Knowledge of the impact of physical health conditions in the context of life-stage and child development

Knowledge of relationships between life-stage and adjustment to illness

An ability to draw on knowledge that in children and younger people the relationship between chronological age and developmental stage is not fixed, and hence there can be considerable variation in the capacity for understanding illness variation across individuals of the same age
An ability to draw on knowledge that (in normative developmental terms) positive adjustment to illness can be thought of as the maintenance of positive emotional well-being, age appropriate behaviour and developmentally appropriate self-esteem/self-worth at the same time as following (potentially complex) healthcare regimens
An ability to draw on knowledge that illness whose onset is perceived as 'age-appropriate' may be easier to adjust to than when the onset is unusual for the person's life-stage

Understanding of illness and its management in children. adolescents and young adults

An ability to draw on knowledge of the ways in which their developmental stage impacts on the young person's capacity to understand and manage their illness e.g.:		
	older school-aged children and adolescent**s** will be capable of understanding their illness and its treatment, but concordance with healthcare regimens may be impacted by a number of developmentally-relevant reactions, for example:	
		reactions to a sense that a chronic illness is forever and will adversely impact on their life plans
		experiencing illness as imposing an increasing sense of difference from their peers
		difficulty in relating to the longer-term consequences of poor adherence
An ability to draw on knowledge of the impact of long-term conditions on the development of functional independence (e.g. on independence, personal care, mobility and communication)		
An ability to draw on knowledge that chronic physical illness can:		
	impact on the ability to form attachments in infancy	
	impact on the ability to play and explore in young children	
	hinder the development and maintenance of friendships	
	inhibit the development of independence in adolescence, as well as impact on that which has already been achieved	
	force an increasing dependence on parents or significant others	
	result in lower quality of life	
	lead to disruption in family structures	
	lead to higher levels of depression and anxiety in comparison to healthy peers	
An ability to draw on knowledge of the adverse and long-term cognitive impact of some interventions or chronic illnesses (e.g. cognitive problems after bypass surgery, learning difficulties in children/young people with childhood-onset epilepsy)		
An ability to draw on knowledge of the impact of physical and neurological illness on education and schooling e.g.:		
	arising from the direct impact of symptoms including pain and fatigue	
	impact on attendance of regular healthcare appointments	
	impact of illness on motivation	
	adverse impact on the development and maintenance of peer relationships	
	adverse impact on achievement (e.g. on examination performance)	

Impact on family development

An ability to draw on knowledge that the presence of a physical health condition in a child/young person	
	can impact on family roles and lifecycle
	can make significant family transitions more challenging (e.g. birth of new family member, starting school, bereavement).
	can make it harder for families to cope with other adversities that arise
	can impact on family finances
An ability to draw on the knowledge that effective parenting of a child/young person with a physical health condition will present challenges and complexities beyond those associated with usual patterns of parenting and parental responsibilities	

*refer to competency on “ability to prepare CYP for transition to adult services” for further information

Knowledge of a generic model of 'Medically Unexplained' Symptoms (MUS)

Detailed descriptions of potential interventions for MUS can be found in the "Interventions" sections of this framework (applicable information can be found in the competences relating to "Ability to respond to distress and promote adjustment"; "Pain", "Chronic Fatigue Syndrome", "Gastrointestinal Conditions" and "Neurological Conditions")

An ability to draw on knowledge that a physical cause cannot always be found for bodily symptoms which are 'medically unexplained' and that it is helpful to think about other non-physical causes to manage these conditions
An ability to draw on knowledge that generic models of MUS assume that symptoms may be generated or maintained not by one specific disease process but by the self-sustaining interaction of physiological, behavioural and cognitive factors within an individual
An ability to draw on knowledge that symptoms that are 'medically unexplained' can (and often do) co-exist with symptoms for which there is a medical explanation
An ability to draw on knowledge of presentations commonly denoted as 'MUS' in children and young people, such as:
persistent and recurrent headaches,
persistent and recurrent stomach pains
persistent and recurrent tiredness
non-epileptic attack disorder (NEAD)
An ability to draw on knowledge of the biopsychosocial model of illness when understanding MUS
An ability to draw on knowledge that acknowledging that physical symptoms can be impacted on by thoughts, feelings and behaviour is not the same as saying that these symptoms are "all in the mind"
An ability to draw on knowledge that physical symptoms, irrespective of cause (i.e. whether medically explained or medically unexplained) can be impacted on by other factors e.g. emotional, behavioural or cognitive factors

