A publicly engaged academic

Community psychologist **Jim Orford** is interviewed by Ian Florance

Interest in community psychology is growing. Jim Orford has written influential textbooks in the area and is involved in the Society's Community Psychology Section. He is also, according to the *Guardian*, the UK's 'leading academic expert on addiction'. Not bad for someone who started university with the intention of becoming an industrial chemist.

'I'd expected university teaching to be more like school,' he tells me. 'It was disconcerting to be left so much to my own devices. In my second year I started a half subject in psychology and was immediately fascinated: we weren't just imbibing and regurgitating facts but working in smaller rooms in small groups debating theories. I ended doing a natural science degree with psychology as my main subject, recognised by the Society, although I'd only done the equivalent of a year and a half's psychology!

Unusually Jim was married with a child when he finished his degree, 'so I couldn't just sit around. I had to get a job and the choice was between market research and clinical psychology. Studying the latter was less of a commitment than it is now. Various interviewers confirmed my suspicion that I wasn't cut out for market research. One said "If heroin was legal we'd research it" so I was out of there! The research element in the Institute of Psychiatry (IOP) prospectus attracted me. I applied and got in, which surprised me. I'd been going through a time of change during my first degree and didn't get a good one. Nowadays I probably wouldn't have got on a clinical psychology course at all. It took just 13 months, and required only a further year of supervision to qualify. Times have changed.'

The head of the course was Monte Shapiro whose interest in studying 'single cases' was quite radical at the time. 'He was interested in the unique experience of individuals which could easily get lost if data from multiple people were aggregated. I'm still interested in the detailed experiences of individual's lives, particularly their family and community lives. I'm increasingly disappointed that much of that detail gets lost in psychological research.' As we'll see, this approach had a huge influence on Jim's future work.

Jim spent a year in Manchester working in a general hospital psychiatry department and would have stayed there if he could have got on a PhD course. But, as Jim recounts, chance intervened. 'Griffith Edwards was a major international figure in developing alcohol and drug studies. I got a call from him when he was setting up the Addiction Research Unit at the IOP, inviting me to work there and register for a PhD. I knew nothing about addictions but the experience started a continuing fascination.'

Jim worked as a researcher on a number of projects while completing his doctorate. He then got a senior lectureship in clinical psychology at the University of Exeter, 'a joint post between the University and the Health Service, working alongside Jim Drewery on a new clinical psychology course.'

After 17 happy years in Exeter, Jim moved to Birmingham University 'They were about to change a two-year clinical Masters to a three-year Doctorate and they needed to appoint someone as chair. I ran the course for five years, took early retirement in '98, carried on doing research and research supervision for nine more years and then became Emeritus Professor. Since then I've been writing as much as possible, collaborating with others doing research and development, engaging in policy matters, and generally carrying on the life of, as I like to see it, a publicly engaged academic, without the burdens of teaching or administration.'

Jim says he was very lucky to do his PhD with Griffith Edwards: 'an exceptional psychiatrist with a wide range of interests. His drive to link research to community action was an inspiring model. Griffith was interested in how social policy affected addiction and its effects at family and community levels – not just what was going on inside the head of the individual person with an addiction. The work we did there is one of the sources of the brief therapy movement. We were asking what seemed to us very basic questions: "How do

people overcome addictions?" "What is an effective treatment?" That experience also underpins my continuing interest in familial aspects of addiction which was the subject of my PhD. Here we were trying to answer different questions: "How do you cope with someone else's addiction?" "What support do affected family members need?" "How does this affect your health, stress levels?". The Alcohol, Drugs and the Family (ADF) group which several of us started later when I was in Exeter has continued to do a lot of work in this area since then.'

I can see where this approach seems to fit in with community psychology. 'People who work in community psychology have a strong inclination to see the adversities people face as real rather than mentally appraised or constructed. What you think is not the main thing that matters. You can trace the European roots of community psychology back to studies in the 1930s but I first came across the US form when I was doing my PhD. The approach started in the USA in the 50s and 60s, influenced by the campaigns for racial equality and community mental health. At the time the Addiction Research Unit was also looking at wider issues of dependence: issues like the role of the police and GPs, what support structures there were in different communities, how relationships coped with addiction. Community psychology widened my vision.'

