The Role of the Clinical Psychologist in Supporting Older Persons with Multiple Sclerosis within the NHS

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January 2014

Abstract

Multiple sclerosis (MS) is a neurological disease that mostly affects younger women, however with increasing longevity many people will age with MS. There is a limited evidence-base regarding the issues of, and treatments for, older persons with MS (OPwMS). The voices of a specific population of OPwMS suggest that aging with MS requires adjustment to increasing mobility and disability as well as continued management of common symptoms such as balance, weakness and fatigue issues. The literature suggests that the clinical psychologist should be embedded in NHS multi-disciplinary teams (MDTs) and, aligned with New Ways of Working for Applied Psychologists, should work directly with OPwMS; delivering psychological therapy to enhance symptom management and wellbeing, or indirectly; training and supervising MDTs to deliver such interventions. Accountability and professional protection of the clinical psychologists role should be considered when working in this way. Whilst the evidence-base regarding OPwMS restricts firm conclusions due to methodological limitations, group and individually-delivered cognitive behavioural therapy is potentially an efficacious intervention for this client group, demonstrating efficacy for falls, fatigue, depression, and facilitating adjustment. OPwMS accounts also suggest that socially and physically supportive environments are important for successful adjustment, therefore drawing on community psychology approaches may be useful, although there is a lack of evidence to support such an approach. The significant gap in the literature suggests a further role for the clinical psychologist; conducting research and informing evidence-based practice, which is crucial for the allocation of resources within publically funded healthcare services.

Introduction

Multiple sclerosis (MS) is an incurable long-term condition (LTC) that is neurological in origin. It is an autoimmune disease caused by central nervous system (CNS) inflammation, demyelination and axonal degeneration, which creates varied presentations of symptoms depending on the location of CNS damage (Sorkin, Molton, Johnson, Smith and Stern, 2012). Common symptoms include fatigue, pain, sensory deficits, emotional lability, cognitive dysfunction, bladder frequency and urgency problems, sexual dysfunction, spasms, weakness and ataxia (Sorkin et al., 2012; Murray, 2006).

MS is predominantly diagnosed in females between the ages of 20 and 40 (Sorkin et al., 2012). Approximately 85% of PwMS are diagnosed with relapsing-remitting MS (RRMS), which is characterised by recurrent symptom episodes separated by a remission of symptoms. Approximately 10% of PwMS are diagnosed with primary progressive MS (PPMS), which is characterised by a gradual occurrence of symptoms without relapse. Approximately 30% of those with RRMS develop a progressive form of MS after about 10 years (Sorkin et al., 2012). Late-onset MS (LOMS) is diagnosed in adults 55 years and older, presenting as PPMS in the majority of cases (Martinelli, Rodegher, Moiola, and Comi 2004; Polliack, Barak, and Achiron, 2001). Whilst MS is a debilitating LTC, life expectancy remains the same. Older persons with MS (OPwMS) already represent a large number of PwMS (National MS Society, 2003) and with increasing longevity, many PwMS will age with MS.

Literature Review

Specific Issues for OPwMS

MS appears to be age-accelerated, therefore OPwMS are more likely to have a progressive form of the disease (Finlayson, 2009; Sorkin et al., 2012). Considering this and the existing gerontological literature, it is plausible that OPwMS have differing needs than younger PwMS (YPwMS), however the evidence-base exploring the needs of, and efficacious interventions for, PwMS is mostly conducted with adults of working age (18 to 65 years of age) and is thus inadequate to confirm this hypothesis and to inform efficacious interventions for OPwMS (Finlayson, 2004).

