Using Cognitive Behaviour Therapy in counselling non-adherent hypertensive patients: A nurse counsellor perspective

Lee K.¹*

¹Department of Nursing and Rehabilitation, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia, Serdang, Malaysia.

*Corresponding author: Lee Khuan, Department of Nursing and Rehabilitation, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia, Serdang, Malaysia, leekhuan@upm.edu.my

ABSTRACT

Hypertension is a chronic illness that requires the patient to take medicine in the long-term. In hospitals, non-adherent hypertensive patients may be referred to a counsellor by his/her medical officer. Non-adherence is a multifactorial and multifaceted problem that needs intervention through a multidisciplinary health care approach. Counselling non-adherent patients can be a challenging task for a counsellor. This review discusses cognitive behavioural therapy as one of the counselling theories used in counselling hypertensive patients. Some practical applications of cognitive behavioural therapy are suggested to help patients in adhering to antihypertensive therapies.

Keywords: adherence, hypertension, cognitive behavioural therapy, counselling

1.0 Introduction

People often fail to adhere to health recommendations, especially for chronic illnesses like hypertension that are asymptomatic and where the nature of the illness is lifelong. This results in unsatisfactory hypertension management and control. The goal of the management of hypertensive patients is to improve the quality of life and to prevent complications. Promoting adherence to medicine is one way to achieve this aim. However, addressing the issues of non-adherence of the patients is a collective task, and requires cooperation among nurses and other health care professionals. The aim of this review is to discuss using cognitive behavioural therapy (CBT) in counselling non-adherent hypertensive patients from a nursing perspective. The structure of this article is as follows. The article starts with a discussion concerning some relevant literature relating to hypertension and adherence followed by a brief description of CBT. The subsequent section contains a discussion relating to the application of CBT in helping patients with adherence problems.
2.0 Hypertension and adherence

Hypertension is a major risk factor in the development of cardiovascular disease and poses a significant worldwide public health problem (WHO, 2003). Generally, the term hypertension denotes that the BP is constantly increased above the normal limit (120/80mmHg). Most authorities would consider a sustained BP of ≥ 140/90 mmHg as being hypertensive (WHO, 2003). Greenstein (2004) reported that this is due to the raised peripheral resistance, which is secondary to vasoconstriction. Although the causes of hypertension are unknown, some are diagnosed as inherited, and due to psychosocial and environmental factors; raised blood pressure is also caused by kidney and endocrine disorders.

WHO (2003) reported that chronic illnesses require the long-term self-administration of medicine and that poor adherence is the primary reason for suboptimal clinical benefit. Adherence to a long-term therapy is defined as “the extent to which a person’s behaviour-taking medicine, following a diet and executing lifestyle changes, corresponds with the agreed recommendations from a health care provider” (WHO, 2003, p. 3). However, adherence is a multifaceted problem and is always neglected by health care providers, and, consequently, poor adherence receives little direct, systematic intervention.

Poor adherence to antihypertensive therapy substantially increases the near- and long-term risk of stroke among hypertensive patients. (Herttua, Tabák, Martikainen, Vahtera, Kivimäki, 2013). Nevertheless, compared with patients with poor adherence, the risk of all causes of death, stroke, or acute myocardial infarction is significantly lower in patients with good and excellent adherence (Esposti et al., 2011). Despite the availability of effective medicine, poor adherence to medicine leads to poor control of blood pressure, thus, increasing the morbidity and mortality in hypertensive patients. Suleiman, Sulaiman, and Albarq (2010) reported that poor adherence to antihypertensives is significantly associated with hospital admission. Studies in Malaysia reported that non-adherence has been identified as the main cause of failure to control hypertension. (Ramli, Ahmad, & Paraidathathu, 2012. Turki, & Sulaiman, 2010). Thus, there is a call to develop multidisciplinary intervention programmes to improve adherence and blood pressure control (Kretchy, Owusu-Daaku, Danquah & Asampong, 2015; Ramli, Ahmad, & Paraidathathu, 2012).

