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Healthcare Psychology and Communication Skills

BP103T — B.Pharm Semester I

Concept Mastery Notes

Deep concepts for GPAT & competitive exams — nothing missed

As per PCI B.Pharm (NEP 2020) syllabus

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Unit I — Introduction to Psychology in Healthcare

1.1 Definition, scope, and relevance of psychology in health sciences

Psychology is the scientific study of behaviour and mental processes. Read that definition slowly, because every word earns its place:

- Behaviour = what people do — taking a tablet on time, skipping doses, shouting at the counter, following a diet chart. It is observable and measurable.
- Mental processes = what people think and feel behind the behaviour — beliefs about medicines, fear of side effects, trust in the pharmacist. You cannot see these directly, but you can infer them from what the patient says and does.
- Scientific = psychology does not run on opinion. It uses observation, experiments, and measurement. When we say "patients forget most verbal instructions within days," that comes from repeated studies, not from one pharmacist's hunch.

Why does a pharmacy student need this? Because drugs treat the body, but behaviour decides whether the drug gets taken. A perfectly prescribed antihypertensive does nothing sitting in a drawer. Non-adherence — not taking medicines as advised — is one of the biggest reasons treatments fail, and it is almost entirely a psychological problem: forgetfulness, wrong beliefs, fear, cost anxiety, or simply not understanding the instructions. You, the pharmacist, are often the most accessible health professional a patient meets. A patient may see their doctor once a month but walk into your pharmacy every week. That makes you the last checkpoint before the medicine reaches the mouth — and psychology is your toolkit for making that checkpoint work.

Scope of psychology in health sciences — the areas where it directly touches your future work:

- Patient behaviour and adherence — why patients take, skip, or stop medicines, and how to change that
- Provider-patient relationship — trust, rapport, and communication quality, which measurably affect outcomes
- Pain and symptom perception — two patients with the same injury report very different pain; perception is not a fixed readout
- Stress, coping, and recovery — how illness-related stress slows healing and worsens conditions like hypertension
- Health promotion — shaping habits: exercise, diet, quitting tobacco, vaccination acceptance
- Mental health screening — spotting anxiety or depression early, right at the pharmacy counter, and referring in time

GPAT angle: The biopsychosocial model (Engel, 1977) is the backbone of health psychology: illness is explained by biological factors (the disease, the drug), psychological factors (beliefs, stress, emotions), and social factors (family support, income, culture) acting together. A question may ask you to name the three components or identify which model replaced the purely biomedical view.

1.2 Branches of psychology with healthcare relevance

Branch	What it studies	Pharmacy example
Clinical psychology	Assessment, diagnosis, and treatment of mental disorders using interviews, tests, and therapy	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 behaviour	Counselling a diabetic patient on lifestyle change alongside medicines; designing adherence programmes
Behavioural psychology	Observable behaviour and how it is learned through conditioning	Using reminders, praise, and pill organisers to reinforce regular tablet-taking
Developmental psychology	Psychological changes across the lifespan, from infancy to old age	Counselling a child's parent very differently from an elderly patient with memory problems

A few deeper points examiners appreciate:

- Clinical psychology is the "diagnosis and therapy" branch. You will not practise it as a pharmacist, but you must know its territory so you can recognise and refer instead of guessing. A pharmacist who spots depressive symptoms and refers the patient has done clinical psychology's job at the screening level.
- Health psychology is your home branch. It asks questions like: why do educated patients still skip doses? How does stress raise blood pressure? It runs on the biopsychosocial model above.
- Behavioural psychology comes from the behaviourist school (Pavlov, Skinner, Watson). Strictly speaking, behaviourism is a school of thought about learning rather than an applied branch like the other three — but the syllabus lists it as a branch, so in exams treat it as the branch dealing with learned behaviour and conditioning. Its power for pharmacy: it gives you practical tools (reinforcement, modelling) that work even when you cannot change a patient's deep beliefs.
- Developmental psychology (Unit II in full) matters because a 6-year-old, a 16-year-old, and a 76-year-old are psychologically different patients, not just different body weights.

Trap alert: Students mix up health psychology and clinical psychology. Clinical = mental disorders, diagnosis, therapy. Health = the psychology of physical health — why people do or don't follow treatment, how stress affects the body, how to promote healthy habits. If the question involves adherence, lifestyle, or stress and immunity, the answer is health psychology.

1.3 Sensation, perception, and attention in clinical assessment

These three are a pipeline: raw input → interpretation → selection.

Sensation is raw input — what the sense organs pick up. You see a patient sweating; you hear a tremor in their voice. The sense organs convert physical energy into neural signals (a step called transduction).

Perception is the brain organising and interpreting that input into meaning. You conclude the sweating patient may be anxious or in pain. Perception is active, not passive — it fills gaps, uses past experience, and can be wrong. Two useful principles:

- Weber's law (difference threshold): we notice a change in a stimulus only when it crosses a threshold — roughly a constant proportion of the original. A patient may not "perceive" a small dose change, which is why you must point it out explicitly ("this strip looks the same, but the strength changed from 5 mg to 10 mg").
- Gestalt principles of organisation: the brain groups what it sees by proximity, similarity, and figure-ground separation. Pharmacy use: a medicine label where warnings blend into decorative text will be perceived as decoration. Clear figure-ground contrast (bold red warning box on white) is perception science applied to label design.

Attention is selectively focusing on some inputs while ignoring others. Types:

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

Why this trio matters in clinical assessment: a pharmacist constantly runs all three. You sense a tremor in an elderly patient's hands, perceive that they may struggle to open a child-resistant cap, and attend to both their words and body language while counselling. Practical rules: if a patient squints at a label or keeps asking you to repeat, perceive the real problem (poor vision, hearing loss) and adapt — larger writing, slower speech, facing the patient — instead of just repeating the same words louder. And never counsel while your attention is divided by the billing screen; inattention blindness is real — when attention is elsewhere, people miss even obvious information, including the patient's confusion.

Trap alert: Sensation = raw data from sense organs (seeing, hearing). Perception = the brain's interpretation of that data (recognising, judging). A question like "the pharmacist notices the patient is sweating and concludes he is anxious" is testing perception, not sensation.

1.4 Learning and memory: reinforcement in health behaviour change

Learning is a relatively permanent change in behaviour due to experience. Three classic types, each with a pharmacy job:

Classical conditioning (Pavlov)

Learning by association. Mechanics, using the famous clinic example:

- UCS (unconditioned stimulus) → UCR (unconditioned response): painful injection → fear and crying (natural, no learning needed)
- CS (conditioned stimulus) + UCS, paired repeatedly: the clinic building, the white coat
- CS → CR (conditioned response): now the clinic alone → anxiety, raised BP — the famous "white-coat hypertension"

Two follow-on processes matter clinically. Extinction: if the CS appears repeatedly without the UCS (painless, friendly clinic visits), the conditioned anxiety fades — which is why a calm pharmacy experience can undo a patient's fear. Stimulus generalisation: the patient becomes anxious in all clinics and pharmacies, not just the original one. When a patient looks terrified at your counter, consider: you may be facing a conditioned response, not a difficult personality.

Operant conditioning (Skinner)

Behaviour is shaped by its consequences. This is where reinforcement lives:

Consequence	What happens	Effect on behaviour	Pharmacy example
Positive reinforcement	Something pleasant is added	Behaviour increases	Praising a patient who brings their BP diary: "Excellent record — this helps your doctor adjust the dose"
Negative reinforcement	Something unpleasant is removed	Behaviour increases	Pain relief after taking the prescribed analgesic on time reinforces taking it on time
Positive punishment	Something unpleasant is added	Behaviour decreases	Scolding a patient for missing doses
Negative punishment	Something pleasant is removed	Behaviour decreases	Refusing to answer further questions after a patient argues

Two critical insights. First, reinforcement (positive or negative) always strengthens behaviour; punishment always weakens it. Negative reinforcement is not punishment — students lose marks here every year. Pain relief removing pain to encourage timely dosing is negative reinforcement, and it is a good thing.

Second, how reinforcement is scheduled decides how stubborn the behaviour becomes:

Schedule	Pattern	Example	Behaviour pattern
Continuous	Every correct response rewarded	Praising every dose taken (early training)	Learned fast, fades fast when rewards stop
Fixed-ratio	Reward after a fixed number of responses	"Bring your BP diary for 4 visits, get a free check-up"	Steady, high response rate
Variable-ratio	Reward after an unpredictable number	Surprise appreciation, lucky-draw adherence programmes	Highest, most persistent behaviour — hard to extinguish
Fixed-interval	Reward after a fixed time	Monthly refill reminder call	Response surges just before the reward time
Variable-interval	Reward after unpredictable time	Random follow-up calls	Steady, moderate behaviour

GPAT angle: Schedules of reinforcement are a favourite. Remember: variable schedules produce the most persistent behaviour (this is why gambling is addictive — variable-ratio). For adherence programmes, continuous reinforcement works best while building a habit; intermittent/variable reinforcement works best for maintaining it.

Observational learning (Bandura)

Learning by watching others. Bandura showed it needs four steps: attention (notice the model), retention (remember what was seen), reproduction (be able to copy it), and motivation (want to copy it). Pharmacy gold: showing a patient a video of correct metered-dose inhaler technique, or a mother learning ORS preparation by watching a nurse. If any step fails — the patient wasn't watching, can't remember the steps, or sees no reason to bother — the learning fails. So demonstrate slowly, repeat, and explain why the technique matters.

Memory: the three-stage pipeline

Memory runs encoding (getting information in) → storage (keeping it) → retrieval (getting it back out). Information flows through three stores:

- Sensory memory — a fleeting snapshot (under a second); most of it vanishes
- Short-term (working) memory — holds about 7 ± 2 chunks (Miller, 1956) for seconds; this is your counselling bottleneck — a patient cannot hold 12 instructions at once
- Long-term memory — effectively unlimited, lasting years; reached through rehearsal and deep processing

Two findings run your counselling technique. Ebbinghaus's forgetting curve: most newly learned verbal information is forgotten within days unless rehearsed — this is why patients nod at the counter and fail at home. Levels of processing (Craik & Lockhart): deeply processed information (understood, connected to experience) is remembered far better than shallowly processed information (just heard). The teach-back method — "just to be sure I explained well, can you tell me how you will take this tablet?" — forces the patient to process deeply, which is why it works better than asking "did you understand?" (which only needs a nod).