Understanding the needs of OPwMS is crucial to enable the development and delivery of evidence-based interventions. Emerging studies exploring the specific concerns of OPwMS suggest that they face both similar and different issues to YPwMS. Similar to YPwMS, a cross-sectional survey found that the most common symptoms in OPwMS are fatigue, balance problems and weakness (Finlayson, 2002), whilst qualitative studies suggest that aging with MS represents a new stage that requires adjustment and adaptation to increasing disability, physical limitations and thus mobility problems (DalMonte, Finlayson and Helfrich, 2003; Finlayson and van Denend, 2003; Finlayson, 2004; Finlayson, van Denend and DalMonte, 2005), particularly in comparison to non-MS peers (Finlayson, van Denend and Hudson, 2004). These studies identified decreasing engagement in community and social environments as a result of such limitations to be a prominent concern and identify access to supportive social and physical environments as crucial (Casey and Dale-Stone, 2010; Fong, Finlayson and Peacock, 2006; Ploughman et al., 2012).

Whilst such studies, carried out by experienced and knowledgeable researchers regarding OPwMS and qualitative approaches, facilitate a rich and in-depth understanding of the needs of OPwMS, it should be considered that the convenience samples interviewed reflect a homogenous group of participants which mostly consisted of white, educated, married females, from American and Canadian metropolitan areas that are well serviced in terms of community and MS-specific resources. Further participants were recruited from MS support groups and the National MS Society, reflecting OPwMS who are more likely to be immersed in the

‘MS community’ (Finlayson et al., 2005). Samples also tended to reflect younger OPwMS (e.g. 55-70), possibly reflecting those with lower levels of disability. Thus the views of older OPwMS (e.g. 70+), males, European and Eastern citizens, rural communities and those not immersed in the ‘MS community’ are less prevalent in the literature limiting transferability of these findings to all OPwMS.

Role of The Clinical Psychologist in the Care of OPwMS

Due to the limited evidence-base, healthcare professionals must draw from the wider MS literature, the gerontological literature and the existing OPwMS-specific literature to inform clinical practice with this client group. Based on such research, and the lack of evidence for, and tolerance to, pharmacological treatments in OPwMS, a biopsychosocial management approach is advocated (Sorkin et al., 2012). A biopsychosocial management approach is reflected in the National Institute of Clinical Excellence (NICE) guidelines, which recommend that PwMS should have access to a specialist neurological rehabilitation multi-disciplinary team (MDT) including doctors, nurses, physiotherapists, occupational therapists, social workers and clinical psychologists (NICE, 2003), reflecting the holistic needs of this population. These guidelines suggest that NHS MDTs should support PwMS to self-manage symptoms and should provide emotional support. Emerging evidence suggests that the clinical psychologists role within NHS MDTs is to support both of these areas (NICE, 2009; Dennison and Moss-Morris, 2010; Hawkes, Ruddle and Freeman, 2012; Manning, Marfleet and Pais, 2013).

The role of the clinical psychologist can involve direct client work; delivering individual, group and systemic psychological therapy, and indirect work; training and supervising the MDT to deliver psychological therapies, consultancy work, service evaluation and research (British Psychological Society, 2007; Manning et al., 2013). Psychological therapy, in particular cognitive behavioural therapy (CBT), is increasingly involved in the management of LTCs (Hawkes et al., 2012), as reflected by its inclusion in NICE guidance. Underlying CBT is the assumption that ones cognitions, behaviours, emotions and physiology are interrelated; thus changes in one area will instigate changes in other areas. By collaboratively exploring cognitions and behaviours, PwMS can learn to recognise certain responses that exacerbate their symptoms and distress and modify these to enhance adjustment to MS (Dennison and Moss-Morris, 2010).

Management of Specific Symptoms of MS in Older Persons

There is a potential role for the clinical psychologist in managing MS-specific symptoms commonly reported by OPwMS. Balance and weakness problems can lead to an increased risk of falling, as can fatigue, which presents as a problem in its own right. Adjustment to increasing mobility issues as a result of balance and weakness problems may also be prevalent in this population, as may depression as a result of such problems and their consequences.