According to the WHO (2003), adherence is a multidimensional phenomenon that is influenced by factors relating to the patient, therapy, health care professionals (HCPs) and the health system. Non-adherence to medical recommendations is common in the majority of patients who need long-term self-administered medicine, especially in chronic illness. Studies have shown that non-adherence is due to several causes, such as the duration of the treatment, complicated drug regimen, forgetfulness, and the cost and frequency of dosing (Mohammad et al., 2016; Osterberg & Blaschke, 2005; Pound et al., 2005; Turki & Sulaiman, 2009). In addition, the adverse effects of antihypertensives are the key factors that determine poor adherence among hypertensive patients (Kretchy et al., 2015; Mohammad et al., 2016; Tedla & Bautista, 2016). Although the factors that affect adherence are complex, they may include beliefs about illness and treatment (Osterberg & Blaschke, 2005). Poor pharmacy service quality and difficulty in coordinating multiple prescriptions have emerged as key barriers in adherence (Hsu et al., 2014). Also, unintentional non-adherence does not appear to be random, and is predicted by medication beliefs, chronic disease, and socio-demographics (Abhijit & Colleen, 2012). Thus, health professionals need to work in partnership with their
patients with an emphasis on patient education and counselling to achieve the treatment goals (Heagerty, 2006; Mohammad et al., 2016).

3.0 Brief description of Cognitive Behavioural Therapy (CBT)

Beck (1963) developed CBT after a long period of treating patients with depression. He found that depressed patients have a negative bias in their cognitive interpretation of certain life events that lead them to their cognitive distortion. He believes that most of the psychological problems arise from clients’ faulty thinking, and making wrong assumptions due to the lack of access to relevant information. Thus, clients are sometimes incapable of distinguishing between fantasy and reality.

Beck, Rush, Shaw, and Emery (1979) proposed that CBT is an active, direct, time-limited approach. The basic principle in CBT is that the client possesses automatic thought, which is an important component in recurrent emotional distress. Automatic thoughts are the immediate interpretation and decision-making thoughts that are triggered when certain events occur in one’s environment. This thought occurs involuntarily in a client’s stream of consciousness and is often taken for granted or unconsciously (Sage, Sowden, Chorlton & Edeleanu, 2008). Therefore, automatic thoughts are very powerful and influential because although clients make decisions based on these automatic thoughts, as they are hardly noticed, they remain unexamined. In addition, these automatic thoughts are rarely changed by experience or new knowledge (Curven, Palmer & Ruddell, 2007).

In addition to schema (core beliefs), assumptions (intermediate beliefs) are the underlying beliefs that form the content of automatic thought. The association among automatic thoughts, core beliefs and assumptions forms the idea of schemas, which affect the way an individual structures reality and organizes a framework for solving problems (White, 2001). Nevertheless, people may have competing schema, either adaptive or dysfunctional schema depending on how their cognitive structures are formed. “Cognitive vulnerability is the term used to describe how a person’s beliefs and assumptions influence him or her in respect of psychological distress” (Beck & Weishaar, 1995, p. 237). As a result, the way in which people construct, organize and interpret their basic cognitive structures determines how they will perceive and behave.

Corey (2009) identified several systematic errors in reasoning. Although some of the thinking errors seem believable at the time of emotional distress, on closer scrutiny, they are not always consistent with objective reality. Some of the examples related to adherence and hypertensive are given as follows:

3.1 Arbitrary inferences

People, whose thinking is distorted by a negative outcome, tend to jump to conclusions without any supporting evidence or if the outcome has proven to be positive. For example, all illnesses must have signs and symptoms; hence, people without any signs and symptoms of illness do not need to take medicine, and, as medicine is made of chemical substances, and chemicals are not good for our body, I will die faster if I continue to take the medicine.
3.2 **Selective abstraction**

People only pay attention to the negative aspects of an event and the significance of the whole picture is ignored. The problem is that people concentrate on the negative detail and do not consider any other positive aspect. For example, hypertension medicine will cause me more harm than good, and I am going to lose my freedom of food choice if I have to take this medicine.

3.3 **Overgeneralization**

People think that because a negative outcome happened to them once, it will always happen. This is how people make sweeping conclusions from a single incident to a different incident, even in a dissimilar context. For example, hypertension can kill me anytime even I take medicine, I will be dependent on medicine for the rest of my life, and without it I will die.

3.4 **Magnification**

People evaluate themselves in situations and are prone to exaggerate the negative components and minimize the positive. For example, I am going to die early like my father who also had hypertension; once I have hypertension, I cannot lead a normal life anymore.

