



Notes by PharmacoLearn

Healthcare Psychology and Communication Skills

BP103T — B.Pharm Semester I

Exam Success Notes

Theory-exam mastery: complete answers, the way examiners want them

As per PCI B.Pharm (NEP 2020) syllabus

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Unit I — Introduction to Psychology in Healthcare

Definition, scope, and relevance of psychology in health sciences

Definition (write this line first in the exam). Psychology is the scientific study of behaviour and mental processes — what people do, and the thinking, feeling, and perceiving behind what they do. The word "scientific" is doing real work here: psychology uses systematic observation, experiments, and measurement, not guesswork or opinion.

Scope of psychology in the health sciences. In healthcare, psychology is not about lying on a couch — it covers six working areas:

- 1 Patient behaviour — why patients take, skip, or stop their medicines
- 2 Provider-patient relationship — trust, rapport, and how communication shapes outcomes
- 3 Pain and symptom perception — two patients with the same injury can report very different pain
- 4 Stress and coping — how illness-related stress affects healing and recovery
- 5 Health promotion — shaping habits such as exercise, diet, and giving up smoking
- 6 Mental health screening — spotting anxiety or depression early, even at the pharmacy counter

Relevance to a pharmacist. You are usually the most accessible health professional a patient meets. A patient may see their doctor once a month but walk into your pharmacy every week. Psychology helps you counsel better, improve adherence, notice when a patient is distressed, and communicate without creating fear. In one line examiners love: drugs treat the body, but behaviour decides whether the drug gets taken.

Exam tip: For a 5-mark question on "relevance of psychology to pharmacy", open with the definition, list 4-5 scope areas, then close with the accessibility argument — the pharmacist sees the patient more often than the doctor does.

Branches of psychology with healthcare relevance

Four branches are named in the syllabus. Learn them as a table — examiners ask "distinguish" questions from exactly this table:

Branch	What it studies	Pharmacy example
Clinical psychology	Assessment, diagnosis, and treatment of mental disorders	Recognising signs of depression in a patient on long-term medication and referring them to a doctor
Health psychology	How psychological and social factors influence health, illness, and healthcare	Counselling a diabetic patient on lifestyle change alongside medicines
Behavioural psychology	Observable behaviour and how it is learned through conditioning	Using reminders and praise to reinforce regular tablet-taking
Developmental psychology	Psychological changes across the lifespan, from infancy to old age	Counselling a child's parent differently from an elderly patient with memory problems

Exam tip: Strictly speaking, behaviourism is a school of thought about learning (Pavlov, Skinner) rather than an applied branch like the other three — but in the exam, treat "behavioural psychology" as the branch dealing with learned behaviour and conditioning. Don't argue with the syllabus in your answer.

Sensation, perception, and attention in clinical assessment

Definitions — write all three before explaining.

- Sensation is raw input: what the sense organs pick up. You see a patient sweating; you hear a shaky voice.
- Perception is the brain's interpretation of that input. You conclude the sweating patient may be anxious or in pain.
- Attention is selectively focusing on some inputs while ignoring others.

Types of attention (a favourite 2-mark question):

- Selective attention — focusing on the patient despite a noisy pharmacy
- Divided attention — handling billing while listening to a patient; risky, avoid it during counselling
- Sustained attention — staying focused through a long patient interaction

Role in clinical assessment. A pharmacist uses all three constantly. You sense a tremor in an elderly patient's hands, perceive that they may struggle to open a bottle, and attend to both their words and body language while counselling. Practical rule: if a patient squints at a label or keeps asking you to repeat, perceive the real problem — poor vision or hearing — and adapt with larger writing or slower speech, instead of just repeating the same words louder.

Exam tip: "Distinguish between sensation and perception" is almost a guaranteed 2-marker. One line each: sensation = raw data from sense organs; perception = the brain organising and interpreting that data into meaning.

Learning and memory: reinforcement in health behaviour change

Learning is a relatively permanent change in behaviour due to experience. Three types matter for the exam:

- 1 Classical conditioning (Pavlov) — learning by association. Example: a patient's blood pressure shoots up in the clinic ("white-coat hypertension") because they have associated the clinic with anxiety.
- 2 Operant conditioning (Skinner) — behaviour is shaped by its consequences. This is where reinforcement sits:
 - Positive reinforcement — adding something pleasant to encourage a behaviour. Example: praising a patient who brings their BP diary: "Very good — this record will help your doctor adjust the dose."
 - Negative reinforcement — removing something unpleasant to encourage a behaviour. Example: pain relief after taking the prescribed analgesic on time reinforces taking it on time.
 - Reinforcement is NOT punishment. Punishment (scolding a patient for missing doses) creates fear and avoidance, not adherence.
- 1 Observational learning (Bandura) — learning by watching others. Example: showing a patient a video of correct inhaler technique, or a mother learning ORS preparation by watching a nurse.

Memory works in three steps — encoding (taking information in), storage (keeping it), and retrieval (recalling it) — moving from sensory memory to short-term memory to long-term memory. Why this matters at the counter: patients forget a large share of verbal instructions within days. So a pharmacist should:

- Keep instructions short and in plain language (small "chunks" are remembered better)
- Give written + verbal instructions together
- Use the teach-back method: "Just to be sure I explained well, can you tell me how you will take this tablet?"

Exam tip: If asked to distinguish positive from negative reinforcement, remember the formula: positive = add something pleasant; negative = remove something unpleasant. Both increase the desired behaviour. Write one pharmacy example for each.

Emotion and motivation: theories and implications in health contexts

Emotion

Emotion is a feeling state with three parts: the subjective feeling, bodily changes (racing heart, sweating), and behaviour (facial expression). Three theories — learn them as a comparison table:

Theory	Core idea	Memory hook
James-Lange	Bodily arousal comes first; the brain reads it as emotion	"I am trembling, so I must be afraid"
Cannon-Bard	Arousal and emotion happen at the same time, independently	Heart races and you feel fear together
Schachter-Singer (two-factor)	Arousal + how you label it = emotion	Same racing heart = fear in an exam hall, excitement on a cricket field

Implications in health contexts. Anxiety before a diagnosis raises heart rate and BP, which can distort readings. Fear of a serious diagnosis makes patients delay check-ups. And practically: a calm, reassuring pharmacist gets more accurate information from patients than a hurried one.