Falls

Many PwMS report falling (Finlayson, Peterson and Cho, 2006; Johnson, 2009; Coote, Hogan and Franklin, 2013). Considering the incidence of falls increases with age (Finlayson et al., 2006) and OPwMS report increasing problems with fatigue, balance, weakness (Finlayson, 2002), all risk factors for falls in the elderly (Rubenstein and Josephson, 2002), it is logical to assume that OPwMS are at especially high risk of falling. However studies have not always found this to be the case. Finlayson et al. (2006) found that fear of falling (FoF), balance, mobility, concentration and incontinence problems were associated with falls, but not age, although it is possible that the retrospective, self-report design led to underreporting of falls in OPwMS due to significant concerns about the consequences of admitting a fall (Walker and Howland, 1992; Matsuda, Sumway-Cook, Ciol, Bombarider and

Kartin, 2012) and cognitive dysfunction experienced by OPwMS. It is also possible that OPwMS experience less falls due to curtailed activity levels to accommodate for increasing risk factors such as fatigue and FoF, therefore the relationship between OPwMS and falls is unclear and likely to be complex.

Regardless of increasing risk, falls are undoubtedly a significant problem for many OPwMS (Finlayson et al., 2006; Coote et al., 2013). A MDT approach to falls prevention programmes that targets amenable risk factors including balance, mobility, concentration problems, fatigue and FoF is advocated. Addressing unrealistic FoF appears especially important as it can lead to unnecessary physical and social activity curtailment (Arfken, Lach, Birge, and Miller, 1994; Ziljstra, van Haastregt, van Eijk, van Rossum, Stalenhoef and Kempen, 2007; Delbaere, Close, Brodaty, Sachdev and Lord, 2010), resulting in physical deconditioning and muscle weakness which further increases risk of falling (Hindmarsh and Estes, 1989), thus creating a vicious cycle. An approach to falls prevention programmes that addresses both cognitive and behavioural factors appears warranted (Masuda et al., 2012). Indeed evidence regarding CBT falls prevention programmes appears to support such a claim.

A randomised-controlled trial (RCT) compared nurse-delivered group-based CBT to a social contact control in a large sample of non-MS adults, mean age 77, in the USA residing in senior housing (Tennstedt, Howland, Lachman, Peterson, Kasten and Jette, 1998). Common CBT techniques including cognitive restructuring of unrealistic beliefs, assertive communication training, graded physical activity and contractual goal setting were taught intertwined with physical and strengths-based exercises, enhancing adaptive conception of the psychological techniques. The CBT programme significantly increased levels of intended activities and perceived mobility control, however these effects were minimal and not sustained 12 months post-intervention. When controlling for the non-compliant participants, modest improvements in falls-related self-efficacy, mobility and social behaviours were found and these improvements were maintained at follow-up.

Another RCT comparing the same group CBT programme with treatment as usual (TAU) in a large sample of community-dwelling adults, mean age 77 years, in the Netherlands cross-validated the findings from the USA study (Zijlistra, van Haastregt, Ambergen, van Rossum, van Eijk, Tennstedt and Kempen, 2009). The CBT programme significantly reduced FoF, associated activity avoidance and recurrent falls. These reductions were maintained at 14 months post-intervention, although activity avoidance was nearing, but non-significant at follow-up. Whilst not reflective of routine clinical practice, subsequent pre-test post-test analysis of the implementation of this programme within Dutch homecare organisations demonstrated the successful clinical application of this intervention (Zijlstra, van Haastregt, Du Moulin, de Jonge, van der Poel et al., 2013).

The repeated replication of such findings within RCTs across different continents and in clinical practice is encouraging and supports other studies exploring the efficacy of similar CBT-based falls prevention programmes for relatively healthy and functioning older adults (Zijlstra et al., 2007). However, the exclusion of participants with physical health conditions and severe disabilities suggests the intervention is not necessarily generalisable to OPwMS considering the worsening disability and functioning of OPwMS and the high non-compliance rates in a relatively high-functioning group of older persons, whilst not unusual with group psychological therapies in older adults (Laidlaw, 2013), is concerning.