Factors thought to predispose to MUS

An ability to draw on knowledge of factors hypothesised to predispose towards MUS in children and young people, including;
heightened reactivity to stressors (beyond that which would be expected at their developmental stage)
'emotional dysregulation' (beyond that which would be expected at their developmental stage) and/or being in a family with a tendency to believe expressions of negative emotion are unacceptable
a family history of serious illness
perfectionistic tendencies and/or catastrophic thinking
a tendency to respond to distress somatically, or not recognising physical symptoms as signs of stress
high levels of premorbid distress and/or anxiety
a family environment characterised by somatic, rather than emotional, expression
traumatic experiences such as bullying, abuse or neglect

Factors thought to precipitate MUS

- An ability to draw on knowledge of factors thought to precipitate MUS in children/young people, including:
  - an episode of physical illness such as an acute infection or injury
  - chronic stress (including high levels of daily stressors over a period of time) and/or major and adverse life events
  - current trauma, or reminders of earlier traumas
- An ability to draw on knowledge that while a number of factors have been hypothesised to predispose towards and to precipitate "MUS", in many children no such factors will be detected

Factors thought to perpetuate MUS

- An ability to draw on knowledge of factors thought to perpetuate MUS, including:
  - physiological factors thought to be involved in the experience of persistent physical symptoms, for example:
    - changes in the functioning of the HPA axis* (i.e. low levels of cortisol associated with chronic stress)
    - central sensitisation (a heightened response to stimuli based on prior experience of them)
    - autonomic dysregulation (e.g. heightened stress or anxiety responses (such as rapid heart rate, headache, fatigue))
  - disturbed circadian cycles (potentiating the experience of physical symptoms)
  - absence of a consistent daily routine including sleep/wake cycle, diet, and activities
  - coping by withdrawing and/or becoming less active, and/or by inconsistent (boom and bust) activity and/or by overcompensating and taking on too much
  - unhelpful illness and symptom-related beliefs (e.g. that activity will be harmful, leading to behavioural restriction and exacerbation of symptoms)
  - focusing on symptoms (selective attention to symptoms and to the thoughts associated with them)
    - a cognitive bias to attend to symptoms, further amplifying them and leading to greater sensitisation
  - making unhelpful attributions e.g.:
    - perceiving symptoms as a significant threat to well-being and/or safety
    - failing to make attributions that help to 'normalise' the experience of physical symptoms (for themselves or for the child)
  - finding it difficult to create a 'narrative' that can account for the symptoms (and so make them less threatening)
  - being exposed to high levels of medical uncertainty (i.e. a lack of explanation for symptoms, guidance regarding their management, or a failure to create an 'end point' by indicating when no further tests are needed))

* HPA – the Hypothalamic-Pituitary-Adrenal axis, which controls reactions to stress and regulates many body processes, including digestion, the immune system, mood and emotions and energy storage and expenditure

Knowledge of the impact of systemic factors

- An ability to draw on knowledge that beliefs and anxieties about symptoms can lead to unhelpful reactions from the 'systems' around the child (e.g. parents/carers and schools) that can inadvertently maintain symptoms and restrict functioning e.g.:
  - focusing on, and reacting anxiously to symptoms
  - inappropriately restricting physical activity

encouraging withdrawal from school rather than planning accommodations that promote attendance and engagement
An ability to draw on knowledge that the cycle of symptoms can be perpetuated by ongoing clinical tests which maintain a focus on a putative physical cause, even when the medical system does not expect these to be found