Practical memory rules for every counselling session: keep instructions short and in plain language (respect the 7 ± 2 limit — chunk information), give written + verbal instructions together, and close with teach-back.

Trap alert: Negative reinforcement (removing something unpleasant to increase a behaviour, e.g. pain relief encouraging timely dosing) is the opposite of punishment (adding something unpleasant to decrease a behaviour, e.g. scolding). Both words contain a negative, but their effects on behaviour are opposite. Also: punishment usually creates fear and avoidance of you, not adherence — a scolded patient hides missed doses instead of reporting them.

1.5 Emotion and motivation: theories and implications in health contexts

Emotion is a feeling state with three parts: the subjective feeling ("I feel afraid"), bodily changes (racing heart, sweating, trembling), and observable behaviour (facial expression, tone of voice). Three theories explain how these parts connect — and they disagree about order:

Theory	Order of events	Memory hook	Pharmacy illustration
James-Lange	Body reacts first; the brain reads the bodily change as the emotion	"I am trembling, so I must be afraid"	A patient notices their hands shaking before a diagnosis and concludes they are terrified — the shaking is the fear
Cannon-Bard	Bodily arousal and the emotion happen simultaneously but independently, both triggered by the thalamus	Heart races and you feel fear, together	The patient feels dread at the exact moment their pulse quickens; neither causes the other
Schachter-Singer (two-factor)	Arousal + the cognitive label you put on it = emotion	Same racing heart = fear in an exam hall, excitement on a cricket field	A patient with a racing heart after climbing pharmacy stairs labels it "something is wrong with my heart" and panics — wrong label, wrong emotion

Why the disagreement matters: James-Lange was challenged because visceral changes are too slow and too similar across emotions to explain distinct feelings (Cannon-Bard's critique) — and Schachter-Singer showed that interpretation decides which emotion you feel. For pharmacy, the practical lesson comes from Schachter-Singer: patients constantly label their bodily sensations, often wrongly. "This tablet makes my heart race, it must be damaging me" (it may be harmless caffeine-like stimulation from a bronchodilator). Correcting the label — calmly explaining what the sensation is — defuses the emotion. That is emotion theory working at your counter.

Health implications of emotion: anxiety before a diagnosis raises heart rate and blood pressure, distorting readings; fear of a serious diagnosis makes patients delay check-ups for months; and a calm, reassuring pharmacist literally gets more accurate information from patients, because a frightened patient misreports, forgets, and hides.

Motivation is what drives and directs behaviour. Two sources:

- Intrinsic motivation — from within: "I want to be healthy for my children." Lasts longer.
- Extrinsic motivation — from outside: rewards, family pressure, fear of the doctor's scolding. Useful to start a behaviour, weaker at sustaining it.

GPAT angle: The overjustification effect — rewarding someone for something they already enjoy can reduce their intrinsic motivation, because they start seeing the activity as "work for the reward." Exam questions love this twist: extrinsic rewards can backfire.

The key theory is Maslow's hierarchy of needs (1943): human needs stack in five levels — physiological (food, water, relief from pain) → safety (security, freedom from fear, affordable treatment) → love and belonging (family, acceptance) → esteem (respect, recognition) → self-actualisation (becoming one's best self). Lower, unmet needs dominate motivation; higher needs only motivate once the lower ones are reasonably satisfied. The bottom four are deficiency needs (their absence creates tension); the top is a growth need.

Health implication — read this twice: if a patient is worried about the cost of medicines (a safety need), lecturing them about ideal lifestyle (esteem/self-actualisation territory) will fail — their brain is occupied by the unmet lower need. Address the cost worry first — suggest generics or Jan Aushadhi options — and then the patient can actually hear your lifestyle advice. Similarly, a patient in pain (physiological need) cannot absorb a lecture on long-term diet plans. Meet the need that is shouting loudest, then counsel upward.

Very short questions (2 marks)

- 1 Define psychology and state why it is relevant to pharmacy practice.
- 2 Distinguish between sensation and perception with one example each.
- 3 What is the difference between positive and negative reinforcement?
- 4 State the three components of emotion.
- 5 Arrange Maslow's five levels of needs in order.

Short questions (5 marks)

- 1 Explain the four branches of psychology with one pharmacy example for each.

- 2 Compare the James-Lange, Cannon-Bard, and Schachter-Singer theories of emotion in a table.
- 3 Describe the three stages of memory and explain how the teach-back method improves recall.

Long questions (10 marks)

- 1 Discuss classical conditioning, operant conditioning, and observational learning with their mechanisms and one pharmacy application for each. Include a note on schedules of reinforcement.
- 2 Explain Maslow's hierarchy of needs and discuss its implications for patient counselling with suitable examples.

How to approach these answers

- Very-short Q1: one-line definition + one line on adherence/communication; keep it tight.
- Very-short Q2: sensation = raw input (one example), perception = interpretation (one example); two lines total.
- Very-short Q3: define each in one line with a pharmacy example; end with "neither is punishment."
- Very-short Q4: list the three components; one phrase each.
- Very-short Q5: write the five levels bottom-to-top in order; no explanation needed.
- Short Q1: open with one-line definitions, then a 4-row table (branch / studies / pharmacy example), close with one line.
- Short Q2: open with what emotion is, then the 3-row comparison table (order of events + memory hook), close with one pharmacy implication.
- Short Q3: name encoding-storage-retrieval, then the three stores with capacity/duration, then 3-4 lines on teach-back and deep processing.
- Long Q1: structure — intro (what learning is), three subheads (one per type with mechanism + example), a small table of reinforcement schedules, conclusion linking to adherence.
- Long Q2: structure — intro, the five levels in order with one-line meanings, deficiency vs growth needs, then health implications with the cost-worry and pain examples, conclusion.

Unit II — Developmental and Behavioural Psychology

2.1 Human developmental stages and healthcare needs

Development is not just physical growth — it is the lifelong unfolding of psychological capacities. Erikson's eight psychosocial stages (1950) describe a core psychological conflict ("crisis") at each life stage. Resolving it well builds a virtue (a strength); resolving it badly leaves a vulnerability that colours later health behaviour — including how the person deals with doctors, pharmacists, and medicines decades later.

Stage (age)	Conflict	What it means	Healthcare need / pharmacy angle
Infancy (0-1)	Trust vs mistrust	"Is the world safe?"	The caregiver must trust you; demonstrate safe syrup measurement, answer patiently — a mistrustful parent won't follow your dosing advice
Toddlerhood (1-3)	Autonomy vs shame	"Can I do things myself?"	Offer small choices (which flavour, which spoon); never force or shame
Preschool (3-6)	Initiative vs guilt	"Is it okay to try?"	Praise cooperation during nebulisation; make the child a helper, not a victim
School age (6-12)	Industry vs inferiority	"Can I do things well?"	Teach inhaler technique the child can master and show off at school; competence builds adherence
Adolescence (12-18)	Identity vs role confusion	"Who am I?"	Respect privacy (acne, contraception, mental health queries); peer pressure drives risky behaviour and hidden non-adherence
Young adulthood (19-40)	Intimacy vs isolation	"Can I form close bonds?"	Support adherence despite chaotic work life; maternal health and contraception counselling
Middle adulthood (40-65)	Generativity vs stagnation	"Am I contributing?"	Chronic disease (diabetes, hypertension) takes hold here; screening reminders; patients respond to "stay healthy for your family" framing

Stage (age)	Conflict	What it means	Healthcare need / pharmacy angle
Late adulthood (65+)	Integrity vs despair	"Was my life worthwhile?"	Polypharmacy review, large-print labels, fall-risk counselling, patience with hearing loss; involve family with consent

Three stage-specific insights worth understanding deeply:

- Why adolescence is the adherence danger zone: the identity crisis makes teenagers hypersensitive to being "different." A diabetic teen may skip insulin at school rather than look ill in front of friends. Add the belief "it won't happen to me" (adolescent invulnerability) and you get hidden non-adherence. The fix is privacy, non-judgmental tone, and framing adherence as their choice and identity ("managing this well is what responsible adults do"), not obedience.
- Why old age needs a different counter: declining working memory, vision, and hearing meet the most complex regimens (polypharmacy — 5+ medicines). Confusion here is not stubbornness; it is cognitive load exceeding capacity. Simplify (once-daily combinations where possible), use pill organisers, write in large print, and loop in a family member.
- Trust built in infancy echoes at your counter: an adult who learned early that caregivers are unreliable may distrust all health professionals. You cannot redo their childhood, but consistent, honest, unhurried behaviour from you builds the specific trust that makes this patient follow this treatment.

GPAT angle: Erikson's conflicts are asked by name — "Trust vs mistrust belongs to which stage?" (infancy), "Identity vs role confusion" (adolescence), "Integrity vs despair" (late adulthood). Learn the eight pairs in order; examiners also ask which virtue each stage builds (hope, will, purpose, competence, fidelity, love, care, wisdom).

2.2 Personality theories and patient interaction styles

Personality is the stable pattern of thinking, feeling, and behaving that makes each patient predictably themselves across situations. Two theories dominate exams:

Freud's psychoanalytic theory: id, ego, superego

Freud proposed the mind has three negotiating parts:

- Id — primitive desires, present from birth, operating on the pleasure principle: "I want it now." A patient demanding antibiotics for a viral cold right now is speaking id.
- Ego — the realistic mediator, operating on the reality principle: "We can manage this sensibly." It negotiates between id's demands, superego's rules, and reality.
- Superego — the moral conscience, internalised from parents and society: "Good patients follow the doctor's orders." It produces guilt when violated.