3.5 **Personalization**

People blame themselves completely for all that goes wrong and relate this as being their fault or weakness. For example, I got hypertension because of my personality, or I got hypertension because of my present lifestyle.

Beck and Weishaar (2008) pointed out that most of the negative thoughts that disturb clients are distorted and unrealistic. Consequently, clients should be taught about strategies for identifying thinking errors that lead them to have negative moods. Furthermore, it is imperative to educate clients that they are not alone in having these cognitive distortions, and that these phenomena are common to humankind and proliferate with emotional distress (Corey, 2009).

It is important to note that clients may have a cluster of thinking errors and not just one of the above-mentioned types of faulty thinking. Likewise, emotional problems, such as anxiety, denial, depression and guilt, tend to have a cluster of cognitive distortions surrounding them. The role of counsellors is to correct the thinking errors in the clients by educating them about methods to identify this distorted and dysfunctional thinking through a process of evaluation. The steps for cognitive behavioural therapy, which are adopted from Corey (2009), are described as follows:
4.0 Application of CBT to help patients with adherence problems

According to Corey (2009), the steps for CBT consist of: 1) Develop a warm, empathic and genuine therapeutic relationship with client. 2) Carry out full assessment on client’s current thinking, emotions, precipitating factors relating to the current problem until cognitive formulation or conceptualization of the client’s problem is made. 3) Apply collaborative empiricism, which means the counsellor and the client become co-investigators, who scientifically examine the evidence to support or reject the client’s distorted thinking. 4) Perform guided discovery by executing Socratic questioning in which the counsellor explores issues from the position of ‘client as expert’ in order to more fully understand them from the client’s perspective. Also, 5) psycho-education in which the patients and their family members are included.

4.1 Develop warm, empathic and genuine therapeutic relationship with client.

A reciprocal therapeutic relationship is encouraged to enable patients to generate an action plan to achieve their health goal. In order to assist patients in setting individual health goals, counsellors should establish a good rapport with them in a constructive and non-judgmental manner rather than dictate that the patient follows the orders set by him/her.

4.2 Carry out full assessment on client’s current thinking, emotions, and precipitating factors relating to the current problem until cognitive formulation or conceptualization of the client’s problem is made.

Carry out one-to-one conversation with the patient, in which the adherence problem is discussed in detail and specific questions are asked to collect information that will inform the counsellor’s understanding of the adherence problem. The three core questions that influence and guide the content of the assessment interview are as follows:

4.2.1 What is the priority adherence problem that the patient would like to seek help for?

4.2.2 What are the thoughts, emotions, behaviours and physical sensations associated with the adherence problem?

4.2.3 What are the immediate and long-term consequences of the adherence problem?

The psychological responses after being diagnosed as hypertensive can serve as a motivator for patients to engage in health seeking behaviour. However, they can also generate fear and negative responses to adherence behaviour. It is important for counsellors to identify and understand how psychological responses have affected patients along the adherence pathway to facilitate planning of the individualised patient-centred intervention.

Furthermore, counsellors are required to identify a patient’s perception of the prescribed medicine, and teach them how to identify negative ideas concerning medicine through a process of cognitive evaluation and supportive environment. If this is followed by instilling positive thinking about the medicine, it will assist the patient in adhering to the prescribed medicine.
4.3 Applying collaborative empiricism means the counsellor and the client become co-investigators, who scientifically examine the evidence to support or reject the client’s distorted thinking.

Counsellors are required to co-construct an action plan with patients with the goal of controlling blood pressure in the long-term. Therefore, it is crucial to educate patients concerning the necessary concepts regarding hypertension and treatment according to the health institute requirements. At the same time, counsellors should provide support and empower patients to make informed choices in decision-making in terms of treatment selection and adherence behaviour.

To help patients to overcome their faulty assumptions concerning the diagnosis and medicine given, counsellors are required to explore and empathise with the patients’ illness experience, and encourage patients to reveal their inner struggles relating to the diagnosis as well as the medicine prescribed. Subsequently, the counsellors collaborate with patients to identify their self-talk that leads to their thinking errors.

For patients who exhibit denial, counsellors are required to discuss the issues they raise, as the role of counsellors is to support and follow up with patients whenever they are ready to accept treatment.