Ability to draw on a coherent, multifactorial model of MUS

While being aware that the pathway for each child and young person will differ, an ability to draw on knowledge of a coherent, multi-factorial empirically-grounded model of MUS - for example:
a predisposition to somatopsychic distress and distress sensitisation, combined with adversity, leads the child/young person to be more sensitive to symptoms by lowering the threshold for their detection
acute illnesses or injury trigger symptoms which are then perpetuated by a cycle of cognitive, behavioural, emotional and physiological interactions, which in turn influence the symptoms
life events and stress lead to physiological changes that produce more symptoms, which sets in train a process of sensitisation and selective attention, which in turn further reduces the threshold for symptom detection
a lack of explanation or advice increases anxiety, symptoms and a greater focus on symptoms
stress cues become associated with symptoms
avoidance of symptom provocation and symptom-led activity patterns leads to further sensitisation
the prolonged stress associated with the illness itself activates physiological mechanisms, producing more symptoms, sensitisation, selective attention and avoidance
the child/young person becomes locked into a vicious cycle of symptom maintenance
An ability to work collaboratively with children/young people and their parents/carers/families to adapt general models of MUS into an individualised narrative that helps them make sense of their illness and their on-going symptoms
an ability to explain the model in a developmentally appropriate manner using “child friendly analogies
an ability to explain the model in a way that can help the systems around the child consider how best to manage the child/young person’s symptoms

Knowledge of and the ability to promote the use of self-management materials

Establishing a framework for using self-help materials

An ability to identify when it is appropriate for self-help materials to be employed:
as a stand-alone intervention, without clinician guidance
as a form of guided self-help, with focused support from a practitioner
An ability to identify when it is appropriate to integrate guided self-help into an ongoing clinician-directed intervention
An ability to ensure that self-help materials used with children/ young people are matched to their cognitive and affective development
An ability to draw on knowledge that self-help materials are not usually appropriate for young children
An ability to maintain a clear distinction between the role of a facilitator of guided self-help and the more extensive role of a therapist or case manager
An ability to select appropriate self-help materials for a specific physical condition or psychological need
An ability to select the appropriate medium for self-help depending on needs and interests of child e.g. written format, digital format
An ability to follow local protocols in use of self-help and digital technologies around duty of care, consent and record keeping

Establishing a context and a rationale for the self-help model

An ability to help recipients of self help (young people and their families) understand that the main purpose of the intervention is to focus on, and facilitate, the use of self-help material(s)
An ability to identify appropriate and specific goals and desired outcomes for the self-help intervention with the young person and their family
An ability to provide a rationale for guided self-help in an encouraging and realistic manner
An ability to establish a context for the intervention, through clear explanation of the role of the practitioner.
An ability to ensure that the child/young person understands the nature, timing of schedule of any contacts
An ability to convey the client led, collaborative nature of a self-help intervention
An ability to impart accurate information about the problems on which self-help materials are focussed (e.g. the nature, course and frequency of a presenting problem)
An ability to give information regarding the likely benefits of self-help interventions (i.e. based on best available evidence of effectiveness)

Decision making regarding the appropriateness of self-help

An ability to agree on the suitability of a self-help intervention for the child/young person and their family
An ability to collaboratively negotiate and agree the next steps in any contact, including organisational arrangements
An ability to understand and convey the potential benefits of self-help including

increased engagement in those who otherwise disengage; increased patient autonomy, empowerment and activation, could reduce need for clinic attendance
An ability to understand and convey the potential risks of self-help including possible negative impact on therapeutic relationship as reduced opportunities for face to face contact, risk of potential disclosure of personal information on digital technology
An ability to identify children/young people whose problems lie outside the scope of a self-help intervention (i.e. when alternative interventions are required)
an ability to refer to another part of the service or to other agencies where this is indicated and appropriate