At that time Jim became more interested in qualitative research. 'This links to Monte Shapiro's interest in "single cases" during my clinical training. I was bought up in the quantitative tradition but in the 1980s I began researching the experiences of family members affected by addiction using open-ended interviews and qualitative analysis. That has continued in our group's international work ever since. We think of what we are doing as facilitating people telling us about the truth of their lives, or at least of an aspect of their lives which they see as dominant. We tend to trust the veracity of what we are told. We view the interviewer's role as that of a fieldworker whose task is to collect and summarise the interviewee's account: some might call this a form of 'naive realism' but I prefer to see it as giving a voice to an otherwise silent group and then advocating for their interests. For example, when it comes to trying to understand how people overcome addictions, I believe that listening to what people have to say about what happened to them personally in their individual circumstances is as important as statistical analysis of such things as mediation and moderation effects. That is why I insisted that we included open-ended interviews about the change process in the follow-up to the UK Alcohol Treatment Trial. The results supported the idea that positive factors for change are principally non-specific, to do with the circumstances that motivates desire for change, the experience of the relationship with a helping person, and whether other people and life conditions are supportive of change. Some might say I've gone soft and unscientific, but I think this leads to better science. Psychology still suffers from an inferiority complex, making us do things just because they appear scientific.'

One of the results of the group's family work has been the development of the stress-strain-coping-support model and the 5-Step Method for helping family members. The group has worked in many countries, including Mexico, aboriginal communities in Northern Australia, and Italy: they are now collaborating with colleagues in Ireland, India, Brazil and South Africa, and have started an international network of people interested in research and practice in this area (see www.afinetwork.info). Jim tells me the family work led him to 'autobiographies, biographies and works of fiction which feature family members affected by addiction – biographies of the wives of the poets Samuel Taylor Coleridge and Dylan Thomas are amongst the very best.'

The group's international family research clearly excites Jim. 'I feel very privileged to hear, in unique detail, about people whose lives are complicated by living with a close relative with an alcohol, drug or gambling problem throughout the world. Being a family member affected by addiction is a disempowering experience involving agonising "addiction dilemmas" (the title of a recent book of mine). Many people face such a dilemma when a family member, friend or colleague has an addiction – should we take some action, and if so what; put up with the situation and say and do nothing; or simply avoid the situation and walk away.'

Jim's first major book was *Excessive Appetites: A Psychological View of Addictions* which featured non-substance addictions. 'I got interested in gambling at the Addiction Research Unit and felt the psychiatric approach was a bit too, well, psychiatric. I took a more psychological approach. We now know just how many things you can become addicted to, which wasn't properly acknowledged in the '70s. Gambling research is a small field. I've tried to keep entirely independent of the gambling industry, which other academics and treatment providers aren't doing, and I've been saying for a long time now that policy is getting it wrong and we're setting up major problems for ourselves. The industry, which controls the funding for research and treatment, is not so keen on serious prevention because it would affect their profits and there's too little help for sufferers and their families. This is a major problem: in fact equivalent in prevalence rate in Britain to the problem of harmful illicit drug use. I've set up a website, www.gamblingwatchuk.org, to help raise awareness about this issue.'

I asked Jim how he'd explain community psychology to someone. 'More than anything it's a way of thinking. In the UK a lot of people who get involved in community psychology are clinical psychologists who've seen the limitations of simply working with individual people, even using diagnostic frameworks like the notorious DSM. They also have come to the conclusion that we need to be very careful about approaches that imply blaming people who should rather be seen as the victims of social arrangements. Community psychology sees individuals in a wider context.'

I had noticed that those interested in community psychology sometimes feel out of place in psychology departments. 'That is partly the clash between studying the mental interiority of individuals – as the late British community psychologist David Smail put it – and addressing the relationship between individuals and social systems. In my latest book *Power, Powerlessness and Addiction* I've tried to draw on clinical and community psychology, moving from the individual, through the family and the community up to the industries that feed addictions.

'Getting down to the details of personal experience is, I see now, one of the continuing themes of my career. The other is a concern to understand how personal experience is shaped by, and shapes, the collective experience of the groups of people of which a person is a part… Social class is traditionally more of a sociological subject of study, but it is profoundly important psychologically. As an undergraduate at Cambridge I was rather shocked to meet people who had had an even more privileged background than I had, and I became interested. Income and wealth inequality were actually decreasing at that time, and we believed that society would continue to become more equitable, less hierarchical. Now, post the 1980s, inequality and its social and psychological effects have been on the increase. The psychological study of inequality, one of the things that is at the heart of community psychology, should be a priority.'

