Psychology people in profile:

Professor Paul Kennedy

Jasmine Hearn

DPhil student Jasmine Hearn interviewed Clinical Psychologist Professor Paul Kennedy of the National Spinal Injuries Centre and the University of Oxford. Paul shared his experiences working in the field of chronic illness, the impact of psychology at the National Spinal Injures Centre, and his advice for others seeking careers in clinical psychology and research.

What brought you to work in clinical psychology?

I started to become interested in clinical psychology when I was very young. I was 15 when I decided I wanted to be a clinical psychologist, and the reason for that was that I spent the summer working in play schemes in West Belfast. I was a young volunteer and I met all of these students doing sociology, anthropology, and subjects I never heard of. That is when I first came across psychology. I can remember we had an event where we had to go on a bus journey for about two hours, and the person I was sitting with was training to be a clinical psychologist, so I had lots of questions. Her enthusiasm was contagious and she really inspired me, and she later became one of my clinical supervisors. I felt it was a logical path to go down, as I was interested in people; observing them, their dynamics and resolving psychological issues.

It's really interesting that you were so sure of a career at such a young age. Are you pleased you chose this career?

It's a career I haven't regretted for one second. It is thoroughly interesting and thoroughly enjoyable. I think psychology in general was under-acknowledged when I was younger. Obviously there were social and cultural issues when I was growing up. I grew up right in the middle of the political upheaval in Belfast, euphemistically called the Troubles, so I lived in a war zone. I'm sure that partly influenced my career choice. There was a fragmentation of society then, and I had a very close friend who was murdered by paramilitaries when I was 14, I don't know whether this was in the back of my mind in developing my psychological interests: the trauma, loss and change. That dimension was not really recognised or attended to. It was a 'just get on with it' societal response to the conflict in general.

I really matured my interest in the second year of my degree. We focused on learning theory and comparative psychology, and I became more aware of the changes that could be made by applying learning theory. I was very influenced by radical behaviourism: very scientific, it seemed credible and challenging. I felt our goal should be to help people cope successfully, not suffer insightfully. I also had a clinical placement in learning disabilities, which was very much about normalisation not labelling, adaptive models, applied learning theory, and social learning models. And I liked that the Watsonian and Skinnerian models could enrich people's lives.

How did you come to work with people with spinal cord injuries?

On my clinical psychology training course there was no particular opportunity to work in an applied clinical health setting. So when I was in my final placement in a neurological setting, I noticed a job at the Royal National Orthopaedic Hospital in the London Spinal Unit which interested me, so I applied. I had previously met one patient with a spinal cord injury, and realised that it had never occurred to me before that someone could survive an injury like that. So when I was seeing patients on the ward who were newly injured, I went to the literature to look for rates of depression, the impact of spinal injury, processes of adjustment and coping, and I couldn't find anything! So I thought, I better do this research! I've always had an interest in research. I published a paper as an undergraduate on an errorless learning intervention, and developed my interest in research.

I managed to get a travel scholarship to visit rehabilitation facilities in North America in the eighties. I visited the Rehabilitation Institute of Chicago, New York University Medical Centre, Rocky Mountain Spine Clinic, Kessler Institute for Rehabilitation (where Christopher Reeves was) and the Bronx VA Medical Center. This galvanised my interest in spinal cord injury, my understanding of the role of a clinical psychologist in that setting, and the need for research. I was interested in obtaining objective information about the impact of having a spinal cord injury, and I was also interested in the differences between those who coped well and those who don't. Interestingly, it's not the injury or biomedical factors that determine outcome after injury, it's the psychological factors.

Could you tell me more about your research?

Most of my research is longitudinal, which I really enjoy. We've just finished a piece of research on a 21-year follow-up of a cohort we started assessing in 1990. We've been able to identify the rates of anxiety and depression, and some of the predictors of adjustment to injury. Linked to that, we've also done a number of studies replicating this across European centres too, so that we can identify which psychological factors predict successful adjustment. In one study we found that psychological factors improved function in terms of mobility. We found that the more psychologically accepting patients are, the more likely they are to engage in rehabilitation and the more likely they are to see benefit of rehabilitation. Common sense really, in a way. On the other hand, the more depressed someone is, the more withdrawn they become and the less they engage with rehabilitation. This helps to highlight that, whilst we can't cure spinal injury, we can use psychology to improve independence and the person's sense of control.

I'm also interested in coping, but early on I realised that coping responses are embedded in our disposition rather than situational responses, and disposition is very hard to change due to its connection with personality traits. I then came to realise that appraisals of life events are important in coping, so we developed the Appraisals of DisAbility: Primary and Secondary Scale (ADAPSS; Dean & Kennedy, 2009; Kaiser & Kennedy, 2011), with three adaptive and three maladaptive dimensions. Those with high levels of negative attitudes towards disability, those who are despondent, distressed and in disbelief, may not cope well, whereas those with self-agency, determined resolve and personal resilience may adapt better. This has been replicated in a number of studies, indicating that appraisals are important. So we need to change people's appraisals of spinal injury as a threat, to appraisals of it as a challenge. Appraising it as a threat interferes with the adjustment process. Perceiving it as a challenge helps people to engage in effective coping strategies. So our challenge is to reframe things like catastrophic thoughts, and try to challenge those thoughts.