Motivation

Motivation is what drives and directs behaviour. Two types: intrinsic (from within — "I want to be healthy") and extrinsic (from outside — "my family insists I take these").

The key theory is Maslow's hierarchy of needs (1943): physiological needs → safety → love and belonging → esteem → self-actualisation. Lower needs must be reasonably satisfied before higher ones motivate behaviour.

Implication for counselling. If a patient is worried about the cost of medicines (a safety need), lecturing them about an ideal lifestyle (a higher need) will fail. Address the cost worry first — suggest generics or Jan Aushadhi options — and only then will the patient actually hear your lifestyle advice.

Exam tip: "Which theory says emotion comes from labelling bodily arousal?" — Schachter-Singer two-factor theory. And for Maslow, always attach the pharmacy implication: meet the patient's most pressing concern (cost, fear) before higher-level advice.

Very short questions (2 marks)

- 1 Define psychology.
- 2 Distinguish between sensation and perception.
- 3 What is negative reinforcement? Give one pharmacy example.
- 4 Name the three steps of memory.

- 5 Which emotion theory states that arousal and emotion occur simultaneously?

Short questions (5 marks)

- 1 Explain the scope and relevance of psychology in health sciences with reference to pharmacy practice.
- 2 Compare the three theories of emotion with examples.
- 3 Describe the branches of psychology relevant to healthcare, with one pharmacy example for each.

Long questions (10 marks)

- 1 Define learning. Explain classical conditioning, operant conditioning (with types of reinforcement), and observational learning, giving pharmacy examples of how each is used in health behaviour change.
- 2 Explain Maslow's hierarchy of needs and discuss its implications for patient counselling, with examples.

How to approach these answers

- Very-short Q1: write the exact definition — scientific study of behaviour and mental processes; one line is enough.
- Very-short Q2: sensation = raw sense-organ input; perception = brain's interpretation; one line each.
- Very-short Q3: definition (removing something unpleasant to encourage behaviour) + one pharmacy example.
- Very-short Q4: list encoding, storage, retrieval — three words, no paragraph.
- Very-short Q5: name Cannon-Bard theory and its one-line core idea.
- Short Q1: open with definition, then 4–5 scope points, close with the pharmacist-accessibility argument.
- Short Q2: three-column table (theory / core idea / example); conclude with one health implication.
- Short Q3: four-row table (branch / what it studies / pharmacy example).
- Long Q1: structure — definition of learning, three conditioning types as subheads with pharmacy examples each, close with teach-back as the memory aid.
- Long Q2: structure — draw the hierarchy pyramid, explain each level briefly, then a paragraph on counselling implications with the cost-versus-lifestyle example.

Unit II — Developmental and Behavioural Psychology

Human developmental stages and healthcare needs

Erikson's eight psychosocial stages (1950) describe one core conflict at each stage of life. The examiner doesn't just want the stages — they want the healthcare angle. Learn this table:

Stage (age)	Conflict	Healthcare need / pharmacy angle
Infancy (0-1)	Trust vs mistrust	Caregiver must trust the pharmacist; demonstrate safe measuring of syrups
Toddlerhood (1-3)	Autonomy vs shame	Let the child choose a flavour if options exist; don't force
Preschool (3-6)	Initiative vs guilt	Praise cooperation during nebulisation
School age (6-12)	Industry vs inferiority	Teach an inhaler technique the child can master and use at school
Adolescence (12-18)	Identity vs role confusion	Respect privacy (acne, contraception queries); peer pressure affects adherence
Young adulthood (19-40)	Intimacy vs isolation	Support adherence despite a busy work life; maternal health counselling
Middle adulthood (40-65)	Generativity vs stagnation	Chronic disease (diabetes, hypertension) management; screening reminders
Late adulthood (65+)	Integrity vs despair	Polypharmacy review, large-print labels, fall-risk counselling, patience with hearing issues

The one-line takeaway for the exam: counselling is not one-size-fits-all. A teenager needs confidentiality; an elderly patient needs simplicity, large writing, and family involvement.

Exam tip: When asked for "developmental stages and healthcare needs", write the conflict names exactly (trust vs mistrust, and so on) and attach one pharmacy-specific need to each stage. That pairing is what converts a psychology answer into a pharmacy answer.

Personality theories and patient interaction styles

Freud's psychoanalytic theory

Personality has three parts in constant negotiation:

- Id — primitive desires; the "I want it now" part
- Ego — the realistic mediator that deals with the real world

- Superego — the moral conscience; internalised rules and ideals

Exam value: definitions of id, ego, superego, one example each.

Trait theory — the Big Five (OCEAN)

Personality is a mix of five measurable traits:

- Openness — curiosity, willingness to try new treatments
- Conscientiousness — organisation and dutifulness (high scorers adhere better to prescriptions)
- Extraversion — sociability; extraverts ask more questions
- Agreeableness — cooperativeness and trust
- Neuroticism — tendency toward anxiety and worry

Patient interaction styles

The theory becomes useful when you map traits to counter behaviour:

Patient style	What you see	How to respond
Anxious / high neuroticism	Repeated questions, visible worry	Reassurance, unhurried explanation, written backup
Low conscientiousness	Missed doses, lost prescriptions	Reminders, pill organisers, simplified regimens
Sceptical / low agreeableness	"Do I really need this?"	Evidence and respect, not orders — "studies show this reduces stroke risk..."
Talkative / extravert	Long stories, drifts off topic	Gentle steering back so counselling stays on track

Exam tip: "How do personality traits affect patient interaction?" — answer with the OCEAN expansion first, then the mapping table. Examiners reward the practical column.

Psychological factors affecting illness perception and recovery

How a patient thinks about their illness shapes whether they recover well. Four factors, each examinable:

- 1 Illness representations — Leventhal's common-sense model. Patients carry five beliefs about their illness: identity (what it is), cause (what brought it), timeline (how long it lasts), consequences (how serious it is), and cure/control (can it be treated). Example: a hypertensive patient who believes "BP tablets are only needed when I feel dizzy" (wrong timeline and control beliefs) will take them irregularly. Counselling corrects the representation.

- 2 Locus of control — internal ("my actions affect my health") versus external ("it's all fate / the doctor's job"). Internals generally adhere better.
- 3 Self-efficacy — belief in one's own ability to follow treatment ("I can remember two doses a day").
- 4 Optimism and social support — supported, hopeful patients recover faster and follow advice more consistently. And stress itself slows wound healing and worsens conditions like hypertension — so reducing patient anxiety is genuinely therapeutic, not just polite.