Behaviour is the outcome of their negotiation. When the negotiation gets painful, the ego deploys defence mechanisms — unconscious tricks that reduce anxiety by distorting reality. The exam-relevant ones, with pharmacy faces:

Defence mechanism	What it does	Patient at your counter
Denial	Refusing to accept reality	"My sugar is fine, the lab must be wrong" — the newly diagnosed diabetic who won't start medicines
Rationalisation	Inventing a logical excuse	"I missed doses because the tablets upset my routine, and routine matters more"
Projection	Attributing your own feelings to others	"The doctor doesn't care about patients like me" (the patient feels uncared-for and projects it)
Displacement	Redirecting emotion to a safer target	Shouting at you about a hospital bill
Repression	Pushing distressing memories out of awareness	A patient who "forgets" a traumatic side-effect episode

Why should a pharmacist care? Because arguing with a defence mechanism never works — it is unconscious, so the patient genuinely believes their version. You work around it: with denial, don't confront ("you're in denial"); instead keep the door open, give small non-threatening facts, and let reality do the slow work.

Trait theory: the Big Five (OCEAN)

Modern psychology mostly describes personality as five measurable traits, each a spectrum:

- Openness — curiosity, willingness to try new treatments vs suspicion of anything unfamiliar
- Conscientiousness — organisation, dutifulness; high scorers adhere better to prescriptions, low scorers lose strips and forget doses
- Extraversion — sociability; extraverts ask more questions and bring relatives along
- Agreeableness — cooperativeness and trust; low scorers argue, doubt, and need evidence, not orders
- Neuroticism — tendency toward anxiety, worry, and emotional instability; high scorers need reassurance and unhurried explanations

Patient interaction styles follow directly — this is trait theory turned into counselling skill:

- Anxious / high-neuroticism patient → slow down, reassure, explain simply, give written backup; never rush
- Low-conscientiousness patient → don't lecture on discipline; instead reduce the organisation burden — pill organisers, alarms, simplified regimens, family support

- Sceptical / low-agreeableness patient → respect their intelligence: "studies show this reduces stroke risk by..." works; "just take it because the doctor said so" backfires
- Talkative / extravert patient → warmly steer back on track so counselling finishes before the queue rebels
- High-openness patient → open to new devices (inhalers, glucometers); demonstrate and let them try

Trap alert: Id, ego, superego get scrambled under exam pressure. Anchor them: id = impulsive desires (pleasure principle), ego = executive mediator (reality principle), superego = moral conscience (guilt). Alphabetical order helps too — id, ego, superego runs from primitive to moral.

2.3 Psychological factors affecting illness perception and recovery

The same diagnosis in two patients produces two different illnesses — because recovery is filtered through the patient's mind. The key frameworks:

Leventhal's common-sense model of illness representations. Patients carry a mental model of their illness built from five beliefs:

- 1 Identity — what is it? ("High BP" vs "just tension")
- 2 Cause — what brought it? ("Too much salt" vs "evil eye" vs "my stressful job")
- 3 Timeline — how long will it last? (acute like flu vs chronic like hypertension)
- 4 Consequences — how serious is it? ("BP is silent, so it must be mild" — dangerously wrong)
- 5 Cure / control — can it be treated? ("Tablets control it" vs "once you start BP tablets you can never stop, so better not to start")

Pharmacy payoff: a hypertensive patient who believes "BP tablets are only needed when I feel dizzy" holds wrong timeline and control beliefs — and will take tablets irregularly. You don't fix this with louder instructions; you fix it by correcting the representation: "BP usually has no symptoms, which is exactly why the tablet is daily, not when-you-feel-it."

Locus of control (Rotter): does the patient believe health outcomes depend on their own actions (internal locus — "my efforts matter") or on fate, luck, or powerful others (external locus — "it's all in God's hands / the doctor's job")? Internals generally adhere better and seek information; externals need counselling that gently builds agency ("this tablet works, but your daily dose is what makes it work").

Self-efficacy (Bandura): the belief "I can do what this treatment requires." It predicts adherence better than almost any other single psychological factor. It is built from four sources: mastery experiences (successfully doing it once — hence demonstration + teach-back), vicarious experience (seeing someone like them manage it), verbal persuasion ("you handled the inhaler perfectly just now"), and physiological feedback (feeling calmer and more capable). Every time

you praise a correct technique, you are dosing self-efficacy.

Optimism, social support, and stress itself: hopeful, well-supported patients follow advice more consistently and recover faster — social support even buffers the physiological damage of stress. And stress itself is not just a feeling: sustained stress hormones slow wound healing and raise blood pressure. So when you take two minutes to calm a frightened patient, you are not just being kind — you are doing something genuinely therapeutic.

GPAT angle: Leventhal's five components (identity, cause, timeline, consequences, cure/control) are a classic list question. Bandura's self-efficacy and its four sources also appear. Remember: self-efficacy = belief in one's capability to perform the behaviour, and it is the strongest psychological predictor of adherence.

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

You will meet these at the counter far more often than in a psychiatry ward. Your job is recognise, respond, refer — never diagnose.

Anxiety: excessive, hard-to-control worry plus bodily symptoms — palpitations, sweating, trembling, restlessness, sleep disturbance. Two pharmacy angles: anxious patients ask the same question repeatedly and may avoid needed treatment altogether (a patient too anxious to start insulin); and several common drugs mimic anxiety — salbutamol tremor, excess caffeine, decongestants, thyroid medicines. Before concluding "this patient is anxious," consider whether a medicine is causing it. Approach: calm unhurried tone, short clear answers, no alarming language ("this may cause..." not "this causes dangerous..."), and referral to a doctor if worry is persistent and disabling.

Depression: persistent low mood or loss of interest and pleasure (anhedonia), plus sleep/appetite changes, fatigue, poor concentration, and feelings of worthlessness, lasting weeks. Why it is a pharmacy emergency in slow motion: depression is a top hidden cause of non-adherence — a depressed patient doesn't argue about medicines; they simply stop caring. A refill gap in a previously regular patient is a red flag worth a gentle question, not a scolding. You can screen informally with two questions ("Over the past two weeks, have you felt down, or lost interest in things you used to enjoy?") and refer — the word diagnose should never cross your mind. If a patient hints at self-harm, take it seriously, stay with them, and connect them to help immediately (Unit V covers crisis response).

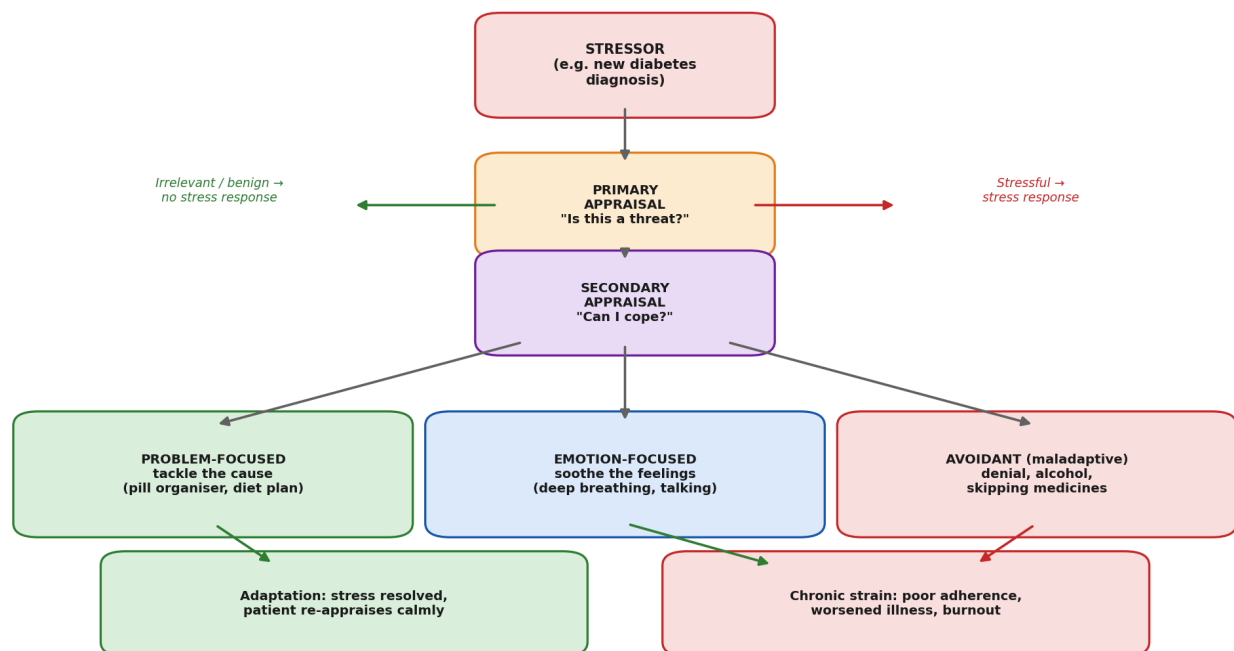
Somatization: physical complaints — pain, fatigue, digestive trouble, dizziness — that are not fully explained by medical findings and are linked to psychological distress. Terminology flag: current psychiatry (DSM-5) calls this somatic symptom disorder; "somatization" is the older term your syllabus uses — they mean the same concept. The golden rule: never say or imply "it's all in your head." The symptoms are real and distressing; psychology is part of the cause, which is different from the symptoms being fake. Approach: acknowledge the suffering, treat the patient with full respect, avoid repeatedly dispensing symptomatic medicines that medicalise the problem, and coordinate with the doctor for a unified plan.

Trap alert: Somatization / somatic symptom disorder does not mean faking illness. Malingering (deliberately faking for gain) is a different thing entirely. A somatizing patient genuinely suffers — dismissing them destroys trust and drives them to doctor-shop for more medicines.

2.5 Coping strategies, resilience, and stress management techniques

Coping (Lazarus & Folkman, 1984) = the constantly changing cognitive and behavioural efforts to manage demands that feel bigger than one's resources. The process runs: stressor → primary appraisal ("is this a threat?") → secondary appraisal ("can I cope with it?") → coping efforts → outcome, followed by re-appraisal.