An adaptation of this programme may be more appropriate for OPwMS. Anecdotal evidence from the non-compliant participants in Tennstedt et al.'s study advocates for in-home, individual-based interventions, which should draw from cognitive-behavioural conceptualisations of falls, particularly addressing FoF in OPwMS. These adaptations are in line with the recommended amendments for CBT with older persons (Evans, 2007; Laidlaw, 2013) and may be more appropriate for OPwMS due to cognitive and physical functioning problems. Indeed a pilot study exploring home-based occupational therapist-delivered falls-prevention sessions based on similar CBT techniques such as addressing knowledge and beliefs about falls and enhancing safe behaviours demonstrated efficacy in changing knowledge and behaviours (Finlyson, et al., 2009), although it is unclear whether this translated into a reduction in falls. The small sample size of younger OPwMS, unreliable assessment measures and uncontrolled nature limit the conclusions of this study, thus further research is needed to explore the efficacy of such adaptations for OPwMS.

The evidence reviewed here suggests that MDT-delivered CBT falls-prevention programmes are efficacious, at least for relatively well functioning older persons. The clinical psychologist may provide training and supervision, inline with the New Ways of Working for Applied Psychologists (NWW) report (British Psychological Society, 2010), or, considering their extensive training in CBT, it is plausible that they may serve as programme facilitators without reducing efficacy. Delivering groups or supervising MDTs may maximise cost-effectiveness, which is crucial within the NHS. However with increasing frequency, clinical psychologists are working directly with LTC clients (Manning et al., 2013). The literature reviewed suggests a sensitive exploration of falls, particularly FoF, and advocates drawing on cognitive-behavioural principles in treatment. If curtailed activity is an issue, then, based on the voiced concerns of OPwMS, exploring the impact of this on wellbeing would also be warranted.

Fatigue

Another potentially amenable falls risk factor and identified problem in its own right for OPwMS is fatigue. Whilst its pathophysiology is poorly understood (Dennison and Moss-Morris, 2010), a cognitive-behavioural model has been advocated to explain the maintenance of MS disease-triggered fatigue (van Kessel and Moss-Morris, 2006; Skerrett and Moss-Morris, 2002). Perpetuating factors including cognitive distortions about fatigue, its causes and consequences, and maladaptive behaviours such as excessive avoidance of activity and/or overexertion, can lead to deconditioning, heightened distress and autonomic arousal, all of which interact and exacerbate fatigue (Knoop, van Kessel and Moss-Morris, 2012). Support for this conceptualisation of MS-fatigue comes from RCTs demonstrating the efficacy of CBT in comparison to active treatments and TAU in non-MS fatigue sufferers (Sharpe, Hawton, Simkin, Surawy and Hackmann, 1996; Deale, Chalder, Marks and Wessely, 1997; Prins, Bleijenberg, Bazelmans, Elving, de Boo, et al., 2001) and emerging evidence from RCTs comparing CBT to TAU and active treatments in MS fatigue.

Van Kessel, Moss-Morris, Willoughby, Chalder, Johnson et al. (2008) compared clinical psychologist-delivered, individual-based CBT to relaxation training for YPwMS. Both interventions demonstrated statistically and clinically significant reductions in fatigue, yielding large effect sizes with CBT more effective than relaxation training. These gains were maintained at follow-up. Improvements in depression, anxiety, stress and functioning were also found, however these were not maintained, possibly due to shortened length of therapy and no booster session (Deale et al., 1997). Whilst these clinically meaningful findings are encouraging, this Auckland-based study consisting of a small sample of YPwMS limits wider generalizability, particularly to OPwMS and a publically funded healthcare system such as the NHS where clinical psychology services are scarce (Thomas, Thomas, Kersten, Jones, Green et al., 2013).