Exam tip: Leventhal's five beliefs have a fixed order — identity, cause, timeline, consequences, cure/control. Write all five; examiners check for completeness here.

Common psychological disorders in healthcare: anxiety, depression, and somatization

Anxiety

Excessive, hard-to-control worry plus bodily symptoms — palpitations, sweating, restlessness, sleep disturbance. Pharmacy relevance: anxious patients ask repeated questions and may avoid needed treatment; also, some drugs cause anxiety-like symptoms (salbutamol tremor, excess caffeine). Approach: calm tone, clear simple answers, avoid alarming language; refer to a doctor if anxiety is persistent.

Depression

Persistent low mood or loss of interest (anhedonia), with sleep and appetite changes, fatigue, and poor concentration, lasting weeks. Pharmacy relevance: depression is a top hidden cause of non-adherence — a depressed patient may simply stop caring about medicines. A pharmacist can gently screen with two questions ("Over the past two weeks, have you felt down or lost interest in things?") and refer — not diagnose.

Somatization

Physical complaints (pain, fatigue, digestive issues) not fully explained by medical findings, linked to psychological distress. Flag: current psychiatry (DSM-5) calls this somatic symptom disorder — if your examiner uses the newer term, it means the same concept. Approach: never say "it's all in your head"; acknowledge the symptoms are real, treat the patient respectfully, and coordinate with the doctor instead of repeatedly dispensing symptomatic medicines.

Exam tip: The golden rule across all three disorders: the pharmacist recognises, responds with empathy, and refers — never diagnoses. Write that line in every answer on this topic.

Coping strategies, resilience, and stress management techniques

Coping (Lazarus & Folkman, 1984)

Coping means efforts to manage stress. Two healthy types:

- Problem-focused coping — tackling the cause. Example: a patient organises a pill box to stop missing doses.
- Emotion-focused coping — managing the feelings. Example: deep breathing before a scary test result.

Avoidant coping (denial, alcohol use) is maladaptive — it worsens outcomes.

Resilience

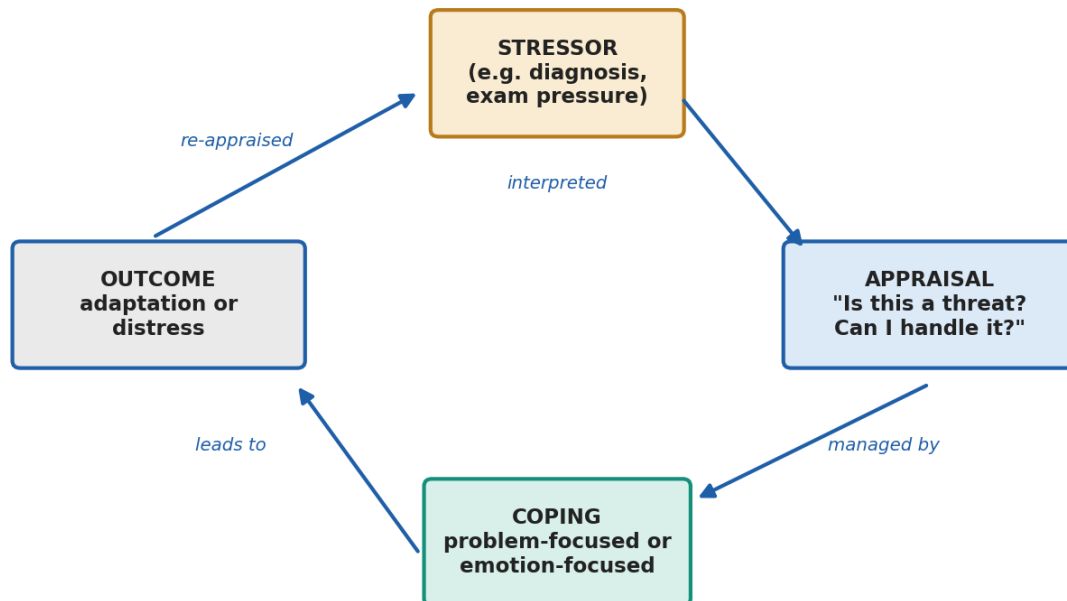
Resilience is the ability to bounce back from adversity. It grows through social support, realistic optimism, self-care routines, and past successful coping — and pharmacists can nurture it with encouragement and practical help.

Stress management techniques

Useful for patients and for you during a hectic dispensing shift:

- 1 Deep breathing / 4-7-8 technique — a 2-minute calming exercise you can actually teach at the counter
- 2 Progressive muscle relaxation — tensing then releasing muscle groups
- 3 Time management — prioritising tasks instead of firefighting
- 4 Regular physical activity and sleep hygiene
- 5 Seeking social support — talking to family, friends, or support groups
- 6 Professional referral — counsellor or doctor when stress is overwhelming

The Stress-Coping Cycle (Lazarus & Folkman)



Avoidant coping (denial, alcohol) is maladaptive — it worsens the outcome, not the stress.

The stress-coping cycle: stressor, appraisal, coping, and outcome

Exam tip: For "stress management techniques", give 5–6 numbered points with one line of explanation each. Numbered points photograph better in the examiner's mind than a paragraph.

Very short questions (2 marks)

- 1 Name the eight conflicts in Erikson's psychosocial stages (any four acceptable — but know all eight).
- 2 Expand OCEAN in the Big Five personality model.
- 3 Define self-efficacy.
- 4 What is anhedonia, and in which disorder is it seen?
- 5 Distinguish between problem-focused and emotion-focused coping.

Short questions (5 marks)

- 1 Describe Erikson's psychosocial stages with the healthcare need of each stage.
- 2 Explain Leventhal's common-sense model of illness representation and its effect on adherence.
- 3 Write short notes on anxiety and depression as seen in pharmacy practice: features and the pharmacist's role.

Long questions (10 marks)

- 1 Discuss the psychological factors affecting illness perception and recovery: illness representations, locus of control, self-efficacy, and social support.
- 2 Define coping. Classify coping strategies and describe six stress management techniques a pharmacist can teach patients.