The Stress-Coping Process (Lazarus & Folkman, 1984) — Adapted for Pharmacy



The stress-coping process flowchart

Three coping families:

- Problem-focused coping — tackling the cause: organising a pill box, planning a diet chart, asking the doctor about a cheaper alternative. Best when the situation can be changed.
- Emotion-focused coping — soothing the feelings: deep breathing before a scary test result, talking to a friend, reframing ("this diagnosis caught it early — that's lucky"). Best when the situation cannot be changed right now.
- Avoidant coping — denial, alcohol, skipping medicines, "forgetting" appointments. Maladaptive: it lowers distress for an hour and worsens everything for a month.

Note the subtlety examiners like: problem-focused is not "better" than emotion-focused. Each fits different situations; skilled copers switch between them. Only avoidance is reliably harmful.

Resilience is the ability to bounce back from adversity — and it is not a fixed trait but a capacity that grows. Its building blocks: strong social support, realistic optimism, self-care routines (sleep, activity), problem-solving skills, and a history of coping successfully ("I got through that, I can get through this"). A pharmacist nurtures resilience with every encouragement, every simplified regimen, every "you're managing this well."

Stress management techniques — learn these properly, because you will teach them at the counter and use them yourself during brutal dispensing shifts:

- 1 Diaphragmatic breathing / 4-7-8 technique — breathe in 4 counts, hold 7, exhale 8. Two minutes, works anywhere, teachable at the counter. It activates the parasympathetic system and measurably slows the heart.
- 2 Progressive muscle relaxation — systematically tense then release muscle groups from feet to forehead; teaches the body what "relaxed" actually feels like.
- 3 Time management and prioritising — for you: triage the queue, batch similar tasks; for patients: schedule doses around fixed daily anchors (meals, prayer times).
- 4 Physical activity and sleep hygiene — the two cheapest antidepressants and anxiolytics in existence.
- 5 Seeking social support — family, friends, patient support groups (diabetes clubs, cancer support groups).
- 6 Professional referral — counsellor, psychologist, or doctor when stress overwhelms coping. Referring is strength, not failure — say that explicitly to patients.

Very short questions (2 marks)

- 1 Name Erikson's conflict for adolescence and for late adulthood.
- 2 Define id, ego, and superego in one line each.
- 3 Expand OCEAN in the Big Five model.
- 4 What is the difference between problem-focused and emotion-focused coping?
- 5 A patient says "it's all in your head" is wrong — why? (somatization)

Short questions (5 marks)

- 1 Describe Erikson's eight psychosocial stages with one healthcare need for each.
- 2 Explain Leventhal's common-sense model of illness with a pharmacy example.
- 3 Describe the signs of depression a pharmacist can observe and explain the pharmacist's role (recognise, respond, refer).

Long questions (10 marks)

- 1 Discuss Freud's structural model of personality (id, ego, superego) along with defence mechanisms, giving pharmacy-relevant examples. Add a note on how the Big Five traits guide patient interaction styles.

- 2 Explain the stress-coping process of Lazarus and Folkman with a labelled diagram. Describe problem-focused, emotion-focused, and avoidant coping with examples, and list stress management techniques.

How to approach these answers

- Very-short Q1: two pairs only — adolescence = identity vs role confusion; late adulthood = integrity vs despair.
- Very-short Q2: one line each — id (desires/pleasure), ego (reality/mediates), superego (morals/conscience).
- Very-short Q3: expand the five letters; no explanation needed.
- Very-short Q4: one line each — problem-focused attacks the stressor, emotion-focused soothes feelings; note avoidance is maladaptive.
- Very-short Q5: two lines — symptoms are real; psychology is part of the cause, not proof of faking.
- Short Q1: table with 8 rows (stage / conflict / pharmacy angle); keep each cell to a phrase.
- Short Q2: list the five beliefs, then apply all five to one example (hypertension works well), close with the counselling implication.
- Short Q3: bullet the observable signs (mood, anhedonia, sleep, fatigue, refill gaps), then the 3 Rs — recognise, respond with empathy, refer; never diagnose.
- Long Q1: structure — intro, three subheads for id/ego/superego with examples, a table of 4-5 defence mechanisms with patient examples, then Big Five with interaction-style mapping, conclusion.
- Long Q2: structure — intro, the appraisal sequence, labelled diagram of the stress-coping process, three coping types with examples, 5-6 stress management techniques, conclusion.

Unit III — Foundations of Health Communication

3.1 Elements and models of communication in healthcare

Every act of communication — from a shouted "next!" to a careful inhaler demonstration — runs on the same elements:

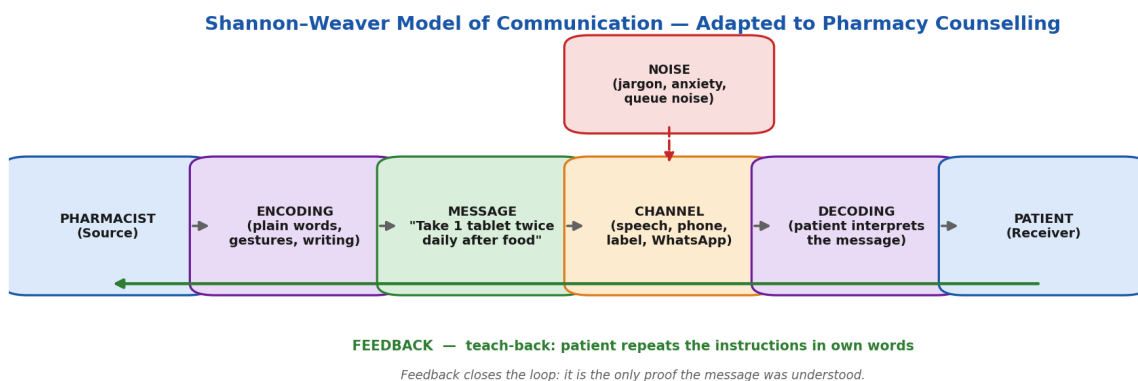
- Sender (source) — who initiates: the pharmacist
- Encoding — converting the idea into words, gestures, tone, or writing ("take after food" in simple Hindi, plus a hand gesture)
- Message — the information itself: content, order, and clarity
- Channel — the means of transmission: speech, phone call, WhatsApp message, printed label, demonstration

- Decoding — the receiver interpreting the message through their own knowledge and feelings
- Receiver — the patient or caregiver
- Feedback — the receiver's response, which tells the sender whether the message landed
- Noise — anything that distorts the message: literal noise, jargon, anxiety, pain, a crying child
- Context — the situation around it: a rushed counter vs a quiet counselling corner, a festival-day crowd vs a Tuesday lull

Three models arrange these elements differently, and examiners love asking you to compare them:

Shannon-Weaver model (1949) — the transmission view

A linear chain: sender → encoder → message → channel → decoder → receiver, with noise attacking the signal along the way. Born in telephone engineering, its genius was naming noise as a formal element — communication fails not only from bad messages but from interference.



Reading the flow: the pharmacist encodes the message into words the patient can decode; noise (anything that distorts meaning) attacks mainly at the channel and decoding stages.

Shannon-Weaver model adapted to pharmacy counselling

Its limitation is also its lesson: the model is one-way. It has no feedback loop, so it describes announcing, not counselling. A pharmacist who only "transmits" ("take twice daily, next!") is running Shannon-Weaver without feedback — and has no idea whether the patient understood. The diagram above adds the missing piece: feedback via teach-back, which converts transmission into real communication.

Schramm's model (1954) — the interactive view

Schramm made the receiver a sender too: both parties encode, interpret, and decode in a continuous loop. His key addition is the field of experience — the shared background (language, knowledge, culture) that must overlap for meaning to transfer. If your field of experience (pharmaceutical training) doesn't overlap the patient's (daily life, beliefs, language), the message falls into the gap.

Pharmacy implication: counselling fails most often not from unclear speech but from non-overlapping fields of experience. "Take on an empty stomach" is crystal clear inside your field — and meaningless inside the field of a patient who eats five small meals a day and has no concept of "empty stomach." Your job is to step into their field: "take it one hour before breakfast."

Berlo's SMCR model (1960) — the quality view

Berlo kept the linear shape but asked: what decides the quality of each element? Each of the four — Source, Message, Channel, Receiver — is shaped by five factors: communication skills, attitudes, knowledge, social system, and culture.

- A source (you) with poor communication skills or a dismissive attitude produces poor messages regardless of knowledge
- The message must fit the receiver's code — same language, familiar words, logical structure
- The channel must suit the receiver's senses — written labels fail for non-readers; speech fails for the hearing-impaired
- The receiver's attitudes and knowledge filter everything — a patient who distrusts "English medicines" decodes your perfect message as suspect

A later refinement worth knowing (bridging beyond the syllabus): the transactional model (Barnlund) treats communication as simultaneous — both people sending and receiving at once through words, tone, and body language. That is what real counselling feels like: you are reading the patient's face while they are reading yours.

Model	Structure	Core insight	Pharmacy lesson
Shannon-Weaver (1949)	Linear: sender → channel → receiver + noise	Communication is transmission; noise is the enemy	Reduce noise; but don't stop here — add feedback
Schramm (1954)	Interactive loop + shared field of experience	Meaning needs overlapping background	Enter the patient's field of experience; use their words
Berlo SMCR (1960)	Source-Message-Channel-Receiver, each shaped by skills, attitudes, knowledge, social system, culture	The quality of each element decides the outcome	Check yourself (source), the wording (message), the channel choice, and the patient (receiver)

Trap alert: Shannon-Weaver is linear (one-way, no feedback); Schramm is interactive (two-way loop with feedback). If a question mentions "field of experience," it is Schramm. If it mentions "noise" as the central problem, it is Shannon-Weaver. If it lists factors like communication skills, attitudes, knowledge, culture shaping each element, it is Berlo's SMCR.

