Meaning & Purpose
Living with
Long-Term Conditions

Factsheet date: 28/01/2019

What clinical practitioners say about IMACC

"One thing that stood out for me in your presentation was how your model seems to fit most people and as such can be a blueprint for anyone's recovery."

Dr Bill Gallagher, USA
Chiropractor and owner at Phoenix Medical Legal Services

IMACC in Pain Management

IMACC was implemented by several practitioners in a Pain Management Unit around 2011 and the below quotes and data was gathered retrospectively in 2017.

Senior Lead Physiotherapist:

"The IMACC model allowed me to conceptualise the process patients go through when adjusting to a long-term condition, chronic pain. It helped me identify where the patient was having difficulty and helped me focus my rehabilitation as it enabled me to align the rehab with the appropriate stage."

Occupational Therapist:

I started using this model in my Occupational Therapy interventions when I started to do community based group work in the Pain Management Service. We used it to inform patients of their new coping skills, which help in managing their pain, and to explore barriers as well.

Seeing the benefits the patients had in seeing this information in black and white, I started using it in my occupational therapy one to one sessions with patients. For patients, who demonstrate some resistance to behavioural changes, I found it helped them to 'name' that resistance, which is usually the conflict they experience with their beliefs, thoughts

*and emotions that lead to failure in making the changes to manage their pain. Helping them to understand this process and balancing it with what they have learnt that helps them can help them to effect the changes they need to make**. I continue to use this model frequently in my clinics and I have found it valuable in my practice.*** *[…]*

[Case story NN] – always capable, everyone goes to her for help and she has never needed to ask for help from anyone. Has sons in university, but she continues to look after them, tidying up. Complains no one helps her but she does things if her sons take too long to do them. When we discussed the pattern via the IMACC model, she related to it and said it's the first time she has acknowledged this barrier.

Highly Specialist Psychologist (Counselling Psychologist):

"I can't recommend this enough. [The IMACC] has been invaluable to me in my work with individuals and groups with chronic pain. It has a wide variety of applications across different healthcare settings, patient populations and disciplines."

Highly Specialist Psychologist (Clinical Psychologist):

IMACC used in up to 15 Pain Management Programmes (PMP) (approximately 150 patients)

Examples of responses on the PMP:

- that acceptance and adjustment to chronic pain is an ongoing ***process*** (that often prompted a response of relief and gradual acceptance (after disbelief/frustration)
- the ***letting go*** phase often prompted tears/acknowledgement of unprocessed grief
- the area of ***social support*** then offers patients the permission to learn specific skills for interacting with others, especially assertiveness

Later on in the PMP, we introduced a video (from Bristol Pain Service using actors) and patients seemed better able to relate to the concepts in the IMACC when they could see the behaviours of others on the video (i.e. when they had perspective and able to step out of themselves and observe others in their situation)

Individuals
The IMACC was a stable model in probably 70-80% of clients I saw individually in the pain unit 1-to-1, especially after 2013-2014 when I had time to practice it and was more familiar with it. When the 8 session

therapy model was introduced (around that time), then I found it a model I would introduce from session 2-3 onwards (of the 8) as it allowed me to assess where the time could be best spent in therapy. The only people I would not use it with were others with specific needs elsewhere (e.g. risk concerns took a priority), or their main needs were not pain management (i.e. more acute mental health distress). It's hard to know just exactly how many people I assessed/offered therapy too across my time in the unit. Therapy clients were getting into the 50-60+ completed cases and I think we estimated 50-60 people a year through the PMPs a year.

Anecdotally, I found that **Taking stock** allowed permission for frustration, anger and resistance to come out and be better processed, ***Letting Go*** allowed the acknowledgement of grief to be spoken about, ***Accepting/integrating*** helped name areas of strength, and ***learning new*** allowed for the introduction of Mindfulness, and other compassion-based ideas to be incorporated.

The model seemed to often describe a person's experience of living with a chronic condition in a way that other models seemed to miss the mark - e.g. all the anger, stuckness, grief, strengths and relationship barriers are accounted for within the model and explainable. It was often a fairly simple and digestible way of introducing the role of psychology and emotions to pain patients.

As I got more experience with CAT [*Cognitive Analytic Therapy*], and a focus on relationships, and relational ways of working, I found that the **Social Support** area allowed me to really open up conversations about personal relationships with others and self-to-self relationships as a key part of adjustment (and therefore important to work on in therapy).

In terms of my clinical practice, overall, I think I would have struggled to work in pain management without IMACC holding everything together for me. It was such a useful model to bring in other theory (CBT, CFT, CAT, ACT - none of which were specifically tailored towards pain) in a way that allowed the team to have a similar message but also individual therapy styles and emphases. Therefore, it was a key part of formulating.

If I had stayed on in the pain unit, I think the IMACC could have formed the basis to the initial psychology assessments in a more systemic way than we used it – i.e. to specifically enquire about each general area/domain in the model.

Other areas
If I am working with someone now in pain in private practice (maybe 6-8

people in total so far), the IMACC model will still come in at a fairly early stage and will help me direct the intervention in a more focused way - i.e. we see where the 'stuck' parts are quicker.

Quotes from evaluations of the IMACC workshops (2018-19):

Useful model – thank you!

It'll be a useful model to use for guiding assessments with patients

[Most useful]: Consideration of adjustment as a process, not just a list of factors

[Most useful]: Breaking what appears to be complex model initially into a very practical and easy to understand tool

I found this workshop to be extremely helpful

[Will you apply the model?]: Yes, using the attachment model as central to assessment & relational support/therapeutic relationship

Understanding the model as a process model was helpful