Supporting the translation of such findings to UK health services, a pragmatic RCT comparing group-based, MDT-delivered CBT to TAU for MS-specific fatigue in YPwMS found CBT effectively reduced fatigue severity and enhanced fatigue self-efficacy (Thomas et al., 2013). Further, an analysis of an assistant psychologist-delivered CBT group intervention for different fatigue conditions, including MS, demonstrated statistically and clinically significant improvements in fatigue and depression outcomes, and acceptability of the intervention (Hawkes et al., 2012). Whilst such studies may reflect more motivated samples due to the opt-in nature of the services and may not control for factors such as therapist attention and spontaneous remission, the pragmatic nature of the studies reflect routine clinical practice within the NHS and are aligned with the findings of existing RCTs, lending support to the role of MDT-delivered group-based CBT supervised by clinical psychologists in managing MS-specific fatigue. Further, this format addresses the issue of scarce clinical psychology services, enhancing cost-effectiveness and applicability to NHS MS services.

A further alternative to scarce clinical psychology resources is computerised CBT (CCBT). Although traditional packages have been demonstrated to be unacceptable to PwMS, MS-specific CCBT packages appear more acceptable and efficacious for YPwMS, yielding large treatment effects (Moss-Morris, McCrone, Yardley, van Kessel, Wills et al., 2012). CCBT appears attractive option for OPwMS as it addresses the issue of increasing disability, however it remains untested with this client group and may add to the sense of social isolation reported by many OPwMS. Further the limited computer literacy skills of OPwMS may compromise acceptability and accessibility, and is something that future research should explore.

CCBT and group CBT, delivered by MDT members trained and supervised by clinical psychologists, may offer plausible solutions to scarce clinical psychology resources in physical health teams, whilst maintaining effectiveness and enhancing cost-effectiveness (Thomas et al., 2013). However the computer literacy of many OPwMS and the inability to individually tailor the interventions may limit the accessibility and therefore effectiveness of the interventions. Considering the support for the cognitive-behavioural conceptualisation of MS fatigue and the strong efficacy demonstrated by clinical psychologist-delivered CBT, individual-based CBT may be an effective treatment for fatigue in OPwMS, either delivered by the clinical psychologist or a member of the MDT supervised by a clinical psychologist thus enabling MS and gerontological-specific issues to be addressed. The absence OPwMS within study samples however, restricts the drawing of firm conclusions.

Depression and Psychological Wellbeing

Depression is common in PwMS (Patten, Beck, Williams, Barbui and Metz, 2003). It is unclear whether OPwMS are at increased risk of depression as research is conflicting. Finlayson (2009) suggests that MS progression and related activity limitations are age-related and age-accelerated, and as depression is associated with lowered activity levels (Jensen, Molton, Gertz, Bombardier and Rosenberg, 2012) one would assume OPwMS are at increased risk of experiencing depression. In one sample, almost a third of OPwMS reporting high rates of disability and impaired mobility, reported depressed mood and suicidal ideation (Klewer, Pöhlau, Nippert, Haas and Kugler, 2001). Whilst causation cannot be inferred, the findings are aligned with the qualitative findings of Finlayson et al., who reported increased distress related to increasing disability, immobility and social isolation, with some patients reporting they would rather die than move into a nursing home.

Direct comparisons with YPwMS however, have found lower levels of depressive symptoms (Kneebone, Dunmore and Evans, 2003) and improved mental health (DiLorenzo, Halper and Picone, 2009) in OPwMS. However, it is suggested that older adults underreport psychological distress for a myriad of reasons (Zarit and Zarit, 2007) and that depression can present as unexplained somatic complaints, anxiety, or hopelessness rather than sadness (Gallo and Rabins, 1999). Thus it is plausible that age-insensitive subjective diagnostic screens and healthcare professionals lack of knowledge regarding depression in older persons may result in significant under-detection.