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

- Interpersonal communication — one-to-one: counter counselling, "take this after food, twice daily." The core of pharmacy practice. Rich in feedback (you see confusion instantly) but time-expensive.
- Group communication — one-to-a-small-many in person: a diabetes education session at a clinic, an asthma awareness camp in a village, a support group for TB patients. Efficient, and patients learn from each other's questions — but shy patients won't speak up.
- Mass communication — reaching the public at scale: posters, radio spots, newspaper ads, social media campaigns (antibiotic-awareness week posts, vaccination drives). Huge reach, zero feedback — you never know who misunderstood. That is why mass messages must be pre-tested for clarity.
- Telehealth communication — remote care: video consultations, phone follow-ups, telepharmacy counselling for distant patients. Exploded after COVID-19 and is now a standard skill. Strengths: reach, convenience, follow-up without travel. Limits: no physical examination, technology barriers for the elderly and poor (the digital divide), and the loss of body-language cues on audio-only calls — so you must compensate with extra verbal checking ("can you repeat that back to me?").

Choose the type by purpose: counselling one confused patient → interpersonal; spreading one message widely → mass; following up a stable patient in a distant village → telehealth.

3.3 Barriers to effective communication in clinical settings

A barrier is anything that distorts, blocks, or degrades meaning between sender and receiver. The full taxonomy:

Barrier type	What it is	Pharmacy example	How to beat it
Physical	Environment and distance	Noise, no private counselling space, a high wide counter	Create even a small counselling corner; step closer; lower your voice rather than raising it
Physiological	Receiver's bodily state	Hearing loss, pain, drowsiness from sedatives	Face the patient, speak slowly, write key points down; counsel when they are alert
Psychological	Mental and emotional filters	Anxiety, fear of diagnosis, distrust, denial, stigma	Calm tone, empathy, privacy; never argue with the emotion — acknowledge it first

Barrier type	What it is	Pharmacy example	How to beat it
Semantic / language	Words themselves	Medical jargon ("take tds pc"), English label for a Hindi reader	Plain language, patient's own tongue, demonstrate; health literacy — the patient's ability to understand health information — is the real variable, not intelligence
Cultural	Norms and beliefs	Gender norms, religious fasting vs dose timing, deference that stops patients questioning	Ask respectfully about routines and preferences; adapt timing advice to their day
Organisational	System pressures	Time pressure, staff shortage, no follow-up system	Triage: give full counselling to high-risk patients (new diagnoses, complex regimens); use printed handouts for the rest

Two mechanisms deserve deeper understanding:

- Why jargon fails: jargon is efficient inside a profession and opaque outside it. "Take tds pc" encodes three pieces of information (three times daily, after food) in six characters — but only if the decoder shares your training. The patient decodes it as noise. Plain language is not "dumbing down"; it is choosing a code the receiver can decode.
- Stigma as a psychological barrier: a patient who feels ashamed (TB, HIV, mental illness, sexual health) will withhold information, avoid questions, and rush away. Your counter behaviour — neutral tone, normal volume, no raised eyebrows — is the barrier-remover. (Full treatment in Unit V.)

GPAT angle: "Health literacy" appears increasingly in competitive exams: the degree to which individuals can obtain, process, and understand health information to make decisions. Low health literacy predicts poor adherence and worse outcomes — and it is your communication, not the patient's intelligence, that must bridge it.

3.4 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 (or stand) squarely facing the patient
- O — Open posture: uncrossed arms, no barrier of the billing machine between you
- L — Lean slightly forward: signals interest

- E — Eye contact: culturally appropriate — steady but not staring; in some Indian contexts, softer eye contact with elders shows respect
- R — Relax: don't fidget, don't glance at your phone; a tense listener makes a tense speaker

SOLER is the body; these are the verbal skills:

- Minimal encouragers — nodding, "hmm," "go on": keeps the patient talking without steering
- Paraphrasing — restating content: "So you're saying the tablet makes you dizzy in the morning?" (checks understanding)
- Reflecting feelings — naming the emotion: "That sounds frightening." (shows you heard the person, not just the words)
- Summarising — pulling threads together: "Let me make sure I have this right: dizziness every morning, about an hour after the tablet..."
- Silence — deliberate pauses give patients space to think and to say the difficult thing. Don't rush to fill every quiet second.

Questioning techniques

- Open-ended — "How have you been taking your blood pressure tablets?" Invites full answers. Best for starting — it reveals what the patient actually does, not what you assume.
- Closed — "Did you take today's dose?" Yes/no. Best for confirming specifics at the end.
- Probing — "Can you tell me more about the dizziness — when exactly does it happen?" Digs deeper where it matters.
- Funnel technique — the sequence: start open (broad picture), then probe (details), then close (pin down facts). Open → probing → closed.
- Leading questions — "You took it correctly, right?" Pushes the answer you want, not the truth. Avoid. Anxious patients will simply agree, and you will learn nothing.

Empathy vs sympathy — the classic 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; patient opens up, shares the real problem	Creates distance; patient feels pitied and closes down

Why empathy works is worth understanding, not just memorising: when a patient feels understood, their threat response drops — they stop defending and start disclosing. That disclosure ("actually, I stopped the tablet last week because...") is the information you need to

help. Sympathy, by contrast, positions you above the patient looking down, which triggers shame and withdrawal. Empathy is a clinical tool, not just good manners: it measurably improves disclosure, adherence, and satisfaction.

Trap alert: Empathy = understanding their perspective ("it must be hard for you"). Sympathy = pity from your perspective ("poor you"). In exams, any sentence starting "I feel sorry for you" or "you poor thing" is sympathy. Any sentence that names the patient's feeling from their viewpoint is empathy.

3.5 Culturally appropriate and inclusive communication

India is not one patient — it is 22 official languages, every major religion, vast literacy gaps, and strong norms around gender, age, and authority. Counselling that ignores this fails. Principles:

- Language first: counsel in the patient's language where possible. Where not, use simple words, pictures, and live demonstration — never rely on a complex English label alone. A pictorial dosing schedule (rising sun = morning dose, setting sun = evening dose) works where text fails entirely.
- Don't assume literacy: ask gently, never test. "Many people find this chart helpful — shall I mark your doses on it?" preserves dignity.
- Respect gender and family norms: some women prefer discussing certain issues with a female pharmacist; some elderly patients want a family member present for all medical talk. Accommodate where you can; it is their comfort, not your convenience, that decides.
- Religion and routine: dose timing must fit the patient's day, not the textbook's. A diabetic patient fasting during Ramzan or Navratri needs a different dosing plan, worked out with the doctor — not a scolding about non-adherence. Vegetarianism, Ayurvedic beliefs, and ideas about "hot" and "cold" medicines all shape whether your advice is followed; acknowledge them instead of dismissing them.
- Person-first language: put the person before the condition — "person with diabetes," not "diabetic"; "person with depression," not "mental patient." Language shapes how patients see themselves, and labels stick.
- Disability-inclusive practice: face a hearing-impaired patient when speaking (lip-reading helps), write key points down, allow extra time, keep the counselling space physically accessible.

The underlying rule: adapt the message to the receiver, never demand the receiver adapt to the message. That single sentence is the whole of culturally appropriate communication.

Very short questions (2 marks)

- 1 List any four elements of the communication process.
- 2 What is "noise" in the Shannon-Weaver model? Give one pharmacy example.
- 3 Expand SOLER.

- 4 What is the difference between an open-ended and a closed question? Give one example of each.
- 5 What is person-first language? Give one example.

Short questions (5 marks)

- 1 Compare the Shannon-Weaver, Schramm, and Berlo models of communication in a table.
- 2 Describe the barriers to effective communication in clinical settings with one pharmacy example for each.
- 3 Distinguish between empathy and sympathy with examples. Why is empathy clinically useful?

Long questions (10 marks)

- 1 Discuss the elements of the communication process. Explain any two models of communication with diagrams and their relevance to pharmacy counselling.
- 2 A newly diagnosed diabetic patient speaks only a regional language, cannot read, and is anxious about the diagnosis. Discuss how you would counsel this patient, covering active listening, questioning techniques, empathy, and culturally appropriate communication.

How to approach these answers

- Very-short Q1: any four — sender, message, channel, receiver (add feedback/noise if you like); list only.
- Very-short Q2: one-line definition + one example (jargon, queue noise, anxiety).
- Very-short Q3: expand the five letters; one phrase each.
- Very-short Q4: one line each with the two example questions; note open is for starting, closed for confirming.
- Very-short Q5: one-line definition + one example ("person with diabetes").
- Short Q1: 3-row table (structure / core insight / pharmacy lesson); one line introducing models first.
- Short Q2: table with 6 rows (barrier / example / how to beat it); keep cells brief.
- Short Q3: comparison table first, then 3–4 lines on why empathy improves disclosure and adherence.
- Long Q1: structure — intro listing elements with one-line meanings, two subheads (one per model with diagram), pharmacy relevance under each, conclusion.
- Long Q2: structure — intro (the challenge), subheads for listening (SOLER), questioning (funnel), empathy, cultural adaptation (language, literacy, anxiety), close with teach-back; keep it practical and specific.

Unit IV — Professional Communication in Healthcare Settings

4.1 Communication with patients, caregivers, and interdisciplinary teams

With patients: a counselling flow that works under pressure

Even with a queue stretching to the door, follow the same skeleton every time — routine is what keeps quality steady when you are tired:

- 1 Greet warmly — name, eye contact, a moment of human recognition. It lowers the patient's guard in seconds.
- 2 Assess what they already know — "What did the doctor tell you about this medicine?" This prevents both repeating and contradicting, and reveals wrong beliefs early.
- 3 Explain in plain language — what it is for, how to take it, for how long, what to watch for. Short chunks, no jargon.
- 4 Demonstrate — inhaler, insulin pen, eye drops, ORS preparation. Watching beats hearing.
- 5 Check with teach-back — "Just to be sure I explained well, how will you take this?"
- 6 Invite questions — "What would you like to ask me?" (not "any doubts?" — which invites a no).