How to approach these answers

- Very-short Q1: list four conflict pairs correctly (trust vs mistrust, etc.); spelling of the pairs matters.
- Very-short Q2: expand all five letters — one line.
- Very-short Q3: definition — belief in one's own ability to carry out the needed behaviour.
- Very-short Q4: loss of interest/pleasure; seen in depression — two short phrases.
- Very-short Q5: problem-focused = tackles the cause; emotion-focused = soothes the feelings; one example each.
- Short Q1: eight-row table (stage / conflict / healthcare need); close with the one-size-does-not-fit-all line.
- Short Q2: list the five beliefs, explain each in one line, then the hypertension example showing wrong beliefs → poor adherence.
- Short Q3: two subheads (anxiety, depression); under each — features, pharmacy relevance, pharmacist's approach ending with "refer, not diagnose".
- Long Q1: structure — intro line, four subheads (one per factor) with examples, conclusion on how counselling targets these beliefs.
- Long Q2: structure — definition of coping, classification (problem-focused / emotion-focused / avoidant-maladaptive), then six numbered techniques with one-line explanations each.

Unit III — Foundations of Health Communication

Elements and models of communication in healthcare

Every act of communication — from a counter instruction to a health campaign — is built from the same elements:

- Sender (source) — e.g., the pharmacist
- Message — the information itself
- Encoding — putting the message into words, gestures, or writing
- Channel — how the message travels: speech, phone, WhatsApp, leaflet
- Decoding — the receiver interpreting the message
- Receiver — e.g., the patient

- Feedback — the receiver's response, confirming understanding
- Noise — anything distorting the message (literal noise, jargon, anxiety)
- Context — the situation around it (a rushed counter vs a counselling room)

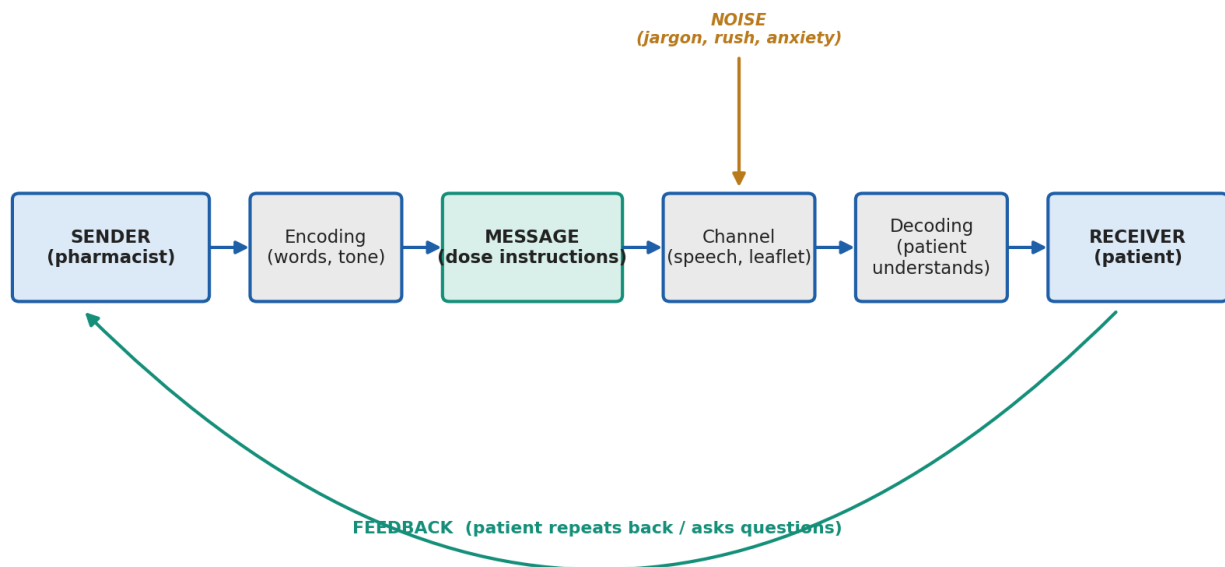
Three models examiners love — learn as a table:

Model	Structure	One-line summary
Shannon-Weaver (1949)	Linear: sender → message → channel → receiver, with noise	Communication as transmission; noise is the enemy
Schramm (1954)	Interactive: sender and receiver swap roles, feedback loop, shared "field of experience"	Communication works when both sides share enough background
Berlo's SMCR (1960)	Source-Message-Channel-Receiver, each with influencing factors (skills, attitudes, knowledge)	The quality of each element decides the outcome

Pharmacy example tying it together: you (source) explain (message) verbally (channel) to a patient (receiver); the patient repeats it back (feedback); a crying child nearby is noise; your shared language is the field of experience.

The Communication Process in Healthcare

CONTEXT surrounds everything: a busy counter vs a quiet counselling room



The communication process: sender, message, channel, receiver, feedback, noise, and context

Exam tip: "Draw and explain any one model of communication" is a classic diagram question. Draw Shannon-Weaver or Schramm with all labels, then write 4-5 lines explaining each part. A labelled diagram here is easy marks.

Types of communication: interpersonal, group, mass, and telehealth communication

- Interpersonal communication — one-to-one. Counter counselling: "take this after food, twice daily." This is the core of pharmacy practice.
- Group communication — one-to-many in person. A diabetes education session at a clinic, an asthma awareness camp in a village.
- Mass communication — reaching the public at scale. Posters, radio spots, newspaper ads, social media campaigns (e.g., antibiotic-awareness week posts).
- Telehealth communication — remote care: video consultations, phone follow-ups, telepharmacy counselling for patients in distant areas. It grew enormously after COVID-19 and is now a standard professional skill.

Exam tip: For "types of communication", give each type with a definition and one pharmacy example. Four types, four examples — that's the full 5 marks.

Barriers to effective communication in clinical settings

Barrier type	What it means	Example at a pharmacy
Physical	Environmental obstacles	Noise, no private counselling space, long counter distance
Physiological	Body-based limitations	Patient's hearing loss, pain, drowsiness from medicines
Psychological	Mental/emotional blocks	Patient anxiety, fear of diagnosis, distrust, preconceived notions
Semantic / language	Meaning gets lost in words	Medical jargon ("take tds pc"), English label for a Hindi-speaking patient
Cultural	Norms and beliefs interfere	Gender norms, religious beliefs about treatment, deference to elders
Organisational	System-level problems	Time pressure, staff shortage, no system for follow-up

Overcoming barriers: use plain language, confirm understanding with teach-back, arrange privacy where possible, and never rush a confused patient. In the exam, after listing barriers, always add 2-3 lines on overcoming them — examiners reward the solution, not just the problem.

