NHS Talking Therapies:

National Curriculum For CBT In The Context Of Long Term Persistent And Distressing Health Conditions[1]

Version 2.2

December 2023

[1] This curriculum was developed on behalf of NHS England by members of the Talking Therapies Education & Training Group and reviewed and amended following the first wave of implementation.

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Key changes to version 2.1 following review of curriculum in October 2022

1. Inclusion of neurological conditions and long-Covid in long-term physical conditions (throughout document)
2. Neurological conditions scope is described as follows within the revised curricula: "Including neurological conditions with sudden onset (e.g. stroke), intermittent conditions (e.g. epilepsy), progressive conditions (e.g. Parkinsons), and stable conditions with changing needs (e.g. cerebral palsy)". This way of describing the range of conditions is consistent with the Neurological Alliance website
3. Family members and carers to be included or taken into account (with patient consent) in relation to general assessment principles and formulation and treatment planning (pg 9 and 10)
4. Reasonable adjustment examples provided as part of treatment planning (pg 11)

Revised Curriculum – October 2022

Entry Requirements

This curriculum assumes that practitioners attending training will have a professional accreditation in CBT and be competent in working with people with anxiety disorders and depression. As such there is an expectation that core therapy skills (such as active listening,warmth, empathy, positive regard and engagement of clients) are already established, alongwith a capacity to work with clients using guided discovery and adopting an open and inquisitive stance across all stages of therapy. In addition practitioners should have established problem-specific competences for working successfully with depression and anxiety disorders.
All entrants to the training must have:

(1) Passed a Talking Therapies accredited postgraduate training in CBT (or another Postgraduate CBT programme or Clinical Psychology Doctorate accredited at Level 2 by BABCP)*OR*

(2) Be accredited by British Association for Behavioural and Cognitive Psychotherapies(BABCP) as a CBT therapist

Competencies

Competencies outlined in this document, both general and specific, are detailed in Roth andPilling (2015) *A competence framework for people with persistent physical health problems:* accessed at www.ucl.ac.uk/core/competenceframeworks

Outline structure of the curriculum

There are three sections to the curriculum, each containing a number of units. The first two sections set-out competences applicable to all long-term health conditions; the third de- scribes intervention 'packages' for people with specific health conditions. Each section con-tains a number of units

Section 1: Underpinning competences for work with people with long-term health conditions

UNIT 1.1	Therapists' Beliefs, Values and Assumptions about people with Long Term Health Conditions
UNIT 1.2	Knowledge of physical health conditions (including neurological conditions[2]) and their presentation and impact on the person
UNIT 1.3	Psychological processes associated with distress, depression and anxiety in

[2] Including neurological conditions with sudden onset (e.g.stroke), intermittent conditions (e.g. epilepsy), progressive conditions (e.g. Parkinsons), and stable conditions with changing needs (e.g. cerebral palsy).

	the context of Long Term Health Conditions
UNIT 1.4	Conducting a comprehensive bio-psychosocial assessment
UNIT 1.5	Formulation and treatment planning
UNIT 1.6	Working within and across organisations

Section 2: Generic intervention skills for work with people with long term health conditions

UNIT 2.1	Adapting CBT for clients with anxiety and depression which presents in the context of long-term health conditions (including neurological conditions and long covid)
UNIT 2.2	Promoting cognitive and behaviour change and self-management
UNIT 2.3	Including the partner in assessment and treatment

Section 3: Evidence-based interventions for specific health conditions

UNIT 3.1	Working with people with conditions currently labelled as having "Medically Unexplained Symptoms" or "Persistent and distressing physicalsymptoms"
UNIT 3.2	Irritable Bowel Syndrome
UNIT 3.3	Chronic Fatigue Syndrome (CFS) / Myalgic Encephalopathy (ME)
UNIT 3.4	Chronic Pain
UNIT 3.5	Psychological Interventions for type 1 and type 2 Diabetes
UNIT 3.6	Chronic Obstructive Pulmonary Disease (COPD)
UNIT 3.7	Coronary Heart Disease (CHD)
UNIT 3.8	Cancer

Overarching aims and objectives

Aims

To increase students' theoretical and research knowledge in working with people with anxiety disorders or depression in the context of Long Term Physical Health Conditions (LTHCs) and with people who experience persistent and distressing medically unexplainedsymptoms (MUS).

To provide practical, intensive and detailed skills training for working with people with anxietydisorders or depression in the context of LTHCs and people with distressing MUS.

Objectives

At the end of the course students will be able to:

I. Identify and reflect on their own values and attitudes to people with Long TermHealth Conditions and the implications this has for engagement

II. Demonstrate a critical understanding of theoretical models and evidence base that underpin interventions for anxiety and depression with Long Term Health Conditions, and become knowledgeable regarding the range of presenting conditions
III. Have knowledge of the application of cognitive behavioural models and generic models of adjustment to physical health conditions
IV. Conduct effective clinical assessment of people presenting with Long Term Health conditions (in the context of age, life events, personal and medical history, medication (benefits and side effects) and planned medical/healthcare interventions), using this to inform clinical decision making
V. Manage engagement and formulation collaboratively
VI. Develop specific treatment plans incorporating existing evidence base for anxiety and depression and promoting the client's capacity for adjustment and self-management
VII. Develop idiosyncratic CBT-based treatment plans in relation to specific long term health presentations
VIII. Manage complex issues arising in Long Term Health Conditions presentations
IX. Demonstrate self-direction and originality in tackling and solving therapeutic problems
X. Practise as 'scientist practitioners', advancing their knowledge and understanding and developing new skills to a high level
XI. Demonstrate an ability to adapt therapy sensitively to ensure equitable access for people from diverse cultures and with different values
XII. Understand the importance of multi-agency and inter-professional working and collaboration and work effectively with other professionals