Knowledge of a generic model of adjustment to physical health conditions

- An ability to draw on knowledge that adjustment is not an end-point but a process of assimilation that takes place over time, and which can be expected to vary in response to changes in the child/young person's physical condition and any relevant life-experiences
- An ability to draw on knowledge that optimal adjustment (and expectations about the adjustment that can realistically be expected) will be condition and person-specific, and hence:
  - the degree to which the condition and/or treatment impacts on the achievement of developmental tasks e.g.
    - playing and exploring
    - educational achievements
    - developing peer relationships
    - developing age-appropriate independence
  - the impact on family routine and development of the additional demands of a child with physical health needs
  - the specific symptomatology and treatment with which children and young people are contending
- An ability to draw on knowledge that optimal adjustment will not always be signalled by preserved functional status or low negative affect e.g.:
  - in juvenile idiopathic arthritis an adaptive outcome is one of maintaining quality of life in the face of pain and progressive disability
  - in advanced terminal illness the key task may be coping with (rather than being overwhelmed by, or not expressing) distressing feelings relating to imminent death
- An ability to draw on knowledge that adjustment to a health condition can be understood as the child/young person and families' capacity to maintain or restore their sense of emotional equilibrium, their identity and quality of life, and that this will be determined by:
  - predisposing factors:
    - personal background factors (e.g. early life experiences, personality (optimism, neuroticism), beliefs about themselves and the world, cultural and religious beliefs, values and life goals)
    - illness-specific factors (e.g. nature of symptoms, degree of uncertainty, prognosis, impact of treatment regimen)
    - background social and environmental factors (e.g. social support and relationships, availability of health and social care; parental coping styles and mental health)
    - beliefs about the meaning of symptoms and their implications
    - beliefs about treatment
  - precipitating factors:
    - possible critical events (e.g. reactions to initial symptoms, or to the diagnosis of a chronic condition; effects of, and response to, treatment; disease progression; threat to physical, emotional, social and cognitive development; mortality; future implications for fertility, changes to identity or life roles)
    - significant transitions (e.g. relocating to a new school, moving from paediatric to adult health services)
    - possible ongoing stressors (e.g. threats to development of autonomy and independence, management of stressful treatments and/or side effects, experience of relationships with healthcare professionals and systems, difficulties acknowledging their own limits)

Factors promoting emotional regulation and quality of life

An ability to draw on knowledge of factors thought to help a child/young person develop and maintain emotional regulation and quality of life, including:
biological factors e.g.:
shorter duration and course of illness
circumscribed physical symptoms
good general health and physical fitness
cognitive factors e.g.:
their sense of control regarding illness management
their sense of self-efficacy in relation to the illness itself as well as their general life situation
their tendency to positively connote their experiences
their acceptance of the illness
their perception that the social support they receive is appropriate
behavioural factors e.g.:
setting and working towards goals
making use of social support
engaging in positive health behaviours (maintaining a healthy lifestyle)
adhering to medical and self-management regimes
maintaining activity levels in the face of illness
appropriate expression of emotion
social factors e.g.:
receiving and accepting appropriate support from family and significant others
maintaining a productive engagement with education
maintaining appropriate peer relationships

Factors inhibiting emotional equilibrium and quality of life

An ability to draw on knowledge of factors thought to maintain emotional dysregulation and poor quality of life, including:
biological factors e.g.:
chronic duration and course of illness
co-morbid physical symptoms whose interaction exacerbates difficulties (e.g. conditions restricting options for exercise and play)
failing to achieve developmental milestones at expected ages (e.g. walking, puberty)
cognitive factors e.g.:
high perceived stress
consistently coping through 'wishful thinking'
negative and/or shameful beliefs about the illness/symptoms
unhelpful cognitions and cognitive biases (e.g. catastrophising)
Rumination
helplessness and hopelessness
consistent suppression of negative affect
behavioural factors e.g.:
consistent avoidance
excessive information seeking (e.g. via online media or seeking reassurance from parents/family members)
changing medical regimen inappropriately on the basis of incorrect information
maintaining unsustainably high levels of activity

