAD-7 at assessment too. The CORE-10 is a ten-item measure of general psychological distress for routine use in the psychological therapies (Barkham et al., 2013), and it includes an item about making plans to end one’s life, which Chapter 9 explains how to act on. Read the PHQ-9 with care in this population: its items on sleep, energy, appetite and concentration can be raised by the condition itself, so look at the items about mood, interest and self-worth, and at the client’s own account, before drawing conclusions from the total. The worked examples in this guide follow one composite client, Fiona, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner’s part has three particular demands here. The first is to keep medical care at the centre: to ask at every contact whether anything new or changed has been reported to the medical team, to know the symptoms that need the same day rather than the next contact, and never to judge the cause of a symptom. The second is to keep the balance between change and acceptance. Pacing, the thought record and graded return to avoided activity are about change; module 5 is about making room for what cannot be changed. Clients swing between pushing to restore their old life and giving up on it, and the most useful question is often which of the two this situation needs. The third is to adapt the programme to the condition. A client with an inflammatory condition needs to know the medical team’s signs of a flare; a client with ME/CFS needs pacing within their energy limits, as national guidance advises, rather than planned increases; a client with a progressive condition may have realistic fears that are not distortions at all. Chapter 5 shows how a thirty-minute contact can keep its attention on all three.

CHAPTER 2

What the research shows

The scale of the problem

Long-term physical conditions and mental health problems travel together. A report by the King's Fund and the Centre for Mental Health estimated that at least 30 per cent of people with a long-term physical condition in England also have a mental health problem, about 4.6 million people, and that co-morbid mental health problems raise the total health care costs of each person with a long-term condition by at least 45 per cent (Naylor et al., 2012). For the practitioner, this means that a client who has come for help with living with their condition will often also have depression or anxiety that deserves to be assessed and treated in its own right.

Chronic pain and the risk of suicide

Chronic pain carries a raised risk of suicide. In a review of the evidence, the risk of death by suicide appeared to be at least doubled in people with chronic pain compared with controls, the lifetime prevalence of suicide attempts was between 5 and 14 per cent, and about one in five reported suicidal ideation; among the risk factors were the type, intensity and duration of pain, sleep-onset insomnia alongside pain, helplessness and hopelessness about pain, the wish to escape from it, and pain catastrophising (Tang and Crane, 2006). Several of these are exactly what the programme works on, which is one reason it helps. It is also why the risk questions at every contact are not a formality in this programme, and why a passive wish not to wake up, which clients in severe pain sometimes describe, needs the full questions and not reassurance.

Psychological therapies for chronic pain

The evidence for psychological therapies in chronic pain is real but more modest than clients are sometimes led to expect. A Cochrane review of 75 trials found that cognitive behavioural therapy had small benefits over usual care at the end of treatment for pain and disability (standardised mean differences of 0.22 and 0.32), with very small benefits over active comparison treatments; the quality of evidence was moderate, and adverse events were poorly reported across the trials (Williams et al., 2020). For acceptance and commitment therapy, a meta-analysis of eleven trials found medium to large effects on pain acceptance and psychological flexibility, and small to medium effects on functioning, anxiety and depression, while pain intensity and quality of life did not differ significantly from the control conditions (Hughes et al., 2017). The pattern matters for how the practitioner describes the programme. The gains to expect are chiefly in distress, functioning and the life the client is able to lead, with smaller changes in pain itself, and an honest description protects the client from the disappointment of waiting for the pain to go.

The national guidance

For chronic primary pain, the National Institute for Health and Care Excellence (2021) guideline NG193 recommends offering a supervised group exercise programme, acceptance and commitment therapy or cognitive behavioural therapy for pain, and, within limits, a course of

acupuncture; the guideline also covers the assessment of all chronic pain and shared decision-making. For depression alongside a chronic physical health problem, NICE guideline CG91 recommends considering low-intensity options at step 2, among them individual guided self-help based on cognitive behavioural principles with a practitioner who reviews progress, a structured group physical activity programme and peer support (National Institute for Health and Care Excellence, 2009). Guided self-help of the kind this programme offers is therefore a recognised step for the people it is written for.

The guidance on ME/CFS needs particular attention, because the programme includes fatigue syndromes in its scope. The National Institute for Health and Care Excellence (2021) guideline NG206 advises that programmes based on fixed, incremental increases in physical activity or exercise, such as graded exercise therapy, should not be offered for ME/CFS, and recommends energy management, in which the person stays within their energy limits. It describes post-exertional malaise, the worsening of symptoms after even minimal activity that typically begins 12 to 48 hours later and can last for days or weeks, and it says that CBT is not a cure for ME/CFS, though it may help people to manage their symptoms and the distress of living with a chronic illness. The pacing in module 3 should be applied to clients with ME/CFS in that way, as the contact notes explain.

Self-management

The programme's emphasis on self-management has a long research history. In the Stanford trial of a chronic disease self-management programme, participants improved at six months in exercise, the management of symptoms, communication with their doctors, self-rated health, health distress, fatigue, disability and limitation of social and role activities, and had fewer hospital admissions, although pain, breathlessness and psychological wellbeing did not differ from controls (Lorig et al., 1999). In England, a trial of the lay-led Expert Patients Programme found considerably greater self-efficacy and energy at six months, without a significant reduction in the use of routine health services, and the programme was likely to be cost-effective (Kennedy et al., 2007). Both trials underline the value of people meeting others who live with similar conditions, which module 8 recommends.

Pacing, avoidance and fear

Pacing is the skill most consistently taught in pain and fatigue services, and the programme calls it the central behavioural skill. The research on it is less straightforward than its standing suggests. In a systematic review of 41 studies, avoidance of activity was consistently associated with more pain, poorer psychological functioning and more disability, and persisting with activity to the point of severe pain aggravation was linked to poorer outcomes, while pacing was associated with better psychological functioning but with more pain and disability; the authors could not determine causation and suggested that pacing may need to be used to increase activity gradually to be effective (Andrews, Strong and Meredith, 2012). The practitioner should present pacing as the programme does, as a way out of both the boom and the bust, and should watch that it does not become a new form of avoidance. The fear-avoidance model module 4 teaches was set out by Vlaeyen and Linton (2000), and pain catastrophising, which the programme describes in its three components of rumination, magnification and helplessness, was given its standard measure by Sullivan, Bishop and Pivik (1995).

Sleep and pain

Sleep and pain affect each other, but not equally. A critical review of the prospective and experimental research found that sleep impairment was a stronger and more reliable predictor of pain than pain was of sleep impairment, and that disturbed sleep may impair the body's own pain inhibition (Finan, Goodin and Smith, 2013). Cognitive behavioural therapy for insomnia remains effective when insomnia occurs alongside medical conditions, though the improvement in the medical condition itself tends to be small (Wu et al., 2015). Module 6 applies the elements of that therapy that are safe in self-help, and leaves the more demanding parts to clinicians.

What the research does not show

No trial has tested this programme in its present form. It brings together methods with good support, for a broad range of conditions, in a format the national guidance recognises. It is not a substitute for specialist pain management or fatigue services, for condition-specific psychological care, or for the medical investigation of new symptoms, and the stepping-up guidance in Part 2 and in module 8 is the safeguard for clients for whom it is not enough.