You established the department of clinical psychology at the National Spinal Injuries Centre in 1988. In your time here, how do you feel the department has grown or changed?

I was working at Stanmore before I came here, and that was the first centre to have a clinical psychologist attached to it. When I was planning to come here I was told there were four consultants who have patients here, and two of them didn't believe in psychology! It turned out that those two people who didn't believe in psychology referred the most patients to me! So, I think there was a certain reluctance and lack of understanding of what psychology means. I came here, rolled up my sleeves and got involved in thinking about how we could maximise the engagement in rehabilitation for patients and how we can normalise and address their emotional responses, as well as foster and facilitate effective adjustment. We get people here with extremely complex situations in terms of pre-existing mental health problems or histories of major social fragmentation, and when they come here they feel their life disintegrating in some ways, so we need to provide support for those people. So, we have developed a framework to help those people engage and be supported, and I feel this has demonstrated the contribution that psychology can make.

When I first came here there was one psychologist. Now we have five clinical psychologists and an assistant psychologist. The impact has been the improved ability to provide access to psychological interventions and emotional support to people having to manage the trauma of a spinal injury. We can now enable them to feel like participants in life. We are also able to provide support and training to the team here who manage these complex situations on a daily basis, and provide normative information to those who are coping well, in order to validate and support them too.

As a clinical psychologist I'm not just interested in seeing a patient for an hour a week. I'm interested in the 24/7 environment, and to what extent this environment is psychologically constructed to enable people to learn. This is a rehabilitation centre, where people come to learn to manage the consequences of their disability, so when they come here we provide them with a psychologically informed framework, and we use goal planning and the needs assessment checklist. The needs assessment checklist is a behaviourally anchored checklist of 300 items that maps out the domains that are impacted by the injury, including bladder, bowel, skin, psychological and social reintegration, and activity engagement. Goal planning is a way of harnessing potential and fostering engagement in rehabilitation to prevent disengagement, allowing us to specify who does what, where and when.

I'm in a fortunate position to work with trainee clinical psychologists who are interested in research and are looking for supervised projects. So a lot of our research has moved forward as a result of interested, enthusiastic and competent trainee clinical psychologists. We've got data on thousands of patients and see progress of categories of patients and their progress, such as people with mental health issues, and on the whole these people do have their needs addressed. Irrespective of your age – our research shows that those who are 65 benefit just as much as those who are 45 and 25 – they all significantly improve in rehabilitation. There are also no differences in male and female outcomes.

That's great to hear. Could you tell me about your grant finding strategies, and what you feel makes a good grant?

There are a number of ways that I have approached that in my career. I realised I had to look for short-term funding opportunities relating to audit that I could make into research as well. I received funding from a variety of trusts interested in spinal cord injuries, with very specific proposals. My advice to people applying for grants is to

research the funding body to make sure you are framing your information or ideas to their specific interests. Find out why they are providing the funding, and what or whom the research is benefitting. Find out who the people are and see if they have interest in psychological research, otherwise they may not view your proposal favourably. Also, put a lot of effort into your rationale and design. Make sure it is scientifically sound and theoretically based with observable outcomes. Incorporating service user perspectives is critical.

What do you enjoy most about your work?
I think it's the interplay between clinical work, research and training. I feel that provides me with a real range of activities that are never boring. They each feed into one another. We can have an idea that is researched and is then pitched to other staff and having them take that on into routine practice gives me a real sense of achievement.

What do you feel like you have gained through your experiences of research and working here?
I think the National Spinal Injuries Centre is a very honest environment to work in. You are working with people dealing with very real issues in a frank manner, which I enjoy. In this setting you can see people progress, in the early stages of rehabilitation through to community placement. Being part of the team that make a difference to people facing such adversity is very rewarding. Working here also gives you a broader perspective on life. You never know what could happen to us at any time, so it is important to value relationships and know what really makes a difference to life, not to take it too seriously and remember to have fun.

What was the proudest moment of your career?
There were two. The first was when I heard that the University of Oxford were making me a professor in 2006 – I would never have a believed it! I was quite amazed when that happened and felt very honoured. The second was when the service user group The Spinal Injuries Association, in their rebuilding lives awards, presented me with the Outstanding Psychologist Award in 2014. It was like the Oscars, with all other nominees at a table. Again, I was very honoured as that came from service users.

Finally, what advice would you give to others looking to work in research or clinical psychology?
I went into my career without a long-term game plan; I just remained interested in the demands of where I was at the time. This then broadens and other perspectives and opportunities emerge. I think it is always important to remain in contact with other psychologists. Consider and explore a clinical field you are interested in, as that is what will sustain you in the future, but be flexible in how you respond as your career unfolds and remain open to different possibilities. Find people who can and will support you, as well as organisations with affirmative attitudes that are forward-looking. Get involved in work at different levels. Build up your clinical skills but look for opportunities in research, management and training. Get involved in the British Psychological Society, as it is a great opportunity to meet like-minded people, go to conferences and get inspired. They have proved to be a rich source of ideas, sharing knowledge and support.

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