Exam tip: This table is a ready-made 5-mark answer. Six barrier types with one pharmacy example each, plus a closing line on overcoming them.

Active listening, questioning techniques, and empathy

Active listening

Active listening means listening with full attention to understand, not just to reply. The SOLER technique (Egan) gives it a physical form:

- S — Sit squarely facing the patient
- O — Open posture (uncrossed arms)
- L — Lean slightly forward
- E — Eye contact (culturally appropriate)
- R — Relax — don't fidget or glance at your phone

Add verbal skills: paraphrasing ("So you're saying the tablet makes you dizzy in the morning?"), reflecting feelings ("That sounds frightening"), summarising, and minimal encouragers (nodding, "hmm", "go on").

Questioning techniques

- Open-ended questions — "How have you been taking your blood pressure tablets?" Invites full answers. Best for starting.
- Closed questions — "Did you take today's dose?" Gives yes/no. Best for confirming specifics.
- Probing questions — "Can you tell me more about the dizziness — when exactly does it happen?"
- Funnel technique — start open, then probe, then close to pin down details.
- Avoid leading questions — "You took it correctly, right?" pushes the answer you want, not the truth.

Empathy vs sympathy — a favourite exam distinction

	Empathy	Sympathy
Meaning	Understanding the patient's feelings from their perspective	Feeling pity from your own perspective
Sounds like	"It must be hard managing all these tablets alone."	"Oh, poor you."
Effect	Builds trust; the patient opens up	Creates distance; the patient feels pitied

Exam tip: "Distinguish between empathy and sympathy" and "Expand SOLER" are both high-probability 2-5 mark questions. For SOLER, expand each letter with one phrase — five lines, full marks.

Culturally appropriate and inclusive communication

India's patients differ in language, religion, literacy, gender norms, and disability — counselling must adapt:

- Language — use the patient's language where possible; otherwise simple words, pictures, and demonstrations. Never rely on complex English on a label alone.
- Gender and family norms — some women prefer discussing certain issues with a female pharmacist; some elderly patients want a family member present. Respect the preference.
- Literacy — don't assume it. Pictorial schedules (sun = morning dose) work where text fails.
- Person-first language — "person with diabetes", not "diabetic"; "person with depression", not "mental patient". The person comes before the condition.
- Disability inclusion — face a hearing-impaired patient when speaking, write key points down, allow extra time.

Exam tip: "Person-first language" is a neat 2-marker: define it and give two examples ("person with diabetes" instead of "diabetic"). It also earns you credit whenever you use it in other answers.

Very short questions (2 marks)

- 1 List any five elements of the communication process.
- 2 Expand SOLER.
- 3 Distinguish between open-ended and closed questions with one example each.
- 4 What is person-first language? Give one example.
- 5 Name the four types of communication in healthcare.

Short questions (5 marks)

- 1 Explain the Shannon-Weaver, Schramm, and Berlo models of communication with a pharmacy example.
- 2 Describe the barriers to effective communication in clinical settings with pharmacy examples.
- 3 Distinguish between empathy and sympathy. Why does empathy matter in patient counselling?

Long questions (10 marks)

- 1 Define communication. Describe its elements with a labelled diagram of the communication process, and explain how each element operates in a pharmacy counselling session.
- 2 Explain active listening (SOLER), questioning techniques (open, closed, probing, funnel), and culturally appropriate communication, with examples.

How to approach these answers

- Very-short Q1: any five — sender, message, channel, receiver, feedback is the safest set.
- Very-short Q2: expand each letter with one phrase; five lines.
- Very-short Q3: one definition + one example for each type; keep it to four lines.
- Very-short Q4: definition (person before the condition) + one example like "person with diabetes".
- Very-short Q5: interpersonal, group, mass, telehealth — four words.
- Short Q1: three-row table (model / structure / one-line summary), then one pharmacy example tying the elements together.
- Short Q2: six-row table (barrier type / pharmacy example); close with 2–3 lines on overcoming barriers.
- Short Q3: empathy-vs-sympathy table, then a short paragraph on trust and disclosure.
- Long Q1: structure — definition, list of elements, labelled diagram, then a walkthrough of one counselling session element by element.
- Long Q2: structure — three subheads (active listening with SOLER, questioning with funnel order, cultural adaptation with person-first language), each with examples.

Unit IV — Professional Communication in Healthcare Settings

Communication with patients, caregivers, and interdisciplinary teams

With patients

Follow a simple counselling flow — examiners like stepwise answers, so learn it as steps:

- 1 Greet warmly — first impressions decide whether the patient trusts you
- 2 Assess what the patient already knows ("What did the doctor tell you about this medicine?")
- 3 Explain in plain language — no jargon
- 4 Demonstrate — inhaler, insulin pen, ORS preparation; show, don't just tell
- 5 Check understanding with teach-back
- 6 Invite questions — "What would you like to ask about this medicine?"

Keep it unhurried even when the queue is long; rushing destroys steps 2, 5, and 6.

With caregivers

Involve family for children, elderly, and seriously ill patients — but with the patient's consent where the patient is competent. Brief the caregiver on dosing schedules, warning signs, and storage, since they often supervise the actual medicine-taking at home.

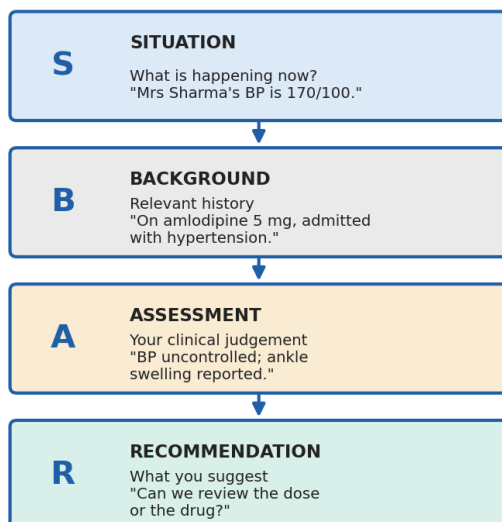
With interdisciplinary teams

Pharmacists work with doctors, nurses, and lab staff. Keep communication structured and respectful — state facts, not opinions. The standard tool is SBAR (borrowed from safety-critical industries, now routine in hospitals) for handovers and calls:

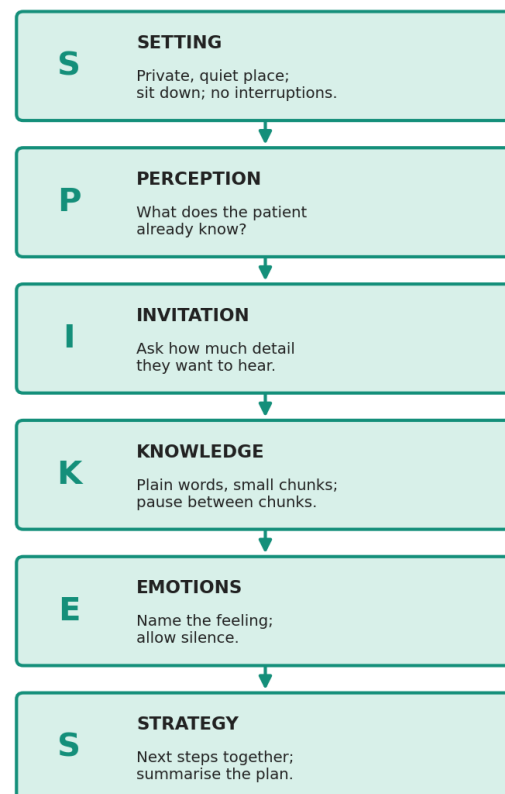
- S – Situation: "I'm calling about Mrs Sharma in Ward 3..."
- B – Background: "...admitted with hypertension, on amlodipine 5 mg..."
- A – Assessment: "...her BP is still 170/100 and she reports ankle swelling..."
- R – Recommendation: "...could we review whether the dose or the drug needs changing?"

SBAR prevents the vague, rambling calls that cause medication errors.

SBAR — talking to the healthcare team



SPIKES — delivering difficult news



SBAR keeps team messages short and complete • SPIKES keeps bad news humane and clear

SBAR for team communication and SPIKES for delivering difficult news

Exam tip: "Expand SBAR and explain with an example" is almost guaranteed. Write the four expansions, one line of meaning each, then the Mrs Sharma-style example walking through all four letters. That example is what separates a full-marks answer from a bare expansion.

Delivering difficult news and handling emotionally charged situations

The SPIKES protocol (Baile et al., 2000)

Originally from oncology, SPIKES is the standard six-step method for delivering difficult news — a medicine being unavailable, a treatment not working, a serious diagnosis:

- S – Setting: private, quiet place; sit down; no interruptions
- P – Perception: find out what the patient already knows ("What have the doctors told you so far?")
- I – Invitation: ask how much detail they want ("Would you like me to explain what this means for the treatment?")
- K – Knowledge: give the news in small chunks, plain words, no jargon; pause between chunks
- E – Emotions: acknowledge feelings explicitly ("I can see this is upsetting") and allow silence — don't rush to fill it
- S – Strategy/Summary: discuss next steps together and summarise the plan

Handling emotionally charged situations

For angry or weeping patients and relatives:

- 1 Stay calm — don't match their volume or argue
- 2 Acknowledge the emotion before the facts — "I understand you're upset — let's sort this out"
- 3 Move to a private corner if possible
- 4 Listen fully before explaining, then offer concrete next steps
- 5 Know when to escalate — call a senior or security if needed; your safety matters too

Exam tip: SPIKES and SBAR are the two mnemonics of this unit — examiners ask for both by expansion. For SPIKES, the most commonly forgotten letters are P (Perception) and I (Invitation); writing "find out what they know, ask how much they want to know" shows you actually understand the protocol.

Legal and ethical issues in health communication: confidentiality and consent

The syllabus names two pillars. Stick to these two for exams.

Confidentiality

Patient information — prescriptions, diagnoses, even the fact that someone visited the pharmacy — must not be disclosed to others without consent. Practical rules for the counter:

- Don't discuss one patient's medicines within earshot of the next person in the queue
- Keep records secure — locked storage, password-protected systems
- Never share patient details on social media or WhatsApp groups

Informed consent

Before any procedure, treatment, or sharing of data, the patient must understand the purpose, benefits, risks, and alternatives, and agree voluntarily. In pharmacy: explain before counselling-based services (e.g., BP screening camps), and get consent before sharing patient data for any purpose beyond their care.

Exam tip: If the examiner drifts into wider ethics, know the four background principles — autonomy, beneficence, non-maleficence, justice — in one line. But your answer's core stays on confidentiality and consent, because those are the syllabus-named issues.

Writing patient records, reports, and discharge summaries

Good documentation is both a legal record and a communication tool. Golden rules: factual, concise, dated and timed, legible, and free of abbreviations others won't understand.

SOAP notes (Weed, 1960s)

The standard structure for patient records:

- S – Subjective: what the patient reports — "Patient complains of dizziness every morning after taking amlodipine."
- O – Objective: what you measure or observe — "BP 150/95 mmHg, pulse 88."
- A – Assessment: your clinical judgement — "Possible amlodipine-related dizziness; adherence good."
- P – Plan: what you'll do — "Counselled on rising slowly; advised to report to doctor; will follow up in 3 days."

Reports

Example: ADR (adverse drug reaction) reports to the Pharmacovigilance Programme of India (PvPI) — what happened, which drug, dose, timing, outcome. Accurate ADR reporting by pharmacists directly protects other patients.

Discharge summaries

Contents an examiner will check for: medication list with doses and timings, duration of treatment, warning signs to watch for, follow-up date, and lifestyle advice — written so the patient and the next provider both understand the plan.

Exam tip: "Write a sample SOAP note" is a very likely 5-marker. Memorise the four expansions and practise one full example — Subjective (complaint), Objective (numbers), Assessment (your judgement), Plan (next steps). Write it exactly in that order.

Use of technology and digital communication tools in healthcare services

- Telehealth / telepharmacy — video or phone consultations and remote counselling; essential for rural and distant patients
- Electronic health records (EHR) — shared digital patient histories that reduce errors from lost paper prescriptions
- Reminders — SMS/WhatsApp dose reminders and refill alerts (only with patient consent; never discuss diagnoses in casual chats)
- Drug information tools — apps and databases for checking interactions quickly at the counter

Cautions (examiners ask "what are the limitations?" — keep these ready):

- Protect patient data — passwords, no public computers for records
- Never diagnose or prescribe over a casual message
- Digital tools support but don't replace face-to-face counselling

Exam tip: Structure this answer as two lists — uses, then cautions. The caution list (privacy, no diagnosis over chat, technology as support not replacement) is where the extra marks hide.