With caregivers

For children, elderly patients, and seriously ill patients, the caregiver often supervises the actual medicine-taking at home — so briefing them is briefing the treatment. Rules: involve family with the patient's consent where the patient is competent (an adult's medicines are not family property); brief the caregiver on dosing schedules, warning signs, and storage; and give the caregiver written backup, because verbal instructions decay fastest in a worried relative's memory.

With interdisciplinary teams: SBAR

Pharmacists work with doctors, nurses, and lab staff — and vague, rambling communication between professionals causes real errors. SBAR (borrowed from safety-critical industries like aviation, now standard in hospitals) structures every handover and every call:

Letter	Meaning	Example
S — Situation	What is happening right now, in one line	"I'm calling about Mrs. Sharma in Ward 3 — her BP is 170/100 this morning."

Letter	Meaning	Example
B — Background	The relevant history, briefly	"Admitted with hypertension, on amlodipine 5 mg daily for two weeks."
A — Assessment	Your professional judgement of what it means	"BP is uncontrolled and she reports ankle swelling — possible dose-related effect with inadequate control."
R — Recommendation	What you suggest, as a question not an order	"Could we review whether the dose or the drug needs changing?"

Why SBAR works is worth understanding, not just memorising. First, it slashes cognitive load: the receiver doesn't have to hunt through your story for the point — the structure delivers situation first, so the brain can file everything after it correctly. Second, it creates a shared mental model: both sides process the same four slots, so nothing critical gets skipped. Third, it flattens hierarchy: a junior pharmacist or nurse who might hesitate to "question" a senior doctor gets a sanctioned, professional frame for raising a concern — the Recommendation slot is an invitation to speak up. That is why SBAR reduces errors: it fixes the human dynamics, not just the words.

Trap alert: Three frameworks, three jobs — SBAR = speaking to the team (handover, calling the doctor); SOAP = writing the patient record; SPIKES = breaking difficult news to patients/families. Examiners deliberately mix them. SBAR speaks, SOAP writes, SPIKES breaks bad news.

4.2 Delivering difficult news and handling emotionally charged situations

Difficult news in pharmacy: a medicine is out of stock with no alternative nearby, a treatment isn't working, a drug the patient depends on has been banned or recalled, a family learning a prognosis the doctor already gave. The SPIKES protocol (Baile et al., 2000, from oncology) gives you six steps — and the order matters:

Step	What to do	Why it works (the psychology)
S — Setting	Private, quiet place; sit down; no interruptions; have the facts ready	Privacy protects dignity; sitting signals "I am not rushing" — body language regulates the patient's threat response
P — Perception	"What have the doctors told you so far?"	Reveals what they already know and their emotional state — so you don't blurt out what they know or miss what they fear

Step	What to do	Why it works (the psychology)
I — Invitation	"Would you like me to explain what this means for the treatment?"	Respects autonomy: some patients want every detail, some want the headline. Asking prevents information overload
K — Knowledge	Give the news in small chunks, plain words, no jargon; pause between chunks; a brief "warning shot" helps ("I'm afraid I have difficult news...")	Chunking respects working-memory limits; pauses let emotion surface instead of being suppressed
E — Emotions	Acknowledge feelings explicitly ("I can see this is upsetting"), allow silence, don't rush to fix	Unexpressed emotion blocks all further information processing — the patient hears nothing until the feeling is named
S — Strategy / Summary	Discuss next steps together; summarise what was decided; arrange follow-up	Ends with agency, not despair — a plan converts helplessness into action

Handling emotionally charged situations — the angry or weeping patient or relative:

- Stay calm; never match their volume. Your calm is contagious in both directions — so is your agitation.
- Acknowledge the emotion before the facts: "I understand you're upset — let's sort this out." Facts offered to an unacknowledged emotion bounce off.
- Move to a private corner if possible; audiences escalate conflict.
- Listen fully before explaining. Interrupting an angry person restarts their anger from zero.
- Offer concrete next steps, not just apologies: "Here's what I can do right now..."
- Know your limits: if someone becomes threatening, disengage and call a senior or security. Your safety is not negotiable.

GPAT angle: SPIKES step order is a favourite trap — Setting, Perception, Invitation, Knowledge, Emotions, Strategy/Summary. Note that Perception and Invitation come before Knowledge: you assess and ask before you tell. A question giving the steps scrambled is testing exactly this.

4.3 Legal and ethical issues in health communication: confidentiality and consent

The syllabus names two pillars. Know them cold.

Confidentiality — the patient's information stays the patient's. This covers prescriptions, diagnoses, and even the fact that someone visited your pharmacy or takes a particular medicine. Practical rules:

- Never discuss one patient's medicines within earshot of the next person in the queue
- Keep records — paper and digital — secure; lock screens, locked cabinets
- Never share patient details on social media or WhatsApp groups, not even "anonymised" stories that are identifiable
- Share information with other health professionals only as needed for the patient's care

Why it matters beyond law: confidentiality is the foundation of trust, and trust is the foundation of disclosure. A patient who suspects gossip will not tell you about the missed HIV doses or the depressive symptoms — and then you cannot help.

Informed consent — before any procedure, treatment step, or sharing of data, four things must hold:

- 1 Disclosure — the patient is told the purpose, benefits, risks, and alternatives in understandable language
- 2 Comprehension — they actually understand (check, don't assume)
- 3 Voluntariness — the decision is theirs, free from pressure or manipulation
- 4 Competence — they are capable of deciding (for children or incapacitated patients, a guardian decides)

Pharmacy applications: explain before you do BP screening or blood-sugar testing at a camp (what it involves, what happens with the result); get consent before sharing patient data for any purpose beyond their direct care; and in telepharmacy, confirm the patient understands the limits of remote advice. Consent is not a signature on a form — it is a process of understanding and agreeing.

Trap alert: Confidentiality and consent are related but different. Confidentiality = not revealing patient information. Consent = getting permission before acting on or sharing it. A question about "telling the patient's family about their TB medicines without asking" tests confidentiality; "doing a screening test without explaining it first" tests consent.

4.4 Writing patient records, reports, and discharge summaries

Good documentation is a legal record, a clinical tool, and a message to the next professional who sees the patient. Rules that never change: factual (what happened, not what you think of the patient), concise, dated and timed, legible, and free of abbreviations others won't understand.

SOAP notes (Weed, 1960s) — the standard structure for patient records:

Letter	Meaning	Example
S — Subjective	What the patient reports — symptoms, feelings, in their words	"Patient complains of dizziness every morning, about an hour after taking amlodipine."

Letter	Meaning	Example
O — Objective	What you measure or observe — signs, readings	"BP 150/95 mmHg, pulse 88/min. Patient appears steady, no pallor."
A — Assessment	Your professional judgement — what the S + O mean	"Possible amlodipine-related morning dizziness; adherence appears good."
P — Plan	What you will do — counselling, referral, follow-up	"Counselled on rising slowly from bed; advised to report to doctor if it worsens; follow-up in 3 days."

Notice the logic: S and O are data, A is thinking, P is action. Mixing them — writing judgements in Subjective or new complaints in Plan — is the classic student error.

Reports: the most important one for you is the ADR (adverse drug reaction) report to the Pharmacovigilance Programme of India (PvPI) — what happened, which drug, dose, timing, dechallenge/rechallenge if known, and outcome. Accurate ADR reporting by pharmacists directly protects other patients; under-reporting is a known national problem, and you are part of the fix.

Discharge summaries (the medication section you may help write or explain): complete medication list with doses and timings, duration of each, warning signs to watch for, follow-up date, and lifestyle advice — written so that both the patient and the next provider understand the plan. A discharge summary the patient can't follow is a readmission waiting to happen.

4.5 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, and for follow-up that would otherwise not happen.
- Electronic health records (EHR) — shared digital patient histories that cut errors from lost paper prescriptions and illegible handwriting.
- Reminders — SMS/WhatsApp dose reminders and refill alerts. Powerful adherence tools, with two conditions: patient consent first, and never discuss diagnoses in casual chat threads.
- Drug information tools — apps and databases for checking interactions, doses, and ADR profiles quickly at the counter.
- E-prescriptions and pharmacy software — reduce transcription errors and keep dispensing histories searchable.

Cautions — technology extends your reach; it doesn't replace your judgement:

- Protect patient data: passwords, locked screens, no patient records on public or shared computers. India's data-protection law (DPDP Act, 2023) treats health data as sensitive — handle it accordingly.

- Never diagnose or prescribe over a casual message. A WhatsApp chat is not a consultation room.
- Mind the digital divide: the patients who need you most — elderly, poor, rural — are least likely to be digitally comfortable. Technology must not become a barrier disguised as a convenience.
- Digital tools support face-to-face counselling; they don't replace it. The therapeutic relationship still does the heavy lifting.

Very short questions (2 marks)

- 1 Expand SBAR and state where it is used.
- 2 Expand SOAP and state what each letter records.
- 3 Expand SPIKES.
- 4 Where do pharmacists in India report adverse drug reactions?
- 5 State any two cautions in using digital communication tools for patient care.

Short questions (5 marks)

- 1 Explain the SBAR technique with a pharmacy example.
- 2 Describe the steps of the SPIKES protocol for delivering difficult news.
- 3 Explain confidentiality and informed consent as legal-ethical issues in health communication.

Long questions (10 marks)

- 1 A patient's relative is shouting at the pharmacy counter because a prescribed medicine is out of stock. Discuss how you would handle this emotionally charged situation, covering the SPIKES protocol, de-escalation steps, and your own safety.
- 2 Write a sample SOAP note for a patient reporting morning dizziness after starting amlodipine. Explain the principles of good documentation and the contents of a discharge summary's medication section.

How to approach these answers

- Very-short Q1: expand the four letters + one line on handover/team communication.
- Very-short Q2: expand the four letters + what each records in a phrase.
- Very-short Q3: expand the six letters in order; no explanation needed.
- Very-short Q4: one line — Pharmacovigilance Programme of India (PvPI).
- Very-short Q5: any two — consent for reminders, data protection, no diagnosis over chat.
- Short Q1: table of the four letters with the Mrs. Sharma-style example running through all rows.
- Short Q2: six steps in order with one line each on what to do; mention why Perception and Invitation precede Knowledge.