Learning and teaching strategy

The specific learning and teaching strategy will be decided by the training provider. An over-arching teaching strategy should encompass learning within and across teaching days, with bridging between workshops and communication between facilitators. The following should be incorporated:

I. Didactic, experiential and skills-based workshops providing students with a strong foundation in the clinical procedures of working with people presenting with anxiety disorders and depression in the context of Long Term Health Conditions, and addressing the most up-to-date clinical guidelines.
II. Skills-based competencies developed through small group experiential work and role play
III. Additional self-directed study to include general and specific reading for each module and preparatory reading for each teaching session plus reference to web-based resources.
IV. Use of clinical vignettes, service user involvement and problem-based learning
V. It is strongly recommended that, following training, each training attendee works with appropriate supervision with health professionals with disease specific expertise.

Usual structure of training

Training is typically expected to be spread across a number of months (to facilitate learning between teaching sessions through experience gained in collocated clinical services, and to help services to release staff to attend).

Assessment of Learning

All courses from the second cohort onwards should assess learning by requiring trainees to submit evidence (via a log book) that they have:

a) Completed at least two assessment and therapy cases (and a total of at least 10 sessions of therapy), where CBT has been delivered in the context of a long-term physical health condition or persistent and distressing physical symptoms (preferably with one case of each).
b) Evidence of reflection and learning from the training being applied to these cases
c) Evidence of live supervision of this practice by an appropriately qualified supervisor, and sign off of competence by this supervisor.

An agreement should be in place with participants on the course that performance on anyassessments will be fed back to the clinical lead in the employing/host service. This is so that any action to address concerns regarding competence gaps can be addressed in the service.
Courses should offer the option of a "Continuing Professional Development" pathway thatincludes only this assessment element.

Academic Credit

Courses should offer the option of a programme without academic credit, with assessment oflearning as above. They may also offer an optional academic credit bearing pathway throughthe training. Where academic credit is awarded, additional assessments (e.g. written case studies, essays, formal competence assessments) are likely to be required, and these can add to the learning.
Specific assessment strategies will be for programmes to identify, balancing the need toensure that participants can demonstrate competence, and the need for manageable demands on students and services.

National Curriculum for Long Term Health Conditions

In Sections 1 and 2 the term 'Long Term Health Conditions' refers to individuals with anxiety disorders or depression in the context of physical health conditions (such as Dia-betes, Coronary Heart Disease, neurological conditions or long-Covid) as well as those with persistent and distressing 'medically unexplained' conditions. It is important to bear in mind that the competences listed in these sections are applicable to both; the distinction made between the two groups is somewhat arbitrary, and they will share many similarities in their presentation and their concerns.

Section 1: Underpinning Competencies

UNIT 1.1: Therapists' Beliefs, Values and Assumptions about people with Long TermHealth Conditions

Aims

To help practitioners reflect on their beliefs, values and attitudes towards people presentingwith Long Term Health Conditions

Competences covered in this unit

Ability for practitioners to reflect on their own stance, beliefs, values and assumptions aboutpeople referred with Long Term Health Conditions and any impact that this may have on their work

Ability to draw on knowledge that clients may have had previous negative experiences withhealth professionals/treatment and the implications this has for engagement in therapy

Ability to reflect upon the assumptions and expectations that people with LTHC may have about being referred for assessment and treatment and how this may impact on engagement

Ability to reflect on the assumptions and expectations that referrers may make about referring people with LTHC for psychological therapy

Ability to draw on knowledge of social, cultural and practical barriers faced by people withLTHC attending therapy

Ability to take a stance that conveys respect and promotes engagement by:

- identifying the person's strengths and resources as well as their difficulties
- developing meaningful goals which connect to previously valued roles
- valuing the person' s expertise in relation to their illness
- accepting that some patients will view anxiety and depression as illness-related distress not a mental health problem

UNIT 1.2: Knowledge of physical health conditions and their presentation and impacton the person

Aims

To ensure that practitioners have sufficient knowledge of the conditions with which patientspresent

Competences covered in this unit

Ability to draw on knowledge of the physical health conditions with which clients arepresenting, including:

- diagnostic criteria and epidemiology
- the key physical symptoms that clients usually experience and associated impairment
- the usual medical and pharmacological interventions employed to manage the condition

Ability to draw on knowledge of the impact of physical health conditions in the context of life-cycle

Ability to draw on knowledge of the way in which physical and mental health problems caninteract and impact on functioning (including the role of social, psychological, family and biological factors

Ability to draw on knowledge of the ways in which both psychological and physiologicalmechanisms contribute to client presentations, and how these can interact, e.g.:

- low mood leading to reduced physical activity, resulting in deconditioning
- symptom exacerbation leading to increased pain or breathlessness and to increasedlow mood or anxiety
- the impact of some medications on cognition

UNIT 1.3: Psychological processes associated with distress, depression and anxiety in the context of Long Term Health Conditions

Aims

To give practitioners an understanding of psychological processes that contributes to thedevelopment and maintenance of distress, depression and anxiety in people with LTHCs