Support for this hypothesis comes from a RCT comparing a training programme for MDT staff on detection and evaluation of depression in older persons, which demonstrated increased detection rates without compromising sensitivity and specificity (Eisses, Kluiter, Jongenelis, Poot, Beekman et al., 2005). In line with NWW, it is plausible for the clinical psychologist to deliver such education and training programmes to MDT colleagues. Evaluation of such approaches and further empirical research exploring the relationship between OPwMS, depression and detection as well as designing valid and reliable assessment measures, are also within the clinical psychologists remit as a scientist-practitioner. Considering the high rates of suicidal ideation and completed suicide attempts in the general MS population (Klewer et al., 2001; Stenager, Stenager, Koch-Henrikksen, Brønnum-Hansen, Hyllested et al., 1992), under-detection of depression, argued to be the most important risk factor for suicide (Feinstein, 1997), is a concern and an important area of exploration.

Nevertheless, the existing literature proposes that for many OPwMS, depression is a problem that warrants clinical attention. Research suggests that in both OPwMS and YPwMS, cognitive attributions are associated with coping behaviours, adjustment (Ploughman et al., 2012) and depression (Kneebone et al., 2003; Kneebone and Dunmore, 2004). Whilst such cross-sectional studies do not infer causation, a RCT comparing CBT to supported listening demonstrated CBTs superiority in reducing distress and enhancing adjustment in YPwMS (Moss-Morris, Dennison, Landau, Yardley, Silber et al., 2013) indicating the active nature of the cognitive-behavioural components.

To date, only one case study exploring the efficacy of CBT for treating depression in OPwMS has been reported (Wong and Laidlaw, 2012). Whilst one cannot generalize from case studies to the wider population of OPwMS, the problems described by the client reflect common symptoms and problems reported in OPwMS such as balance and mobility problems, fatigue and fears of the future, in particular losing control, independence and becoming a burden. This case study reported a course of psychiatrist-delivered traditional CBT consisting of cognitive restructuring, behavioural experiments and behavioural activation, finding encouraging results. Whilst a clinically significant reduction in self-reported depression was found, firm conclusions about the active factors are difficult to conclude from an uncontrolled case study, which did not control for confounding variables such as therapist attention and life events. However, the clinically significant findings were in the context of worsening MS symptoms, plausibly suggesting that the intervention may have facilitated adjustment and adaptation. Further, these encouraging findings replicate the results of previous RCTs conducted with non-MS older persons (Laidlaw, Davidson, Toner, Jackson, Clark et al., 2008; Serfaty, Haworth and Buszewicz, 2009) and research exploring adjustment and distress in YPwMS (Moss-Morris et al., 2013).

It should be noted that the intervention incorporated non-CBT techniques such as couples counselling and was modified to address age-related and MS-specific issues. These modifications are in line with the pragmatic adaptations advocated for CBT with older adults with LTCs (Rybarczyk, Gallagher-Thompson, Rodman, Zeiss, Gantz et al., 1992) and non-LTC older adult populations (Wilkinson, 1997; Evans, 2007; Cox and D'Oyley, 2011; Allen and Ranger, 2013). Such adaptations, informed by the gerontological literature and practice-based evidence, include addressing practical barriers to engagement such as cognitive and physical disabilities, involving family members in sessions and treatment, spending longer socializing the client to the model, increasing the length and number of sessions, building a rapport and utilization of an age-appropriate formulation that incorporates cohort beliefs, physical health problems and societal attitudes (Laidlaw et al., 2004). The contribution of these modifications to CBTs efficacy is unknown due to a lack of evidence comparing modified CBT to CBT as usual, although a RCT (Serfaty et al., 2009) comparing modified CBT to TAU and case studies (Rybarczyk et al., 1992; Wong and Laidlaw, 2012) offer support for age-related modifications in clinical practice. An illustrated case example from clinical practice demonstrated successful engagement with an OPwMS who was reluctant to attend CBT sessions due to cohort-related and illness-related beliefs. Through initially contracting 2 sessions with the client where they were invited to suspend these beliefs, the efficacy of CBT was demonstrated through a very brief diaphragmatic breathing intervention. This quick demonstration of success challenged therapy-interfering beliefs and an age-appropriate formulation enabled a clinically significant piece of work to be undertaken.