		unhelpful responses to symptoms (e.g. reducing activity in response to symptoms, stopping school inappropriately, attentional focus on symptoms)
		excessive ventilation or denial of emotions
		excessive reassurance-seeking
	social factors e.g.:	
		social disadvantage (e.g. financial difficulties, poor housing)
		poor social support and social isolation
		consistently rejecting support from others
		difficulty maintaining school attendance
		poor attachment to primary caregiver / lack of significant adult
An ability to draw on knowledge that poor adjustment to a long-term health condition (in either child/young person or parent/carer) could be signalled by:		
	changes in behaviour, psychological well-being or mental health (such as decreased mood, increased anxiety, increases in emotional outbursts, behaviours that reflect a regression to earlier developmental stages)	
	indicators that the child/young person is finding it difficult manage their condition (such as unhelpful health behaviours, social and educational withdrawal, change in relationships with parents/carers and other family members)	
An ability to draw on knowledge that formulating the relationship between psychological issues and physical health problems is critical when planning an intervention, given that:		
	emotional/psychological and mental health issues may be a consequence or precursor of a physical disorder, or	
	may be independent of (and unrelated to) the child's health difficulties	
An ability to draw on knowledge that intervention strategies should focus on the factors that are most likely to help the child/young person and their parents/carers/families manage their health condition more effectively:		
	a focus on psychological and mental health issues may not always be relevant, and hence may not be acceptable	
	helping children/young people and their families to adopt more effective strategies for better condition management may be more relevant than a direct focus on mental health issues	

Knowledge of models of behaviour change and strategies to achieve it

An ability to draw on knowledge that models of health behaviour suggest that achieving behaviour change is a process driven by a number of factors, all of which may be relevant when planning an intervention, including:
- the child/young person, parent/carer and family's sense of the seriousness of a potential illness and their child's susceptibility to it
- their 'common-sense understanding' of the child's illness (or the threat of an illness), influenced by:
- - the child/young person's capacity to understand about their illness/condition (influenced by their developmental age, stage and cognitive ability)
- - the experience of physical symptoms and emotions
- - social influences (such as peers, school and wider family systems)
- - their interactions with (and beliefs about) healthcare providers
- their capability to perform the behaviour (influenced by their developmental, cognitive, physical and emotional capacity)
- their sense of self-efficacy (their confidence that they can carry out and maintain the behaviour)
- their motivation to perform the behaviour
- the intention to perform the behaviour, shaped by:
- - attitudes toward the behaviour (e.g. their expectations regarding its likely benefit)
- - perceptions of their ability to perform the behaviour
- the opportunities to carry out the behaviour
- the influence of social context (which shapes their sense of what is (or is not) normative, and within which behaviour is learned and enacted)
- the external (environmental) support that is available to them (such as support from the wider family, peers, or school)
An ability to draw on knowledge of principles that help to explain how behaviours develop, are maintained and may be changed (particularly the principles associated with theories of learning such as operant and classical conditioning, and social learning theory)
- an ability to draw on these theories to promote developmentally appropriate parenting strategies
An ability to draw on knowledge that behaviour change can be conceptualised as a process, and that:
- it can be characterised as a series of steps (achieving the motivation and intention to change, 'actioning' change and maintaining change)
- each step can be revisited as the process of change takes place
- each step requires planning and the identification of potential barriers to change

Promoting behavioural change

Engaging the child/young person, parent/carer and family in a collaborative process

An ability to draw on knowledge that any proposed behavioural changes should take account of beliefs and values about the child's health condition
An ability to engage the child/young person, parent/carer and family in an open discussion of the ways that they think about and account for their health condition, so as to detect the relevance and acceptability of any proposed behavioural changes

- an ability to adapt communication to the developmental level and cognitive ability of the child/young person
- an ability to promote the engagement of the child/young person in the discussion

Where the child/young person, parent/carer and family's beliefs and values are linked to unhelpful behaviours, working with them to explore whether they can consider different perspectives (while taking care not to suggest that their account is incorrect or invalid), for example, by:

- helping them to assess the short and long-term consequences of their behaviours for their health
- helping them appreciate the impact of developmental stage on motivation and/or ability to engage in behavioural change.
- enhancing their belief in their ability to support behavioural changes (e.g. by promoting their sense of self-efficacy by discussing past successes in changing behaviours)
- evoking and responding to "change talk" (e.g. by creating discrepancy between present and future)
- enhancing a sense that behavioural change is normative by:
  - promoting the child/young person, parent/carer and family's perception of positive health behaviours (for example, where these are valued in their 'reference groups' (the groups to which they compare themselves, or to which they aspire)
  - promoting approval for positive health behaviours in significant others

Setting goals and identifying target behaviours

An ability to work with the child/young person, parent/carer and family to identify both short and long-term goals that are relevant to the child/young person, parent/carer and family's presentation concerns and values

An ability to work with the child/young person, parent/carer and family to agree SMART goals for behaviour change (Specific; Measurable; Attainable and realistic; Results-oriented; Timely (with an agreed time frame for their achievement) and the outcomes that these aim to achieve

An ability to work with the child/young person, parent/carer and family to identify target behaviours that relate to the goals that have been identified and agreed, and:

- that are amenable to change
- that are relevant and developmentally appropriate
- that the child and their family are in a position to effect change, with regard to:
  - their developmental, cognitive, physical and psychological capacity to make the changes
  - the physical, economic and social environment in which they live
  - their motivation to change the specific behaviours
  - the parent/carer's ability to implement consistent parenting strategies to manage challenging behaviours that are a direct response to the proposed changes

An ability to work with the child/young person, parent/carer and family to establish their motivation for changing specific behaviours:

- helping them to think about the pros and cons of these changes (from their own perspective)
- helping them develop an intention to make these changes

Developing action plans

An ability to work with the child/young person, parent/carer and family to develop 'action plans that:
identify when each aspect of the plan should be instituted (i.e. identifying any potential constraints or concerns that may make timing pertinent)
specify implementation intentions regarding when, where, and how often the new behaviour(s) should be enacted
identify coping plans that anticipate potential problems or barriers to enacting the behaviour, focusing on identifying strategies to overcome these
identify whether there are significant others who can support the new behaviour(s), and the roles they might play
identify the criteria which will be used to indicate that outcomes have been achieved
engage with wider systems that may be impacted by, or be able to support, behaviour changes (such as schools)

Using behavioural experiments

An ability to work with the child/young person, parent/carer and family in order to negotiate and plan 'behavioural experiments' which aim to help them test-out their beliefs about the consequences of the behaviours*

* Behavioural experiments are described fully in the CBT competence framework, at: www.ucl.ac.uk/clinical-psychology/CORE/CBT_Competences/Specific_Competences/Behavioural_Experiments.pdf

Habit formation

An ability to help the child/young person, parent/carer and family understand the rationale for focusing on habit formation in sustaining behavioural change (using strategies to make new behaviours 'automatic' rather than being dependent on 'willed' action)
An ability to support the implementation of strategies that will help to make new behaviours more habitual, and that are acceptable and applicable, e.g.:
identifying developmentally appropriate rewards (reinforcers) (e.g. including praise or tangible rewards)
recruiting social support
identifying environmental cues that support or inhibit the new behaviour (for example, both at home and school)
ensuring regular opportunities for repetition
engaging (where developmentally appropriate) in self-monitoring and/or monitoring by parents/carers/school and using this feedback to identify challenges to, and ways of supporting and practising the new behaviour

Monitoring and supporting change

Monitoring change

An ability to help the child/young person, parent/carer and family to monitor the behaviour(s) that they are aiming to change by:
explaining the rationale for keeping a record or diary that details what they did, where they did it, who they did it with, and what happened before and after the behaviour