Competences covered in this unit

Ability to draw on knowledge of the relationship between distress, depression and anxietyand the negative appraisal of symptoms and illness

Ability to draw on knowledge that negative appraisals can be magnified by unhelpful beliefs

Ability to draw on knowledge that interpretations and appraisals are central to the development and maintenance of distress and disproportionate disability

Ability to draw on knowledge that maintaining processes can and do worsen negative interpretations (and physical as well as psychological functioning), so creating cycles

offeedback (“vicious circles”)

Ability to draw on knowledge of specific psychological process that contribute to the development and maintenance of distress, depression and anxiety, such as:

- attentional processes that increase the perceived severity and pervasiveness ofsensations and symptoms
- safety seeking behaviours (for example, excessive checking, avoidance of physical activity or situations, excessive reassurance seeking) which are understandable in the short-term, but which (in the long-term) tend to strengthen unhelpful beliefs, increase preoccupation and exacerbate concern
- rumination in the form of catastrophising and/or worry (“preparing for the worst”)which in turn primes negative ideas and increases preoccupation
- imagery and intrusive memories, increasing negative appraisals and impacting mooddistance
- unhelpfully restrictive behaviour, such as generalised withdrawal from physical activity or from role-related activity (such as relationships, work, hobbies), leading toimpaired mood, confirmation of unhelpful beliefs, reduced self-efficacy and disengagement from rewarding activities
- changes in mood (particularly anxiety and depression) contributing to mood-appraisalspiral
- emotional avoidance/suppression (for example linked to anticipated emotional responses and unhelpful beliefs about those emotions, or “blotting out” illness ideas,but with regular intrusions and unease as a consequence)
- all or nothing (“boom or bust”) behaviours (undertaking activities beyond the level ofwhich the person is physically or psychologically capable, resulting in symptom surges (e.g. fatigue, pain) and leading to more negative appraisal
- interpersonal changes (such as those linked to a sense of unfairness, bitterness, mental defeat) eliciting negative or overly solicitous responses from significant others
- disengagement from significant others because of the health condition
- disuse and deconditioning originating from fear/avoidance patterns

Ability to draw on knowledge of factors and mechanisms that can potentiate (and mediate)vulnerability to distress, depression and anxiety, such as:

- perfectionism (setting unrelentingly high personal standards and concern aboutmistakes (both social and non-social))
- psychological inflexibility (becoming “stuck” in a particular view of the illness andsituation, and so limiting access to alternative, less negative understandings

UNIT 1.4: Conducting a comprehensive bio-psychosocial assessment

Aims

To be able to conduct a comprehensive bio-psychosocial assessment using a range of methods (including clinical interview, standardised instruments, review of clinical records andliaison and discussion with healthcare colleagues, along with self - monitoring of symptoms and activities by the client) to gain a clear picture of:

- the impact of physical health problems on the client's psychological functioning(particularly on their mood and anxiety)
- the long-term history of the client's problems
- the client's strengths and resources and current ways of managing their condition

Competences covered in this unit

Engagement

Ability to engage the client in the assessment process, for example by:

- validating the client's experience and indicating a willingness to hear their account
- responding to and addressing any uncertainty about, or suspicion of, a psychologicalapproach

General assessment principles

Ability to undertake a comprehensive assessment that encompasses:

- the client's account/understanding of their illness, and its impact on functioning
- depression and anxiety, and other co-occurring psychological disorders
- pharmacological and medical interventions and any adverse impacts of theseinterventions
- presence and extent of self-management
- risk (including self-harm related to specific health conditions and to misuse ofprescribed medications, non-adherence to treatment or neglect)
- contra-indications for treatment
- The account of family members or carers (with patient consent), where this could add important information / additional perspectives

Specific areas of assessment

Ability to identify the idiosyncratic psychological processes[3] that may be fostering or hindering the client's adjustment to their condition, and which would be relevant to any intervention strategies

Ability to help the client self-monitor in order to determine antecedents and consequences ofspecific behaviours

[3] As specified in Section 1.3

Ability to assess the reactions of significant others to the client's illness (and the degree towhich this is helpful or unhelpful)

Ability assess the resources available to the client (including physical, social and familial)

Ability to employ appropriate measures, including those applicable to specific Long TermHealth Conditions

UNIT 1.5: Formulation and treatment planning

Aims

To be able to develop collaboratively a coherent, agreed and shared evidence - basedworking model

To be able to formulate the relationship between distress, anxiety and depression and physical health problems, and create an idiosyncratic narrative that helps the client makes sense of their illness and on-going difficulties, fosters hope and helps contemplate change

Competencies covered in this unit

Ability to formulate a maintenance cycle based on specific symptoms, sensations, cognitionsand coping behaviours and to deliver a rationale for treatment, using a recent situation to elicit feedback and foster hope

Ability to formulate the bidirectional relationship between psychological issues and physicalhealth problems and the role of education and self-management in improved outcomes

Ability to engage the client in a collaborative discussion of the treatment options open to them, informed by the information gleaned through assessment, the formulation emergingfrom the assessment, and the client's aims and goals

Inclusion (with patient consent) of family members and carers where this could support effective implementation of learning in therapy

UNIT 1.6: Working within and across organisations

Aim

To be able to draw on knowledge of the benefit of co-ordinating with services offering physical health care to the client and ensuring that (where appropriate) interventions areintegrated with those services

To be able to determine when work across agencies and organisations is important for thewell-being of the client

Competencies

Ability to draw on knowledge that the welfare of the client is the principle reason for workingacross organisations, with other professionals and with carers/families, and to be able to determine when this is an appropriate response for a particular client.