Very short questions (2 marks)

- 1 Expand SBAR.
- 2 Expand SPIKES.
- 3 Expand SOAP (in the context of patient records).
- 4 Define informed consent.
- 5 Where do pharmacists in India report adverse drug reactions?

Short questions (5 marks)

- 1 Explain the SBAR technique with a pharmacy example.
- 2 Describe the SPIKES protocol for delivering difficult news.
- 3 Write short notes on confidentiality and informed consent in pharmacy practice.

Long questions (10 marks)

- 1 Describe the steps of counselling a patient at the pharmacy counter. How does communication differ when dealing with caregivers and with the interdisciplinary team?
- 2 Explain the structure of SOAP notes with a sample note for a given case. Add the essential contents of a discharge summary.

How to approach these answers

- Very-short Q1: four expansions with one phrase each — Situation, Background, Assessment, Recommendation.
- Very-short Q2: six expansions in order — Setting, Perception, Invitation, Knowledge, Emotions, Strategy/Summary.
- Very-short Q3: Subjective, Objective, Assessment, Plan — with "patient's complaint / measurements / judgement / next steps" in brackets.
- Very-short Q4: definition — understanding purpose, benefits, risks, alternatives + voluntary agreement.
- Very-short Q5: Pharmacovigilance Programme of India (PvPI) — name it exactly.
- Short Q1: four expansions with one-line meanings, then the full Mrs Sharma-style example through all four letters.
- Short Q2: six steps in order, each with one line of explanation; emphasise small chunks and allowing silence.
- Short Q3: two subheads; under confidentiality list 3 practical counter rules; under consent list purpose-benefits-risks-alternatives + voluntary.
- Long Q1: structure — six counselling steps as numbered points, then two short paragraphs (caregivers: involve with consent; team: SBAR, facts not opinions).
- Long Q2: structure — SOAP expansions with a complete sample note in order, then a bullet list of discharge summary contents.

Unit V — Health Psychology and Behavioural Interventions

Health belief models and illness behaviour

The Health Belief Model (HBM) — Rosenstock (1966), Becker (1974)

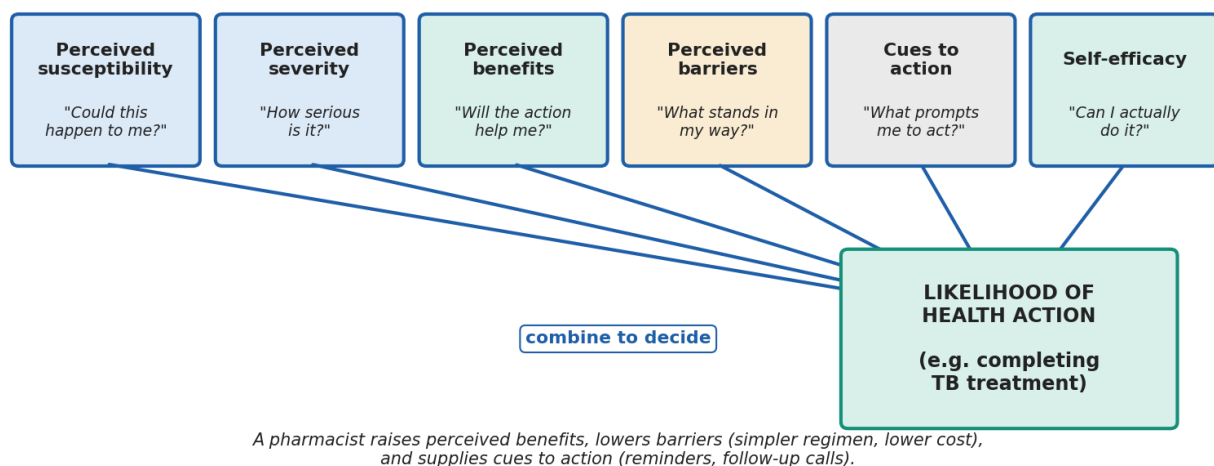
The HBM explains why people do — or don't — take health action. A person acts when these six components line up:

Component	Meaning	Pharmacy example (TB treatment)
Perceived susceptibility	"Could this happen to me?"	"I could develop drug-resistant TB if I stop early"

Component	Meaning	Pharmacy example (TB treatment)
Perceived severity	"How serious is it?"	"TB can damage my lungs permanently"
Perceived benefits	"Will the action help?"	"Completing DOTS will cure me"
Perceived barriers	"What stands in my way?"	Side effects, travel to the clinic, lost wages
Cues to action	Triggers that prompt action	An ASHA worker's visit, a reminder call
Self-efficacy	"Can I actually do it?" (added later)	"I can manage six months of tablets"

The pharmacist's job, in HBM terms: raise perceived benefits, lower perceived barriers (simpler regimens, cost solutions), and supply cues to action (reminders, follow-up calls).

Health Belief Model — why a patient does (or does not) act



The Health Belief Model: six components that combine to decide the likelihood of health action

Illness behaviour

Illness behaviour (Mechanic) = how people perceive, evaluate, and act on symptoms — including delay in seeking care and self-medication, which is extremely common in India, where the chemist shop is often the first stop for health advice.

Related concept: Parsons' "sick role" (1951) — society grants the sick person two rights (exemption from normal duties; not being blamed for the illness) and two obligations (seek competent help; cooperate with treatment). Non-adherence, in this view, is a failure of the sick role's obligations.

Exam tip: "Explain the Health Belief Model with a pharmacy example" is a very likely long question. Draw the six-component diagram, explain each component in one line, then show the pharmacist's three jobs: raise benefits, lower barriers, supply cues.

Psychosomatic illnesses and the mind-body connection

Psychosomatic illnesses are physical conditions significantly influenced or worsened by psychological factors — stress, anxiety, emotional conflict. Classic examples: hypertension, irritable bowel syndrome (IBS), migraine, asthma flare-ups, eczema, and peptic ulcers.

The mechanism is real physiology, not imagination: chronic stress keeps cortisol and adrenaline elevated, raising blood pressure, disturbing gut function, suppressing immunity, and increasing inflammation. The field studying this is psychoneuroimmunology.