- Short Q3: two subheads — confidentiality (definition + 2-3 practical rules) and consent (four elements); close with one line each on why they matter.
- Long Q1: structure — intro, immediate de-escalation steps, SPIKES applied to the stock-out conversation, safety limits, conclusion.
- Long Q2: structure — intro on documentation principles, the four-part SOAP note as a worked example, then discharge summary contents as bullets, conclusion.

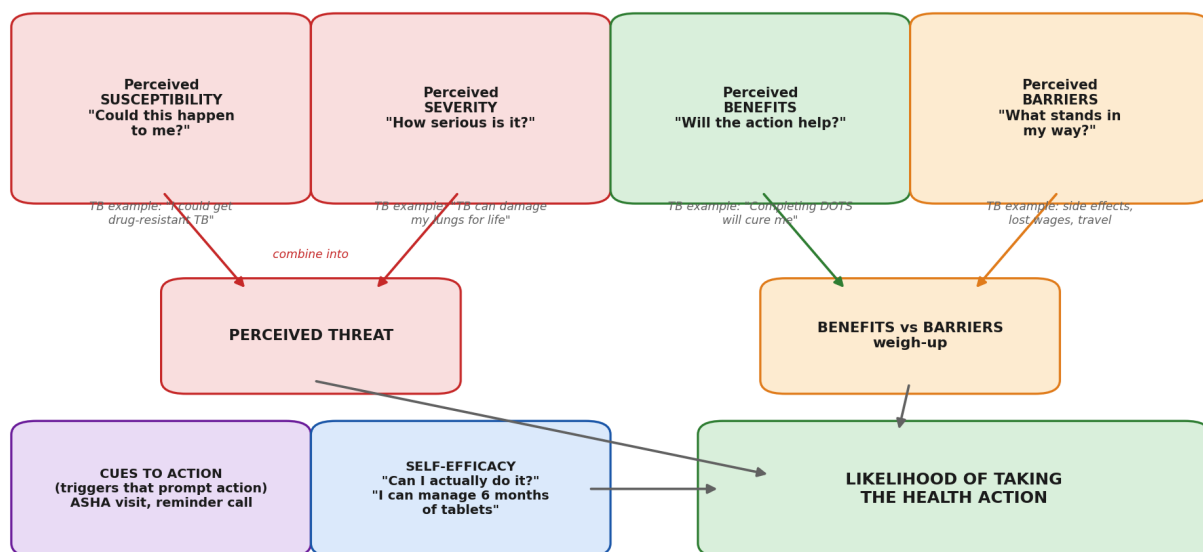
Unit V — Health Psychology and Behavioural Interventions

5.1 Health belief models and illness behaviour

The Health Belief Model (HBM)

The Health Belief Model (Rosenstock, 1966; Becker, 1974) answers one question: why do people act — or not act — on health advice? Its answer: people act when a set of beliefs lines up. Six components:

Health Belief Model (Rosenstock, 1966; Becker, 1974) — Why Patients Act on Health Advice



Pharmacist's lever: raise perceived benefits, lower barriers, add cues to action, build self-efficacy.

Health Belief Model flow diagram

Component	The patient's inner question	Pharmacy example (TB treatment under DOTS)
Perceived susceptibility	"Could this happen to me?"	"If I stop early, I could develop drug-resistant TB"
Perceived severity	"How serious would it be?"	"TB can damage my lungs permanently"

Component	The patient's inner question	Pharmacy example (TB treatment under DOTS)
Perceived benefits	"Will the recommended action actually help?"	"Completing six months of DOTS will cure me"
Perceived barriers	"What stands in my way?"	Side effects, travel to the clinic, lost daily wages
Cues to action	"What triggers me to act now?"	The ASHA worker's visit, your reminder call, a poster at the clinic
Self-efficacy	"Can I actually do it?" (added later)	"I can manage six months of tablets"

The model's logic: susceptibility + severity combine into perceived threat; the patient then weighs benefits against barriers; and cues to action plus self-efficacy push the balance toward actually doing it. Notice what this means for your counselling: telling a patient "TB is dangerous" only raises threat. If barriers stay high (lost wages, side effects) and self-efficacy stays low ("six months is impossible for me"), the patient still won't act — they will just be frightened and non-adherent. The skilled pharmacist works all the levers: raise perceived benefits, lower barriers (simpler regimen, cost solutions, side-effect management), add cues to action (reminders, follow-up calls), and build self-efficacy (small wins, praise, demonstration).

Trap alert: The Health Belief Model is about beliefs (susceptibility, severity, benefits, barriers). The Theory of Planned Behaviour (Ajzen) is a different model: behaviour follows intention, which comes from attitudes toward the behaviour, subjective norms (what others expect), and perceived behavioural control. HBM = "do I feel threatened and able?"; TPB = "do I intend to, given my attitude and social pressure?" Don't merge them.

Illness behaviour and the sick role

Illness behaviour (Mechanic) = how people perceive, evaluate, and act on their symptoms — including delay in seeking care and self-medication. In India this is everyday reality: the chemist shop is often the first stop, not the doctor. Understanding illness behaviour stops you from judging it: a patient self-medicating for a "minor" fever is acting on their symptom evaluation with the resources they have. Your role is to recognise the red flags that need referral and to guide, not scold.

Parsons' "sick role" (1951) describes the unwritten social contract of being ill — two rights and two obligations:

- Rights: (1) exemption from normal duties (leave from work, rest), (2) not being blamed for the illness
- Obligations: (1) seek competent help, (2) cooperate with treatment

Non-adherence, in this view, is a failure of the sick role's obligations — but Parsons' critics note the model fits acute illness (flu, fracture) better than chronic illness (diabetes, hypertension), where the "role" never ends and exemptions run out. For chronic patients, framing adherence

as a lifelong partnership works better than framing it as a duty.

5.2 Psychosomatic illnesses and the mind-body connection

Psychosomatic illnesses are real 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 genuine physiology, not imagination. Chronic stress keeps the HPA axis (hypothalamus-pituitary-adrenal) switched on: cortisol and adrenaline stay elevated, which raises blood pressure, disturbs gut motility and secretion, suppresses immune function, and increases inflammation. The field studying these pathways is psychoneuroimmunology — psychology → nervous system → immune system, in one loop. Add the autonomic nervous system (sympathetic "fight or flight" dominance), and you have a complete causal chain from a worried mind to a damaged body.

Two consequences for pharmacy practice:

- 1 Stress management is a legitimate adjunct to medicines. When a migraine or IBS patient also reports heavy stress, tablets alone may underperform — teaching the Unit II techniques (breathing, relaxation, sleep hygiene) is not "extra," it is part of treating the cause.
- 2 Psychosomatic does NOT mean fake. Say this to yourself until it is automatic: the symptoms are real; psychology is part of the cause, so it must be part of the treatment. Telling a patient "it's just stress" dismisses the suffering and destroys the trust you need to help.

Trap alert: "Psychosomatic" (psychological factors worsening a real physical illness) is not "malingering" (deliberately faking for gain) and not "somatization" either — though they overlap in conversation. Psychosomatic = real disease with a psychological contributor (e.g. stress-worsened hypertension). Somatization = physical symptoms driven mainly by psychological distress without a matching medical finding.

5.3 Behaviour change theories (CBT, TTM) in treatment adherence

CBT — Cognitive Behavioural Therapy (Beck)

CBT's core claim: thoughts, feelings, and behaviour influence each other in a loop. Change the distorted thought, and the feeling and behaviour shift with it. A non-adherent patient is often running on a distorted belief:

Cognitive distortion	Patient's thought	Feeling → behaviour
Catastrophising	"This BP tablet will damage my kidneys"	Fear → stops the tablet

Cognitive distortion	Patient's thought	Feeling → behaviour
All-or-nothing thinking	"I missed one dose, so the whole course is ruined"	Hopelessness → abandons treatment
Mind reading	"The doctor thinks I'm careless"	Shame → hides missed doses
Overgeneralisation	"My neighbour got side effects, so I will too"	Anxiety → never starts

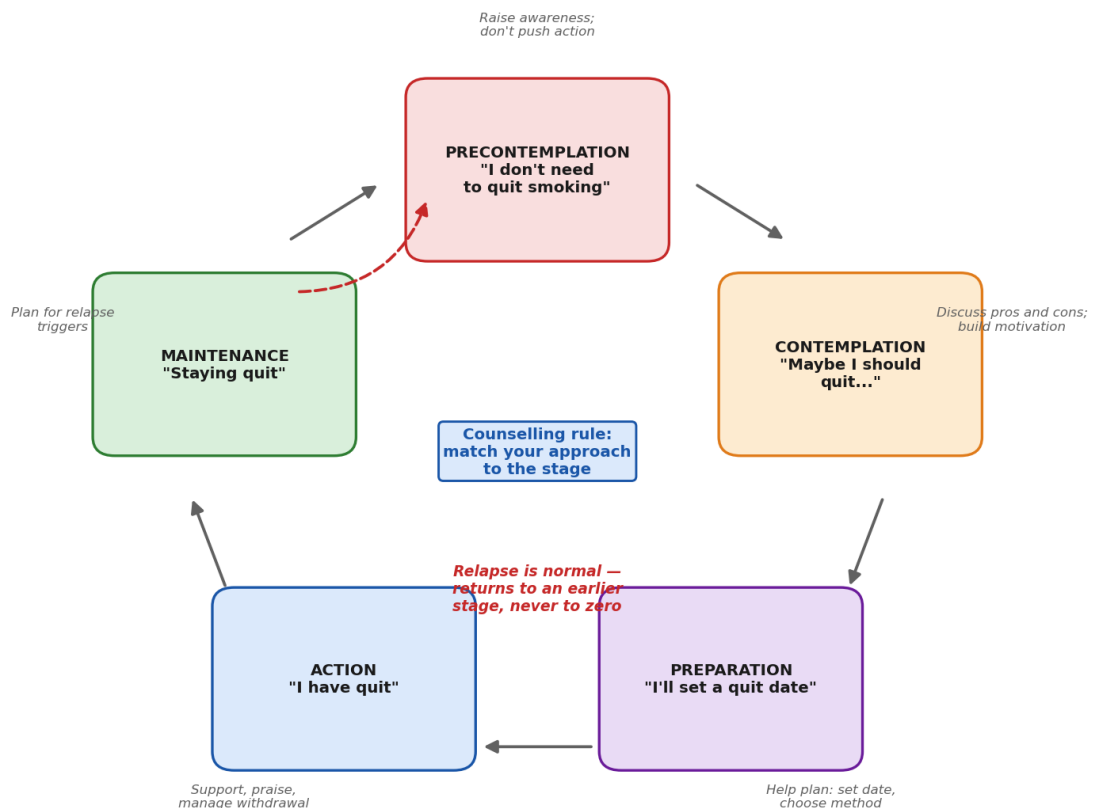
CBT corrects this through two tools a pharmacist can genuinely use (you won't do full therapy — but CBT-style counselling is squarely in your lane):