Considering the results of these case studies, alongside the wider evidence-base advocating the efficacy of CBT for treating depression in non-MS older persons and YPwMS, it is plausible to assume that individual-based CBT delivered flexibly, incorporating adaptations for age and MS-specific needs, is an effective intervention for treating depression in OPwMS, although RCTs with OPwMS are needed to confirm or refute such a claim. Working as a scientist-practitioner, clinical psychologists are able to undertake such research, exploring the efficacy and cost-effectiveness of such interventions and modifications to inform evidence-based practice, which is crucial within the NHS.

It is plausible that the contributory factors to depression in OPwMS are different to YPwMS. Due to the progressive nature of MS, OPwMS are likely to face changes as the disease proceeds (Kneebone and Dunmore, 2004). These changes, as reported by the OPwMS-specific literature, can be distressing. Indeed, the literature suggests that mobility, disability and social support are associated with adaptation, adjustment and wellbeing in OPwMS. Thus interventions that target mobility appear to be crucial in managing depression and distress in this population. Whilst CBT is helpful for modifying mobility beliefs that are maladaptive and unrealistic and that result in unnecessary activity curtailment and thus immobility and disability, for many OPwMS these beliefs are a realistic interpretation of very real mobility and environmental restrictions.

A major limitation of the MS empirical research base (and thus evidence-based treatments) is the focus on intrapersonal factors, which detracts from wider societal factors that contribute to mobility issues. There are many factors than can support as well as hinder mobility (Finlayson and van Denend, 2003) and it is argued that incongruence between mobility-related needs and community resources can negatively affect mobility, independent living and wellbeing (Carp, 1980). This claim appears to be supported by the emerging OPwMS evidence-base. Working from this perspective the clinical psychologist would view disability as a societal issue as well as a personal issue and their role would seek to address environmental and contextual issues that contribute to immobility and disability. Such an approach is aligned with community psychology approaches to alleviating distress and enhancing wellbeing (Rappaport and Seidman, 2000).

Environmental-level interventions advocated by the OPwMS literature could involve working with and alongside OPwMS, empowering and supporting them to address inaccessibility issues within valued community resources including shops, churches, leisure centres, and transport services (Ploughman et al., 2012) to enhance access, mobility and thus wellbeing. Or the clinical psychologist could be involved in the creation and provision of MS services such a support groups, advocated in the OPwMS literature as a crucial social needs that enhances a sense of wellbeing (Finlayson, 2004; Fong et al., 2006; Casey and Stone, 2010). The clinical psychologist could also lobby for policy change at the local and national level, working alongside politicians and members of Health and Wellbeing Boards (HWB) to lobby for the unmet needs of OPwMS for example advocating for adaptations to inaccessible buildings or ensuring funding for MS services (Weiner and Freedheim, 2003; Finlayson and van Denend, 2003). Wider still, the role could involve challenging stigma by holding discussions in their everyday work with healthcare professionals, public and private sector staff and the lay public about the conceptualisation of disability (Finlayson and van Denend, 2003).

A major challenge to working in this way is the significant lack of evidence to support such approaches, perhaps due to the relative infancy of community psychology and a lack of outcome-assessed research studies which are crucial for the funding of public services where clinical psychologists mostly reside. Community psychology approaches do not easily lend themselves to quantitative evaluation, in particular the gold standard RCT methodological approach, and are thus difficult to measure. Perhaps working as a scientist-practitioner, the clinical psychologist could find innovative ways to demonstrate cost-effective outcomes of such approaches.

Although there is no supporting evidence for working in this way with OPwMS, illustrated examples from clinical practice suggest successful outcomes. One example involved inviting local HWB representatives and members of Parliament to attend a psychology services team meeting to highlight the needs of clients with LTCs, including MS. This ensured extra funding to provide community and home-based psychological therapy to this population. Thus working from this approach may facilitate functioning and enhance psychological wellbeing outcomes for a vast number of clients, enhancing adjustment through lobbying and advocating for services that support the needs of OPwMS. As stated, outcome evaluations are required of working in this way before any firm conclusions can be drawn.