The impact of depression affects the patient’s quality of life. Counsellors should encourage and allow depressed patients to express their feelings fully. Fully released emotions may stimulate a positive perception of the prescribed medicine. When necessary, their automatic thoughts and schema should be explored to identify faulty thinking and assumptions that lead them to depression. Regardless of how patients reason the cause of their illness, counsellors are there to treat the individuals as valuable and worthwhile, and not to devalue them. Furthermore, counsellors should support their right to make an informed decision to determine the treatment they will accept, advocate for them when in need and demonstrate sensitive understanding at all times.

Anxious patients are prompted to activate behavioural avoidance towards treatment. There is no answer as to which strategy works best for managing stress associated with hypertension. However, active coping efforts seem to be more consistently associated with good adjustment then avoidance strategies. Therefore, counsellors should encourage multiple strategies that are preferred by the patient to cope better with the stress arising from hypertension rather than leave the patient to engage in avoidance behaviour. For this reason, counsellors could provide patients with the necessary support when they are in need of more information about hypertension.

4.4 Perform guided discovery by executing Socratic questioning in which the counsellor explores issues from the position of ‘clients as expert’ in order to more fully understand them from the clients’ perspective.

Examples of Socratic questions posed to clients are as follows:

4.4.1 Naive approach – the counsellor asks simple and basic questions in an informal manner. The aim of the questions is to encourage clients to reflect on past experiences and
assumptions that influenced their thinking, e.g., what do you mean when you say “hypertension can kill people”?

4.4.2 **Assume nothing** – the counsellor tries not to make assumptions about what is meant or how the other person might feel to enable the counsellor and the clients to better understand what is not fully examined, e.g., what might be the worst that could happen if you refuse to take medicine totally?

4.4.3 **Non-judgemental attitude** – the counsellor is reminded to avoid imposing prejudice about issues raised by the patient to allow the patient to re-examine their views with an open mind to other possibilities, e.g., what leads you to think that taking medicine will make you die faster?

4.4.4 **Advice free discussion** – the counsellor uses questions that focus more on facts, beliefs and opinions related to the problem and to motivate patients to think of alternative perspectives, e.g., what do you mean it is harmful to take the medicine the doctor gave you in the long run?

4.4.5 **Curious minded** – the counsellor explores the possibilities of alternative perspectives, e.g., have you been taking other medicines not prescribed by the doctor in the clinic every day for the past two years?

4.4.6 **Focusing on the constructive outcome** – the counsellor encourages clients to come out with the most helpful alternative ways to solve the problem, e.g., what do you think would happen if you as the patient are allowed to choose your own antihypertensive therapies?

4.5. **Psycho-education**

Obviously, counsellors play an important role in providing information regarding the truth about hypertension. Before the perception of invulnerability to disease complications is formed, counsellors must psycho-educate the patients regarding the susceptibility and seriousness of hypertension. This does not mean scare tactics but helping them to face reality and grasp the meaning of self-care. Butler (2001) suggested that a positive way of doing this is by instilling the benefits of the health behaviour through which patients internalize and understand the logic leading to the perception of personal susceptibility. Therefore, the complications of hypertension should be conveyed to patients who refuse medicine and lifestyle modifications, as it may act as a deterrent and help them to adhere to medicine.

4.5.1 **Involvement of family members in psycho-education**

Nilchaikovit et al. (1993) suggested that an effective strategy to motivate Asian patients to comply with treatment is to discuss the treatment plans with family members and include them in all decision-making. Therefore, counsellors should include caregivers when educating patients on medicine use and lifestyle modification. Being well informed about hypertensive medicine will enable the caregiver to serve as an educator and a reminder to the patient at home. This is important as the patients depend on the caregiver to provide them with the medicine.
5.0 Conclusion

Adherence to antihypertensive therapy is vital to achieve optimal blood pressure control and reduce complications arising from hypertension. Hence the non-adherence problem needs to be addressed by a multidisciplinary team of HCPs. In CBT, the role of the counsellor is to correct the thinking errors in the clients by educating them about the method to identify such distorted and dysfunctional thinking through a process of cognitive and emotion evaluation. Giving psycho-education to the clients and their family members is important to create awareness and avoid personal susceptibility to complications arising from hypertension.

References


Hsu, C, Lemon, J. Wong, E.S., Cheng, E.C., Perkins, M., Nordstrom, M.S., Chuan, F.L.,