Ability to understand the roles of different members of the multi-disciplinary team offering care to the patients and where appropriate how psychological treatment can integrate withthese treatments

Ability to communicate effectively with relevant professionals within and across other agencies in an effective manner, and to understand clinical governance processes and confidentiality issues (e.g. in relation to sharing information across organisations, use of datasystems)

Ability to liaise with healthcare staff in order to integrate psychological treatment with physical management

Ability to draw on knowledge of common challenges to interagency/ interprofessional working and an ability to manage these appropriately

Ability to ensure that the client, their carers and families are appropriately involved in andinformed about decisions and plans arising from inter-professional/interagency working

SECTION 2: Generic Intervention Skills For Work With People With Long Term Health Conditions

UNIT 2.1: Adapting CBT for clients with anxiety and depression which presents in thecontext of long-term health conditions

Aims

To be able to draw on knowledge of the theoretical and research literature of CBT with people with LTHCs presenting with anxiety and depression

To be able to make appropriate adaptations to ‘standard’ CBT intervention techniques tohelp clients who present with anxiety and depression in the context of long-term health conditions

To develop practical competency in CBT for anxiety and depression with people with LTHCs

Competencies covered in the unit

Adapting CBT Strategies for Long Term Health Conditions

Ability to adapt and modify established strategies for depression and anxiety disorders andapply these to presenting difficulties in Long Term Health conditions

Ability to draw on knowledge of ways in which self-management can be influenced bycognitive, behavioural and physical factors, for example:

- low mood adversely impacting on engagement with self-management strategies
- anxiety about long-term complications leading to excessive monitoring of currentsymptoms

Ability to draw on knowledge of the potential impact on mood of negative views of the LTHC,its control and its prognosis

Ability to draw on knowledge of the common barriers to self-management of LTHCs, forexample:

- lack of understanding about the LTHC and its management
- problematic beliefs about the illness and symptoms that interfere with lifestylechanges and appropriate management
- low mood / anxiety / limitations on physical activity

Engagement

Ability to use a range of engagement skills to help clients:

- 'tell their story' and give an account of their experiences of living with their LTHC
- validate the expression of difficult feelings linked to living with their LTHC
- explore emotional reactions and mood changes associated with the illness
- discuss uncertainty about the cause and medium/ long-term outcome of theirproblems

Ability to assess whether depression and anxiety may be barriers to self-managing theirLTHC and identify and discuss, for example:

- the ways in which they interpret and respond to symptoms or to medical results
- low mood leading to poorer motivation or avoidance of self-management
- anxiety about progression leading to excessive self-monitoring, checking behaviours,reassurance-seeking or unhelpfully restrictive behaviour
- anxiety about medical intervention and side-effects

Ability to apply CBT flexibly, mindful of the LTHC (e.g. offering shorter sessions, greatergaps, phone sessions, home visits)

Treatment planning

Ability to develop a shared understanding of the client's presenting difficulties and the factorsthat are relevant to their maintenance

Ability to identify the most appropriate focus (or foci) for intervention, particularly:

- difficulties in adjustment to the LTHC and its management
- depression and/or anxiety that directly contributes to difficulties in self-management
- depression and/or anxiety that is independent of the LTHC (or present premorbidly and exacerbated by diagnosis or symptoms)

Ability to draw on the formulation to judge when 'standard' treatment procedures will be appropriate, and when (and how) these need to be adapted for depression in the context of an LTHC (in a manner that accommodates the client's particular presentation and needs). For example, as a reasonable adjustment sessions may need to be longer or shorter, with breaks, for people with cognitive impairments. Session timing may also need to take account of the needs of families and carers.

Ability to derive a shared treatment plan that incorporates key strategies relevant to the presenting condition – for example:

- with COPD exploring CBT models of anxiety/breathlessness
- with diabetes exploring ways to improve insulin and dietary adherence alongside behavioural activation
- with chronic pain/chronic fatigue exploring graded exercise/activity

Intervention[4]

Ability to select and apply CBT change techniques relevant to the formulation of factors maintaining the client's mood and anxiety

Ability to help clients understand the rationale for specific interventions (e.g. the potential impact of behavioural activation both on mood and on management of the LTHC)

Ability to help clients introduce activities in a manner that is structured, sets realistic (achievable) targets, and that identifies activities that are likely to improve their anxiety/ mood

Ability to help clients identify unhelpful thoughts/ thinking styles/ underlying assumptions or behaviour that adversely impact on anxiety and/or mood or on their ability to manage their LTHC, using examples from their own experiences

Ability to work with automatic thoughts/ thinking styles/underlying assumptions/rules and attitudes using a range of cognitive and behavioural strategies to effect change (for example, diaries, pie charts, graded activity, graded exposure, use of continuums and work with imagery)

[4] Interpersonal issues are often relevant to the way in which clients adapt to and manage health conditions, and it should be routine to address this by working with significant others. Although this is detailed separately in Unit 2.3, delivery of the curriculum should ensure that students can integrate this mode of work into their standard practice.