From training to touchdown

Rob Rooksby on his collision of American football and psychology

In 1983 I enrolled at Coleg Harlech (a mature student college) in North Wales to study sociology. My second-choice subject was psychology: the closest thing on offer. I have studied and taught psychology ever since, and in a curious and certainly unplanned turn of events I have found myself drawing on my knowledge and understanding of psychology more than ever in the last four years.

After undergraduate and incomplete postgraduate studies at Exeter University I guess I 'drifted' into teaching and ended-up spending 24 happy years at my current school – Exmouth Community College. Of course, I have become aware of my own ageing 'psychology' – every year presented new challenges in the teaching of the subject. Funding cuts in education, changing specifications and interesting 'auditory processing' issues – using psychology to deal with these changes is really 'bread-and-butter' working practice to most, if not all, psychology teachers.

I passionately believe that teachers should teach by example. If education is full of exciting opportunities that young people should grasp, why don't teachers grasp the same opportunities? Yet it was by complete accident that my world of psychology teaching 'collided' with what is perceived as one of the most brutal sports in the world – American football. Often compared to the ancient gladiatorial arena, the sport is actually one of the least gender-biased, most inclusive and exciting games that young people can play. Away from the extremes of the NFL, American football promotes all the things we want young people to aspire to – self-confidence, self-respect, physical fitness, anti-drugs and alcohol and true gender equality.

A long story can be told as to why I woke up one day with no sports background or training, a scant knowledge and understanding of American football but a complete belief that introducing the sport into my school would have exciting benefits for the students. I had to drain every last drop of my understanding of psychology to achieve my goal. Some of what I've done was based on unconscious decision making – things that simply 'felt right'. But without doubt much of how I have negotiated the last four years is down to my broad understanding of the subject.

Challenge #1: Get knowledgeable and get trained. At 49, something of a daunting task. However, understanding the 'self-

A linchpin in health service research

Heather Tinkler on her work as a Clinical Studies Officer in the NHS

On graduating from university in 2011 I felt like a tiny drop in the ocean of underemployed psychology graduates. I received little respite in news that only a select few of the people I graduated with had managed to gain a position as an assistant psychologist. My eye turned to further education and the opportunity to delve deeper into an area that has always held great interest for me – forensic psychology. However, after successfully graduating from the MSc I found myself in a familiar situation – struggling to find employment linked with my educational background. It seemed like the role of an assistant psychologist was almost impossible to achieve.

Thankfully, I had remembered the words of my teachers and lecturers through the years and had worked hard to build up experience in relevant fields. During my undergraduate degree I had worked as a support worker for the charity Victim Support. When I moved to complete my master's I began working as a health care assistant in forensic mental health, learning disability wards and in A&E.

I began to branch out further, considering positions that were not necessarily focused on a psychology perspective but would still be highly relevant should I wish to continue my studies to doctorate level. Due to my experience in the NHS I began to look at roles that could encompass some of the skills I had learnt from clinical settings, whilst keeping my psychology knowledge up to date. I had enjoyed my dissertations during my degrees and remained keen to continue work that involved research. After scouring the NHS jobs and discussions with my brother, who had started work in a similar field, I discovered the role of the Clinical Studies Officer (CSO). A CSO supports and manages the set-up of clinical trials. This includes, but is not limited to, document management, patient identification, participant recruitment (consent), and study-specific tasks (venepuncture, questionnaires, interventions), all completed according to the principles of good clinical practice.

I began to apply for some positions and it was not long before I started receiving interview invitations for both research assistant and CSO posts. Shortly after my first interview I was offered a position and took it.

I start at 9am, usually with a few e-mails to attend to. I make a few phone calls about up and coming studies, or deal with questions from study teams. I then move on to preparation for any upcoming presentations. I often have to give talks about research within the Trust.

At times when we are running close to capacity of study uptake I can see up to three patients/participants in one day. Typically, I have one patient visit every few days. Generally I have noticed people tend to prefer afternoon appointments, so late morning usually involves a quick telephone call to check with the (potential) participant that they are still happy to be visited. I always get everything I will need for a visit ready the day before, and then check it all again on the day of the visit. This might include a CRF (Case Report Form), consent form, information leaflet, blood sample kits, saliva sample kits, blood pressure machine, scales,

fulfilling prophecy' – if I believe I can succeed, I will! I threw myself into physical training and took advice on what I needed to know and demonstrate to gain my Level 1 qualification.