- Cognitive restructuring — examining the evidence together: "Your doctor chose this dose because long-term studies show it protects the kidneys in hypertension. What made you worry about kidney damage?" You don't argue; you inspect the thought with the patient.
- Behavioural experiments — small tests of the belief: "Try the morning dose for a week and note your readings and how you feel; let's review them together next Tuesday." Real data beats reassurance.

TTM — Transtheoretical Model (Prochaska & DiClemente, 1983)

TTM says behaviour change moves through stages, and — this is the part that changes your counselling — the right counselling depends on the stage:

Transtheoretical Model of Behaviour Change (Prochaska & DiClemente, 1983)



Transtheoretical Model stages wheel

- 1 Precontemplation — not thinking about change: "I don't need to quit smoking." Your move: raise awareness gently; do not push action — it triggers resistance.
- 2 Contemplation — thinking about it: "Maybe I should..." Your move: discuss pros and cons; tip the decisional balance.
- 3 Preparation — planning: "I'll set a quit date." Your move: help plan concretely — date, method, support.
- 4 Action — doing it. Your move: support, praise, manage withdrawal and practical hurdles.
- 5 Maintenance — sustaining it. Your move: plan for relapse triggers; normalise slips.

Relapse is normal — and the model is explicit: relapse returns the person to an earlier stage, never to zero. A patient who smoked again after three months is not "back to square one"; they are a contemplator with experience. Say that to them, and watch shame turn into renewed effort.

CBT vs TTM — how they differ and combine

	CBT	TTM
Core idea	Distorted thoughts drive feelings and behaviour; correct the thoughts	Change happens in stages; match your strategy to the stage
Question it answers	"What is the patient thinking wrong?"	"Where is the patient in the change process?"
Pharmacist's tool	Cognitive restructuring, behavioural experiments	Stage-matched counselling; relapse normalisation
Best for	Wrong beliefs about medicines ("tablets damage kidneys")	Readiness problems ("I'm not interested in quitting")

They complement each other beautifully: use TTM to find where the patient is, then use CBT tools to clear the specific wrong belief blocking the next stage.

GPAT angle: TTM stage order is a classic sequence question: Precontemplation → Contemplation → Preparation → Action → Maintenance. Mnemonic: "Please Call Patients At Morning" — or make your own. Also remember: self-efficacy appears in both HBM and TTM — examiners like asking what it means in each (belief in capability to perform the health behaviour).

5.4 Psychological first aid and crisis communication

Psychological First Aid (PFA) — WHO's framework — is immediate, humane support for someone in acute distress: an accident, a disaster, sudden terrible news, a suicide attempt in the family. Three things to fix in your head first: it is not therapy, it is not debriefing (don't force people to recount trauma), and it is not something only specialists do — any trained person, including a pharmacist, can give it.

Look, Listen, Link:

- Look — check for safety and urgent needs. Is the person injured? In shock? Alone? Are there people who need immediate physical help around them? Ensure your own safety first — you can't help if you become a second casualty.
- Listen — approach calmly and respectfully. Ask about needs and concerns. Listen without pressuring them to talk — silence is allowed. Acknowledge feelings ("This is a terrible shock") without false reassurance ("everything will be fine").
- Link — connect to practical help and information: family members, medical care, helplines, accurate information about what is happening and what to do next. Help them help themselves — support their own coping, don't take over.

PFA do's and don'ts worth memorising: do stay calm, protect privacy, give practical help; don't force talk, don't say "I know how you feel," don't share the person's story with others, don't make promises you can't keep.

Crisis communication — the pharmacist as the trusted local voice during a drug-shortage panic, an ADR scare, or a disease outbreak:

- Be honest about what you know and don't know — "I don't have that information yet, but here's what is confirmed"
- Stay calm; panic in your voice becomes panic in the queue
- Speak clearly and simply; repeat key safety information
- Never speculate or spread rumours — in a crisis, accuracy matters more than speed
- Direct people to official sources (doctor, health department helplines)

5.5 Mental health promotion and stigma reduction through communication

Mental health promotion means building the conditions for psychological wellbeing — awareness, early help-seeking, supportive families and workplaces — not just treating illness once it arrives. Its biggest enemy in India is stigma: the shame, fear, and discrimination wrapped around mental illness, which keeps people from seeking help until crisis.

Stigma operates at three levels, and your communication can attack all three:

- Public stigma — society's prejudice ("people with mental illness are dangerous/weak"). Counter with facts: mental illnesses are common, usually treatable, and not a character flaw; they are not contagious.

- Self-stigma — the patient internalises the prejudice ("I am weak/crazy for feeling this"). Counter with normalising: "Depression is an illness like diabetes — it needs treatment, not willpower."
- Structural stigma — systems that discriminate (being denied a job, hidden from marriage proposals). Counter by treating mental-health queries with exactly the same professionalism as physical-health ones — no lowered voice, no changed expression.

How communication reduces stigma — your practical toolkit:

- Language: person-first, always — "person with depression," never "mental," "psycho," or "pagal." Labels stick to identities; illnesses shouldn't.
- Normalise help-seeking: "Seeing a counsellor for stress is like seeing a doctor for fever — it's what sensible people do."
- Correct myths directly but kindly when patients voice them.
- Visibility: display mental-health helpline numbers in your pharmacy as routinely as you display a BP chart. When mental health is visible next to physical health, it becomes normal next to physical health.

India-specific anchor — the Mental Healthcare Act, 2017. Know these points:

- Every person has the right to access mental healthcare — the state must provide it.
- Attempted suicide is decriminalised (Section 115): a person attempting suicide is presumed to be under severe stress, not committing an offence — they need care, not punishment or prosecution.
- Patients have rights to advance directives (stating treatment preferences in advance) and a nominated representative.

For you at the counter, this Act means: respond to a distressed patient lawfully and humanely, never moralise, and know that referral to care is the legally supported path.

Very short questions (2 marks)

- 1 List the six components of the Health Belief Model.
- 2 What are the two rights and two obligations in Parsons' sick role?
- 3 What does "psychosomatic" mean? Does it mean the illness is fake?
- 4 List the five stages of the Transtheoretical Model in order.
- 5 Expand PFA and state its three actions.

Short questions (5 marks)

- 1 Explain the Health Belief Model with a pharmacy example (e.g. TB treatment or diabetes).
- 2 Compare CBT and TTM as behaviour-change approaches in improving treatment adherence.
- 3 Describe psychological first aid (Look, Listen, Link) with do's and don'ts.

Long questions (10 marks)

- 1 Discuss the Health Belief Model in detail with a labelled diagram. Explain how a pharmacist can use each component to improve medication adherence, with examples.
- 2 A young man at your pharmacy hints that life is not worth living after a recent crisis. Discuss your response covering psychological first aid, crisis communication principles, stigma-free language, and the relevant provisions of the Mental Healthcare Act, 2017.

How to approach these answers

- Very-short Q1: list the six — susceptibility, severity, benefits, barriers, cues to action, self-efficacy.
- Very-short Q2: two rights (exemption from duties, not blamed) + two obligations (seek help, cooperate); four short phrases.
- Very-short Q3: one-line definition + "No — symptoms are real; psychology is part of the cause."
- Very-short Q4: the five stages in exact order; sequence matters.
- Very-short Q5: expand PFA + the three words (Look, Listen, Link) with one phrase each.
- Short Q1: define HBM in two lines, then walk through all six components applied to one example, close with the pharmacist's levers.
- Short Q2: comparison table (core idea / question answered / pharmacist's tool / best for), then 2–3 lines on how they combine.
- Short Q3: three subheads for Look/Listen/Link with one line each, then 3–4 do's and don'ts.
- Long Q1: structure — intro, labelled HBM diagram, six subheads (one per component with example), pharmacist's levers section, conclusion.
- Long Q2: structure — intro (take it seriously), PFA steps applied, crisis communication principles, stigma-free language examples, Mental Healthcare Act 2017 provisions, close with referral — handle with care and humanity throughout.

How these units connect (30-second revision)

Unit I gives you the psychology toolkit — learning, memory, emotion, motivation. Unit II applies it across the lifespan and to mental health. Unit III teaches the communication process itself — models, barriers, listening, empathy. Unit IV puts that communication to work professionally — SBAR for teams, SPIKES for bad news, SOAP for records, ethics for trust. Unit V uses psychology to change health behaviour — HBM to diagnose why a patient isn't adhering, TTM to match your counselling to their readiness, CBT tools to fix wrong beliefs, PFA for crises, and stigma-free communication for mental health. In the exam, expect cross-unit questions like "How would you counsel a non-adherent diabetic patient?" — answer with HBM (V) + stage-matched counselling (TTM) + active listening and empathy (III) + teach-back (I) + the right interaction style for their personality and age (II).