- reviewing the diary to identify progress, and to identify factors that facilitate or hinder change
- discussing any concerns about completing the record or diary when they have not made progress
- working to review strategies to overcome barriers to change (both in immediate contexts (such as family) and wider systems (such as school), and to maximise the influence of factors that promote change
- helping them to reflect on any implications of feedback from the monitoring process, and to act as an active participant in a collaborative process

An ability to help develop realistic expectations regarding the pace of change (e.g. reinforcing the value of making small changes even if these do not meet agreed targets, having an awareness that setbacks are normal)

Reviewing progress - supporting and maintaining change

An ability to discuss the impact of any changes to behaviour (both on the child/young person and on those with whom they are in contact)

- an ability to work to identify ways in which any adverse consequences of behavioural change can be mitigated

An ability to review goals (e.g. identifying new goals, reviewing whether current goals are too easy or too challenging)

- identifying environmental changes that may facilitate change
- identifying factors that may prompt (and therefore support) the behaviour, e.g.:
  - social support from friends or family
  - support from school
  - identifying rewards for behavioural change

An ability to maintain change by planning for, and guarding against flare-ups or recurrence by helping the child/young person and parent/carer identify:

- the skills they can use to cope with difficult situations and conflicting goals
- environmental cues that may adversely impact on the changes they have made
- coping plans that:
  - distinguish between a ‘lapse’ and a ‘relapse’
  - anticipate indicators of relapse and indicate how these will be managed
  - take account of the ways they anticipate thinking about flare-ups, and how this will influence their motivation to continue sustaining behaviour change

Knowledge of the presenting conditions and their treatment

An ability to draw on knowledge of that children and young people with physical health conditions are at an increased risk of experiencing psychological difficulties	
An ability to draw on knowledge of factors that promote well-being and emotional resilience in children and young people with physical health conditions, for example:	
	high self-esteem,
	secure attachment to caregiver
	higher levels of social support
	age appropriate understanding of their condition
	in spite of their condition, opportunities to engage in age-appropriate activities and to develop age-appropriate levels of independence
An ability to draw on knowledge of factors that may reduce well-being and emotional resilience in children and young people with physical health conditions, for example:	
	younger age at diagnosis
	complexity of treatment regime
	predictability of course of condition
An ability to draw on knowledge that children and young people with physical health conditions will be faced with a number of psychological tasks which can impact on their psychological wellbeing and adjustment, and that:	
	different physical conditions will present specific challenges (e.g. coping with body image; coping with a life limiting diagnosis)
	different physical conditions will have different treatment demands (e.g. treatments with significant side effects, or which require life-long medication)
An ability to draw on knowledge that children and young people with physical health conditions can develop mental health and neurodevelopmental conditions in addition to, or as part of their physical health condition	
An ability to draw on knowledge of the social, psychological, family and biological factors associated both with adjustment and with the development and maintenance of mental health problems	
An ability to draw on knowledge of the diagnostic criteria for child and adolescent mental health conditions specified in the main classification systems (i.e. the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD)	
An ability to draw on knowledge of the incidence and prevalence of mental health presentations across different cultures/ethnicities/social classes	
An ability to draw on knowledge of specific physical health conditions where mental health difficulties are more prevalent	
In relation to presentations where the physiological basis of the condition is uncertain or unknown, an ability to draw on knowledge of positive diagnostic features so as to make a diagnosis of inclusion (rather than of exclusion)	
An ability to draw on knowledge of the ways in which mental health problems can manifest interpersonally, so as to avoid escalating or compounding difficult or problematic behaviour that is directly attributable to the child or their parent/carer's mental health condition	
An ability to draw on knowledge of the interaction between physical and psychological health and development, (e.g. the capacity to maintain intimate, family and social relationships, or to maintain education and play	
An ability to draw on knowledge of development and the ways in which children of different age express psychological distress (e.g. younger children may somatise or act out rather than verbalise)	

An ability to draw on knowledge that the systems surrounding children and young people and their families can sometimes contribute to the development of unhelpful strategies for managing their presentation, and that these interpersonal patterns can escalate or compound difficulties