Ability to help clients evaluate evidence, generate more balanced views, and to identify andwork with assumptions, rules and beliefs

Ability to help clients use appropriate methods to identify and manage significant areas ofworry (e.g. worries about the future)

Ability to help the client use problem-solving techniques to identify, evaluate and implementpotential solutions

Ability to identify, derive, adapt, conduct and evaluate behavioural experiments in and out ofsessions that aim to help the client test-out alternative ways of appraising and managing their health condition

Ability to help the client make behavioural changes intended to improve self-management oftheir LTHC, for example by:

- highlighting the benefits of change (pros and cons (both short- and long-term), reduced risk of complications, increased energy, independence and disadvantages ofpoor self-management
- discussing both past difficulties and successes with self-management and their longterm consequences

Ability to end therapy and derive a relapse prevention plan utilising an idiosyncratic blueprintof therapy which

- identifies possible flare ups and recurrence
- plans for long-term maintenance of gains

UNIT 2.2: Promoting Cognitive and Behaviour Change and Self-Management

Aims

To be able to promote the client's self-management of their health condition through cognitive and behavioural change

Competences covered in this unit

Ability to draw on knowledge that achieving cognitive and behaviour change is a process driven by a number of factors (such as the client's understanding of their health conditionand their beliefs about the potential benefits and costs of behavioural changes)

Ability to draw on knowledge that behaviour change can be characterised by a series of steps (intention to change and motivation for change, 'actioning' change and maintainingchange), each of which can be revisited as change occurs

Ability to draw on knowledge that any proposed cognitive and behavioural changes shouldtake account of the client's beliefs and values about their health condition

An ability to work with the client to identify both short and long-term goals relevant to their presentation, concerns and values

Ability to work with the client to agree SMART goals for behaviour change

Ability to work with the client to develop 'action plans'

Ability to help clients understand the rationale for focusing on habit formation in sustaining behavioural change (using strategies to make new behaviours 'automatic' rather than beingdependent on 'willed' action)

Ability to help the client to monitor the behaviour(s) that they are aiming to change

Ability to discuss with the client the impact of any changes to behaviour (both on the clientand on those with whom they are in contact)

UNIT 2.3: Including significant members of the client's system in assessment andtreatment*

** In this section 'partner' is used as a generic term to include partners as well as individuals who play a significant role in the client's immediate 'system'*

Aims

To establish awareness of the potential impact that partners can have on illness management and psychopathology associated with the illness.

To establish knowledge of the interactions between relationship functioning, distress and outcomes for patients and partners adapting to and coping with long term health conditions

To establish an understanding of general relationship functioning from a cognitive-behavioural perspective

Competences covered in this unit

Ability to assess the role of relationship factors and their interaction with adaptation and coping with LTHCs as well as their interaction with individual psychopathology in one or bothpartners

Ability to draw on knowledge of how the relationship can be used:

- to promote behavioural, cognitive and emotional changes specific to adaptation andcoping with the LTHC
- to promote behavioural, cognitive and emotional changes in areas identified asmaintaining depression and/or anxiety in one or both partners

Ability to assess the presence of significant relationship distress, the impact of this on thepsychological disorder(s), and the long term health condition

Ability to conduct psycho-education about a health condition/ psychological disorder in arelationship context

Ability to conduct a 'partner-assisted' intervention including strategies to help s couples develop communication skills that facilitate 'sharing thoughts and feelings' about the LT HCand its implications for everyone involved

Ability to facilitate decision-making conversations in a partner assisted session that are focalto the disorder, for example:

- decisions about medical treatments and recovery/rehabilitation
- focussing on issues assessed as related to the maintenance of depression and/oranxiety

Ability to address relationship issues and changes stemming from the LTHC as appropriatewithin a partner assisted framework

An ability to refer for further intervention, for example:

- formal Behavioural Couples Therapy where a 'partner assisted' intervention isinsufficient for depression in the context of an LTCHC
- an individual intervention where it becomes clear that a partner has mental healthproblems that are better addressed separately

SECTION 3: Evidence-based Interventions For Specific Health Conditions[5]

UNIT 3.1: Working with people with conditions currently labelled as "Medically Unexplained Symptoms" or "Persistent and distressing physical symptoms"

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with conditions currently labelled as Medically Unexplained Symptoms, and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of the ways in which a range of *specific* biopsychosocial processes can work to maintain symptoms, psychological distress and disability, includingbi-directional interactions in the domains of cognitive, emotional, behavioural, social and physiological factors

Engagement

Ability to draw on knowledge of the conditions/presentations that are currently labelled asMUS

Ability to draw on knowledge of debate regarding terminology, including patients' views ofMUS and labels seen as more acceptable by both patients and professionals

Ability to draw on knowledge of the critical importance of:

- identifying and working with the patient's 'common-sense' model of their condition
- using a shared language that is consonant with their perceptions of their difficulties(e.g. discussing issues in relation to distress rather than depression or anxiety)

Assessment and formulation

Ability to identify problematic interpretations/appraisals of health-relevant events (such assymptoms, information and stimuli) including variants of catastrophising, fear avoidance beliefs and symptom focusing

Ability to work towards a shared conceptualisation with the patient which dovetails with theirbeliefs about the physical nature of the disorder, and includes precipitating factors and linksto a broader model of perpetuating factors (including cognitive, behavioural, emotional, social and physiological)

[5] Because the health conditions identified in this section can carry a significant medical risk an overarching competence is for practitioners to ensure that they are aw are of, and able to implement, local protocols for the management of emergencies

UNIT 3.2: Irritable Bowel Syndrome (IBS)

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with Irritable Bowel Syndrome (IBS) and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of:

- the phenomenology, diagnostic classifications and epidemiological characteristics of IBS.
- the basic anatomy and physiology of the bowel and brain- gut interactions.
- current, evidence-based pharmacological, physical and psychological treatments for IBS
- Ability to conduct a comprehensive assessment including:
- the client's experience of IBS, its onset, symptoms, severity and impact on daily life
- the role of diet (erratic eating rather than what is eaten), medication and whether taken to avoid symptoms, personality, gastrointestinal conditions, stress, current and previous treatment
- family experience of illness, family discussion of bowel/toilet habits

Ability to help the client describe coping mechanisms, beliefs regarding their illness and bowel functioning (diarrhoea [D] predominant, constipation [C] predominant or alternating D& C), identify triggers for symptoms (other than foods), patterns of avoidance, toileting behaviours (time spent on toilet; straining) and safety seeking behaviours

Ability to introduce and develop a shared understanding of the cognitive behavioural model of IBS connecting precipitating events, maintaining factors (3 systems model – physiological,cognitive and behavioural factors) and IBS symptoms and to explain the rationale for treatment using recent examples from the client's own experience

Ability to help clients use self-monitoring diaries to track bowel symptoms, habits, toileting,patterns of eating and stress levels aimed at detecting links between symptoms, thoughts and behaviour

Ability to identify the role of IBS related beliefs (including beliefs about symptoms or bowelhabits, negative perfectionism and emotional expression) and their consequences in maintaining difficulties and generate an alternative perspective through discussion techniques, cognitive restructuring and behavioural experiments

Ability to work with concerns about potential loss of bowel control, normal bowel habits andthe anticipated consequences of constipation and diarrhoea

Ability to help clients review patterns of eating and diet, weight management, identify any unhelpful patterns and work towards more consistent and regular patterns of eating and diet

Ability to use standard and idiosyncratic measures to evaluate outcomes with CBT for IBS

Ability to help clients prepare for ending therapy and maintain improvements by identifyingpossible indicators of relapse and strategies for their management

UNIT 3.3: Chronic Fatigue Syndrome (CFS) / Myalgic Encephalopathy (ME)

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with Chronic Fatigue Syndrome, and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of the aetiology, epidemiology and presentation of CFS/ME, and of its differential diagnosis (and exclusion criteria)

Ability to draw on knowledge of factors considered to contribute to the development of CFS/ME (including physical illness/ serious infections (such as glandular fever), lifestyle, stress, perfectionism and distress)

Ability to draw on knowledge of factors considered to maintain CFS/ME (such as patterns of activity characterised by boom and bust cycles, unhelpful fear avoidance beliefs leading to avoidance of activity), attentional biases towards symptoms) and how these link to physiological mechanisms including poor sleep and deconditioning

Ability to help client feel that their experience of CFS/ME is being listened to and respected (i.e. acknowledging that they are experiencing real, physical symptoms)

Ability to conduct a comprehensive assessment of the client's symptoms, including their medical and prescription history, contextual information and main current difficulties, physicalsymptoms, patterns of activity and rest, coping mechanisms, the impact of CFS/ME on their life and specific concerns about symptoms, fears about engaging in activity, attentional focusand how significant others respond to symptoms

Ability to introduce the CBT model, collaboratively identifying predisposing and precipitating factors and a vicious cycle of fatigue

Ability to introduce and discuss planning activity and rest in the context of short and long term activity targets

Ability to help the client monitor sleep, identify specific sleep problems that exacerbate fatigue and discuss sleep strategies such as an up time and bed restriction

Ability to employ attentional training to address symptom focussing

Ability to work on unhelpful thoughts related to engaging in activity more consistently and perfectionism, generate alternatives and help the client test these out with gradual behaviour change and behavioural experiments

Ability to identify and work with potential obstacles to recovery

Ability to use standard and idiosyncratic measures to evaluate outcomes with CBT for CFS

UNIT 3.4: Chronic Pain

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with chronic pain, and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of the phenomenology, diagnostic classifications and epidemiological characteristics of chronic pain including common symptoms, disease process, investigations and treatments and prevalence of depression and anxiety disorders

Ability to draw on knowledge of current, evidence-based pharmacological, physical and psychological treatment for chronic pain and co-morbid disorders

Ability to draw on knowledge that adjustment to chronic pain is influenced by a number of factors (physiological, psychological, social, pre-morbid personality)

Ability to draw on knowledge of common issues that arise when working with clients with pain, e.g.:

- distinction between acute and chronic pain
- catastrophic beliefs based on a misunderstanding of anatomy/physiology (e.g. interpreting chronic pain as a signal of physical damage)

Ability to carry out a comprehensive assessment which covers medical history, medical interventions received (surgery, medication, investigations, physiotherapy) the impact and effect of chronic pain, current symptoms and pain-related difficulties, and the potential for medication-related side-effects

Ability to apply standardized measures used to assess experience, functioning and cognitions in chronic pain

Ability to draw on knowledge of a range of models commonly applied in pain management, such as:

- CBT (including learning theory (both classical (fear avoidance) and operant conditioning)
- bio-medical model vs bio-psychosocial models
- contextual models (such as ACT)
- the difference between models of acute and chronic pain

Ability to discuss the rationale for treatment rationale with the client, conveying:

- that their pain is real
- that as a bodily and emotional experience pain triggers a range of cognitive and behavioural reactions which can make the experience of pain worse
- that learning different ways to manage these reactions ca n modify the

experience ofpain

Ability to implement Cognitive-Behavioural Therapy for chronic pain, by:

- helping the client identify unhelpful patterns of activity in response to pain, includingavoidance, boom or bust cycles, or restricting range of movement and activity
- using activity management strategies to identify, build on and monitor activities(pleasurable and meaningful activity scheduling, behavioural activation)
- employing exercise as part of a multimodal treatment package (graded exercise,exposure etc)
- using relaxation and breathing strategies
- working with the client to identify and modify unhelpful cognitions, images and beliefsabout their pain and collaboratively construct alternatives /more adaptive cognitions, images and beliefs
- working with attentional techniques

Ability to use standard and idiosyncratic measures to evaluate outcomes with CBT for pain

Ability to help clients prepare for ending therapy and maintain improvements by identifying possible indicators of relapse and strategies for their management

Ability to deliver treatment in a group format as part of an interdisciplinary team approach

Acceptance and Commitment Therapy (ACT)*

***** *ACT is not a required component of the curriculum, but if included it should include:*

Ability to draw on knowledge of the application of Acceptance and Commitment Therapy and Mindfulness Meditation for chronic pain

Ability to help the client identify and discuss their values and goals

Ability to identify within-session examples of behaviours that are both psychologically inflexible and flexible and employ appropriate ACT interventions to decrease the former and enhance the latter

Ability to work with the client to connect with their experiences by developing their skills inobservation and awareness (for example by using techniques such as exposure, skills training and mindfulness)

Ability to help the client allow experiences to be present without attempts to avoid, control or change them when this serves goals and related behaviour change

Ability to help the client accept but not engage with thoughts, feelings and stories about the self and adopt a sense of self that is experienced as separate from and not overwhelmed or threatened by these

UNIT 3.5: Psychological Interventions for type 1 and type 2 Diabetes

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with Diabetes, and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of Type 1 and Type 2 diabetes, their medical management andusual procedures for monitoring and review of the condition (including an understanding of the meaning of blood sugar levels)

Ability to draw on knowledge of developmental issues in relation to the age of onset of diabetes

Ability to draw on knowledge of the relevance of lifestyle factors (including diet, weight reduction and exercise) to optimal management of diabetes

Ability to draw on knowledge of indicators of poor control of diabetes, including signs and symptoms of hypo- and hyperglycemia, and of common medical complications and comorbidities

Ability to draw on knowledge of ways in which self-management can be influenced by cognitive, behavioural and physical factors

Ability to draw on knowledge of common barriers to self-management such as

- low mood/anxiety
- lack of understanding of diabetes
- unhelpful beliefs (e.g. about medication or underestimating the impact of lifestylechanges in Type 2 diabetes)
- adverse social/personal circumstances

Ability to draw on knowledge of the impact of disordered eating on diabetic control

Ability to engage clients by helping them give their account of living with diabetes, and validating difficult feelings associated with this

Ability to conduct a comprehensive assessment, including:

- the client's knowledge of, and beliefs about, diabetes
- the impact of diabetes on daily living
- the impact of the client's management regimen, their satisfaction with it, difficulties infollowing it, and the implications for self-management
- the impact of depression and anxiety on self-management, and the identification ofmaintenance cycles that maintain low mood/anxiety and poorer self-management

Ability to collaboratively formulate current symptoms, emotion, beliefs and behaviours withina maintenance cycle of mood and anxiety

Ability to deliver an intervention best suited to the needs of the individual, including:

- information about diabetes and its management
- problem solving (e.g. obstacles to self-management)
- promoting behavioural change
- identifying the efficacy of current coping strategies and promoting adjustment todiabetes
- working with the client to implement CBT strategies directed towards depression/anxiety

Ability to use standard and idiosyncratic measures to evaluate outcomes with CBT for diabetes

Ability to help clients prepare for ending therapy and maintain improvements by identifyingpossible indicators of relapse and strategies for their management

UNIT 3.6: Chronic Obstructive Pulmonary Disease (COPD)

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with COPD, and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of the characteristics of COPD including common symptoms, disease process, acute exacerbations, investigations and treatments and prevalence of depression and anxiety disorders

Ability to draw on knowledge of pharmacological, multidisciplinary, and psychological treatments for COPD and co-morbid disorders (including smoking cessation)

Ability to draw on knowledge of common manifestations of, and reasons for, anxiety and fearavoidance in people with COPD (e.g. fear that exercise will be harmful, misinterpretation of breathlessness as an indicator of an imminent threat to life)

Ability to draw on knowledge of common reasons for distress and depression in people with COPD (e.g. major changes in lifestyle or life roles making it difficult to adjust to living with thecondition, breathlessness on exertion)

Ability to assess the client's knowledge of, and beliefs about, COPD, and provide information about COPD and its management

Ability to conduct a comprehensive assessment of current symptoms and difficulties, present and past treatment, and the impact of mood and anxiety on self-management of COPD

Ability to assess the client's knowledge of, and beliefs about, COPD, and provide informationabout COPD and its management

Ability to identify patterns of avoidance and safety-seeking behaviours, and any triggers forthese

Ability to derive a shared understanding of the cognitive behavioural conceptualisation of COPD and introduce the rationale for treatment using recent examples from the client's ownexperience

Ability to collaboratively formulate current symptoms, emotion, beliefs and behaviours withina maintenance cycle of mood and anxiety