Challenge #2: Educate a school and community about the actual sport. Moscovici was my guide here and all his thoughts on 'minority influence'. Before me, there was no American football in Exmouth. I used every scrap of understanding to drive forward the changes that needed to be made, at school and in the community. It's an ongoing process and one that still requires a huge amount of effort and determination.

Challenge #3: Create credibility. Attract those that the students and others would relate to. Create something that others respect and people will then respect you. No one was going to take me, personally, very seriously. An ex-NFL player coming to the school because they could appreciate that what I was doing was 'sound football training' gave enormous credibility to the programme (although it also took effort, luck and a year of perseverance to make it happen).

Challenge #4: Deliver an enjoyable and valued programme. It may seem that with such little knowledge, this was an impossible task. But curiously, being able to approach developing the programme without expectations and previous knowledge allowed me to decide how the sport would best fit a school. I looked at it purely from the point of view of a teacher, not a 'football coach'. I have and have had a small number of disabled students play as equals with able-bodied players. That's how inclusive the sport is!

Challenge #5: Get the press on side. A football-friendly journalist appreciated some of the 'exclusives' I was able to arrange for him and as his understanding grew of what I was doing, so did his sympathy and support.

Challenge #6: Create something unique and valuable to the national governing bodies. My starting the programme and gaining a £10K award from Sport England was the first reason I was invited to Westminster in 2011. Four years on and I've grown a programme with a reputation as a leading school programme, resulting in my being invited to appear before a select committee at Westminster in 2014 (see also Challenge #3).

One of the most important lessons I learnt as a postgraduate watching a fellow student develop their reputation and CV is: never be frightened of self-promotion when you have something to promote! Providing you are 'doing what it says on the tin' people will accept and appreciate it. Try and deceive them and they will quickly find you out (well, most of the time!).

I know that had I not had my psychological knowledge, training and experience, the programme here would not exist. Sometimes I can point to this knowledge being explicit in the development of the programme, sometimes it is a more osmotic influence. As a middle-aged man having re-invented himself through a late gained interest and passion, and taking it all the way to Westminster, it just goes to show Pavlov was right – you can teach an old dog new tricks!

tape measure... the list could go on!

On a typical day with a patient visit I make sure I set off in good time. A visit with a participant can take anything from 30 minutes to three hours, sometimes more. On my return to the office I need to fill in the correct paperwork recording the visit, and then ensure the CRF is stored safely ready to eventually be archived or sent to the main study centre. Any samples are packed and sent off for analysis immediately.

Late afternoon is usually a time filled with keeping the Principal Investigators (leads for studies within my site, usually consultants) up to date with how a study is running, if I need relevant documentation from them, if they have screened any patients for their study, etc. A large part of my role is keeping our staff in the loop with what research is going on within the organisation. I ensure all screening and recruitment logs are up to date. If I have a new study, I will start to work through the feasibility checks to see if it is a study that the organisation could be involved in.

There is a lot I enjoy about the job. The variety appeals – new research and the potential for exciting discoveries from research that I have helped to complete. The training has been good – I was amazed at the amount I receive for the role. Due to the nature of research and the number of studies I can be involved in there are often a large number of rating scales, clinical procedures and research skills that I need to be competent in. I am confident that these will be relevant in my future career path. And the patient contact is rewarding – although I am based in an office I still see a range of patients and client groups on a regular basis. It is important to have contact with service users as they offer a unique perspective.

What about the lows? Although I am entitled to clinical supervision it has been hard to obtain this from a pure psychology perspective and I have had to branch into other areas to keep up to date. But what I may miss from the clinical side I gain twofold from a research side. And at times it can be difficult to engage staff. In a time of great pressure for the NHS, they are being required to do more in the same time, and some can see research as an extra burden.

Most of the research I help to conduct is formulated around mental health issues, where the dropout rate for research participation is markedly higher than other areas. At times this can become disheartening, but participating in research is ultimately completely optional and people's circumstances change, it's a part of life and thus a part of the research environment. Sometimes someone will completely surprise you and that's why it's vital to offer everyone the option of taking part in research.

As my role is based solely around research completion it can be difficult to keep contact with psychologists in non-research related matters. Fortunately I have good rapport with psychologists within the trust and am able to regularly attend meetings and seek advice from them.

So where might this lead? Well, it can take a while to get your head around the processes of setting up and then running research in the NHS. I am confident that this is knowledge that will help me should I get the opportunity to continue my education and complete my own research.