Pharmacy angle: when a patient with IBS or migraine also reports heavy stress, medicines alone may underperform — stress management (the Unit II techniques) is a legitimate adjunct to drug therapy.

Exam tip: Write this sentence in your answer and underline it mentally: psychosomatic does NOT mean fake. The symptoms are real; psychology is part of the cause, so it must be part of the treatment. Examiners test exactly this misconception.

Behaviour change theories (CBT, TTM) in treatment adherence

CBT — Cognitive Behavioural Therapy (Beck)

Core principle: thoughts, feelings, and behaviour influence each other. Distorted thoughts ("this BP tablet will damage my kidneys") produce fear, which produces non-adherence. CBT corrects this through:

- Cognitive restructuring — examining the evidence: "Your doctor chose this dose because long-term studies show it protects kidneys in hypertension."
- Behavioural experiments — small tests: "Try the morning dose for a week and note your readings; let's review them together."

A pharmacist won't do full therapy — but CBT-style counselling, spotting and gently correcting a patient's wrong beliefs about medicines, directly improves adherence.

TTM — Transtheoretical Model (Prochaska & DiClemente, 1983)

Behaviour change moves through stages:

- 1 Precontemplation — not thinking about change ("I don't need to quit smoking")
- 2 Contemplation — thinking about it ("maybe I should...")
- 3 Preparation — planning ("I'll set a quit date")
- 4 Action — doing it

- 5 Maintenance — sustaining it (relapse is normal — it returns the person to an earlier stage, not to zero)

The counselling rule: match your approach to the stage. Don't push action on a precontemplator — raise awareness instead. Don't just praise a maintainer — help them plan for relapse triggers. Example: for smoking cessation, ask "Have you thought about quitting?" before handing over nicotine-gum advice.

	CBT	TTM
Focus	Correcting distorted thoughts about treatment	Matching counselling to readiness to change
Key idea	Thoughts → feelings → behaviour	Five stages; relapse is normal
Pharmacy use	Cognitive restructuring of medicine myths	Stage-matched adherence counselling

Exam tip: "Distinguish between CBT and TTM" is a clean 5-mark table question. Three rows — focus, key idea, pharmacy use — and you're done. They complement each other: CBT fixes what the patient believes, TTM times when you push.

Psychological first aid and crisis communication

Psychological First Aid (PFA) — WHO framework

PFA is immediate, humane support for someone in acute distress (accident, disaster, sudden bad news). It is not therapy. Three actions — Look, Listen, Link:

- Look — check for safety and urgent needs: is the person injured, in shock, alone?
- Listen — approach calmly, listen without pressuring them to talk, acknowledge their feelings
- Link — connect to practical help: family, medical care, helplines — and share accurate information

Crisis communication

Principles for communicating during a crisis (drug-shortage panic, an adverse-event scare):

- 1 Be honest about what you know and what you don't know
- 2 Stay calm; speak clearly and simply
- 3 Avoid speculation and rumours
- 4 Repeat key safety information

In a pharmacy during a crisis, the pharmacist is often the trusted local voice — accuracy matters more than speed.

Exam tip: "What is psychological first aid?" — answer in three words first: Look, Listen, Link. Then one line on each, and the line "PFA is not therapy" to show you know its limits.

Mental health promotion and stigma reduction through communication

Mental health promotion means building the conditions for psychological wellbeing — awareness, early help-seeking, supportive environments — not just treating illness. Stigma — shame and discrimination around mental illness — is the biggest barrier to care in India.

How communication reduces stigma:

- Language — person-first: "person with depression", never labels like "mental", "psycho", or "pagal"
- Normalising help-seeking — "Seeing a counsellor for stress is like seeing a doctor for fever"
- Correcting myths — mental illness is not a character flaw, not contagious, and usually treatable
- Visibility — pharmacists, as accessible first-contact professionals, can display helpline numbers and talk about mental health as routinely as physical health

India-specific anchor: the Mental Healthcare Act, 2017 gives every person the right to mental healthcare and decriminalised attempted suicide — a person attempting suicide is presumed to be under severe stress, not committing an offence. Knowing this helps you respond to a distressed patient lawfully and humanely.

Exam tip: The Mental Healthcare Act, 2017 is worth memorising as two points: (1) right to mental healthcare, (2) decriminalisation of attempted suicide. It fits as a closing line in any stigma-reduction answer.

Very short questions (2 marks)

- 1 List the six components of the Health Belief Model.
- 2 What are Parsons' two rights and two obligations in the sick role?
- 3 Name the five stages of the Transtheoretical Model in order.
- 4 What are the three actions of psychological first aid?
- 5 Name any two psychosomatic illnesses.

Short questions (5 marks)

- 1 Explain the Health Belief Model with a pharmacy example.
- 2 Distinguish between CBT and TTM in the context of treatment adherence.

- 3 Write a short note on stigma reduction through communication, with reference to the Mental Healthcare Act, 2017.

Long questions (10 marks)

- 1 Describe the Health Belief Model in detail. How can a pharmacist use it to diagnose the reasons for non-adherence and intervene? Illustrate with an example.
- 2 Explain psychosomatic illness and the mind-body connection. Discuss the role of stress hormones and the pharmacist's role in managing such patients.

How to approach these answers

- Very-short Q1: list all six — susceptibility, severity, benefits, barriers, cues to action, self-efficacy.
- Very-short Q2: rights — exemption from duties, not blamed; obligations — seek competent help, cooperate with treatment.
- Very-short Q3: precontemplation → contemplation → preparation → action → maintenance, in order.
- Very-short Q4: Look, Listen, Link — three words, then one line each if space allows.
- Very-short Q5: any two — hypertension, IBS, migraine, asthma, eczema, peptic ulcer.
- Short Q1: six-row table (component / meaning / example), then the pharmacist's three jobs.
- Short Q2: three-row comparison table (focus / key idea / pharmacy use).
- Short Q3: define stigma, then four communication strategies as points, close with the two Mental Healthcare Act points.
- Long Q1: structure — intro, six components with a TB/DOTS example running through, then a section on the pharmacist's interventions (raise benefits, lower barriers, cues), conclusion.
- Long Q2: structure — definition with the "not fake" line, mechanism (cortisol/adrenaline, psychoneuroimmunology), examples, pharmacist's role (medicines + stress-management adjunct + referral).