Conclusion

The voiced needs of OPwMS suggest that aging with MS requires adjustment to increasing mobility and disability and that socially and physically supportive environments are important for successful adjustment. Whilst such samples are not the voice of all OPwMS, the consistent findings across studies suggest that this is a common need in at least a certain group of OPwMS. The role of psychological therapies in supporting YPwMS has been explored and may be generalisable to OPwMS. Research to date has largely focused on individual-based interventions, mainly CBT. Drawing on this literature and the wider gerontological literature, CBT appears to be a potentially efficacious treatment for managing and adjusting to the common issues faced by OPwMS such as increasing disability and fatigue, although this does not confirm the ineffectiveness of other psychological approaches, which suffer from a lack of research focus and evidence-base. One such approach is community psychology, which could potentially address OPwMS concerns regarding mobility and disability through environmental and societal change.

Whilst the exclusion criteria and populations drawn from restrict the generalizability of such studies to OPwMS, the findings of these studies should not be interpreted in isolation from the existing gerontological evidence-base demonstrating the efficacy of CBT for older persons (Laidlaw, 2013). Further, older persons, whilst potentially having unique needs that require addressing in therapy, should not be treated as different from the rest of the human race. A strength of CBT is its idiosyncratic nature, which lends itself to an adaptable and flexible person-centred approach. It would appear that adapting for the possible specific needs of older adults does not compromise the efficacy of CBT in this population. Further, formulation-led CBT facilitates a conceptualisation of the interrelatedness of MS symptoms, which should not be viewed in isolation. For example, activity curtailment as a result of FoF can lead to deconditioning, increased fatigue, poor adjustment and lowered mood.

An amalgamation of the available evidence suggests that the clinical psychologist, working as a scientist-practitioner, may effectively deliver evidence-based psychological therapy, specifically CBT, to address MS-specific issues such as fatigue, falls, depression and adjustment. Whilst there is no evidence to suggest a preference, an amalgamation of the evidence reviewed and patient predilection suggests that individual-based therapy may be more suited to the needs of both older persons and PwMS, and therefore may be more efficacious than group-based treatments for OPwMS. The evidence also suggests that MDT-delivered group-based and individual-based CBT is efficacious for PwMS and older persons, thus indicating a supervisory and training-based role for the clinical psychologist positioned with physical health MDTs. Working in such a way may address cost-effectiveness and scarce resources, although consideration should be given to maintaining professional accountability and promoting the unique role and contribution of the clinical psychologist to protect the professions identity as an advanced practitioner, consultant, supervisor and researcher (British Psychological Society, 2007).

As discussed, there is a distinct lack of research exploring the needs, issues and efficacious treatments for OPwMS. This gap in the evidence-base is concerning considering increasing longevity and the increasing number of OPwMS. More importantly, it restricts evidence-based practice, which is crucial to inform resource allocation within publically funded services. The clinical psychologist, as a scientist-practitioner, is in a position to address such gaps, potentially further exploring the needs of OPwMS, the relationship between depression and OPwMS, and informing the focus and efficacy of psychological therapies for OPwMS. Such research could also potentially challenge historical perspectives that have influenced the views of the suitability and efficacy of psychological therapy for older adults and limited research until recent decades (Laidlaw, 2013).

Thus the role of the clinical psychologist in supporting OPwMS within the NHS is potentially multi-faceted. An amalgamation of the available evidence-base suggests that, working with NHS MDTs, the clinical psychologist could deliver or supervise the delivery of psychological therapies, specifically CBT, to manage specific MS symptoms including falls, fatigue and depression and to help OPwMS adjust to increasing disability. The lack of OPwMS participants in research however, restrict any firm conclusions from being made and indicates a further role for the clinical psychologist; addressing gaps in the evidence-base.

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