Ability to help the client to identify catastrophic interpretations of bodily sensations, to generate alternative non-catastrophic interpretations, and to test the validity of these throughdiscussion techniques and adapting behavioural experiments

Ability to work with the client to create, conduct and evaluate idiosyncratic behavioural experiments in and out of sessions

Ability to help clients prepare for ending therapy and maintain improvements by identifying possible indicators of relapse and strategies for their management

Ability to use standard and idiosyncratic measures to evaluate progress and outcomes with COPD

UNIT 3.7: Coronary Heart Disease (CHD)[6]

Aims

To be able to demonstrate knowledge of evidence-based interventions for people with CHD,and practical skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of the characteristics of CHD including common symptoms, disease process, investigations and treatments and prevalence of depression and anxiety disorders

Ability to draw on knowledge of pharmacological, surgical, psychological and cardiac rehabilitation based treatment for CHD and co-morbid disorders

Ability to draw on knowledge of factors relevant to the long-term management of CHD (suchas the role of smoking, exercise, weight management, control of hypertension and cholesterol levels)

Ability to draw on knowledge of fears and phobias that could and directly impa ct on the management of CHD (e.g. fear of MRI investigations, or cardiac accelerating drugs)

Ability to assess the client's knowledge of, and beliefs about, CHD, and provide informationabout CHD and its management

Ability to draw on knowledge of common manifestations of, and reasons for, anxiety and fearavoidance in people with CHD (e.g. fear that exercise will be harmful, misinterpretation of chest pain as a signal of a cardiac event)

Ability to draw on knowledge of factors commonly leading to distr ess and depression in people with CHD (e.g. because of difficulties in adjusting to the condition, major changes inlifestyle or life roles)

Ability to conduct a comprehensive assessment of current symptoms and difficulties, present and past treatment, and the impact of mood and anxiety on self-management of CHD

Ability to identify triggers, patterns of avoidance and safety-seeking behaviours

Ability to derive a shared understanding of the cognitive behavioural conceptualisation of CHD and introduce the rationale for treatment using recent examples from the client's own experience

Ability to identify difficulties in adjusting to heart failure (e.g. managing symptoms of breathlessness and fatigue) and any risk of deconditioning

Ability to identify and reduce avoidance and safety behaviours that are being reinforced by significant others who fear the patient having further cardiac events

Ability to collaboratively formulate current symptoms, emotion, beliefs and behaviours withina maintenance cycle of mood and anxiety

Ability to help the client to identify catastrophic interpretations of bodily sensations and to generate alternative non-catastrophic interpretations

Ability to test the validity of catastrophic interpretations through discussion techniques andbehavioural experiments

Ability to work with the client to create, conduct and evaluate idiosyncratic behavioural experiments in and out of sessions (ensuring that these are cognisant of any actual medical risk)

Ability to help clients prepare for ending therapy and maintain improvements by identifying possible indicators of relapse and strategies for their management

Ability to use standard and idiosyncratic measures to evaluate progress and outcomes withCHD

[6] Strategies outlined in Unit 3.1 will be relevant to patients presenting with non-cardiac chest pain

UNIT 3.8: Cancer

Aims

To be able to demonstrate knowledge of evidence-based psychological interventions for people with cancer who are distressed, depressed or anxious and practi cal skills in their application

Competences to be demonstrated in this unit

Ability to draw on knowledge of the types and stage of cancers, medical treatments (e.g. chemotherapy and radiotherapy), prognostic factors and survival rates, and the prevalenceof distress, depression, anxiety

Ability to draw on knowledge of psychological and pharmacological interventions for cancerrelated distress, depression and co-morbid fatigue (including exercise treatments)

Ability to draw on knowledge of common reasons for depression and anxiety in people withcancer (e.g. fear of recurrence, death and pain, or unresolved personal or family issues)

Ability to conduct a comprehensive assessment of current and past difficulties, present andpast treatment, and the impact of distress on quality of life

Ability to assess the client's knowledge of, and beliefs about, the prognosis and recurrenceof their cancer

Ability to identify patterns of avoidance and the link to beliefs and mood (anxiety, depressionor fatigue)

Ability to assess the threat that cancer represents to the client (i.e. core beliefs about their survival)

Ability to assess the client's access to emotional social support

Ability to derive a shared understanding of the cognitive behavioural conceptualisation of cancer related distress, and introduce the rationale for treatment using recent examples from the client's own experience

Ability to collaboratively formulate current symptoms, emotion, beliefs and behaviours withina maintenance cycle of mood, anxiety and fatigue

Ability to help the client to distinguish between unhelpful and realistic beliefs about the future, to generate alternative more realistic beliefs, and to test the validity of these through discussion techniques

Ability to work with the client to test out behaviour change techniques which leads them to lead a better quality of life that is of value to them

Ability to use problem solving when appropriate (e.g. where there are obstacles to self-management)

- to identify the efficacy of current coping strategies
- to promote behavioural and cognitive change

Ability to work with the client

- to implement CBT strategies that promote engagement in valued, meaningful andenjoyable activities
- to encourage expression of distress and any associated losses associated with thecancer diagnosis
- to encourage communication with close family and friends
- to develop coping strategies for managing any adverse impacts from treatment

oftheir cancer

Ability to help clients prepare for ending therapy and maintain improvements by identifying possible indicators of relapse and strategies for their management

Ability to use standard and idiosyncratic measures to evaluate progress and outcomes in people with cancer or those who have survived