



Notes by PharmacoLearn

Healthcare Psychology and Communication Skills

BP103T — B.Pharm Semester I

Rapid Revision Notes

One-night-pass companion: every topic, only the core

As per PCI B.Pharm (NEP 2020) syllabus

Scan to connect with PharmacoLearn



YouTube
Subscribe



Telegram
Join the channel



Website
Read the notes

© 2026 PharmacoLearn. All rights reserved.

No part of these notes may be reproduced, stored, or transmitted without prior written permission.
sites.google.com/view/pharmacolearn-notes

Unit I — Introduction to Psychology in Healthcare

Psychology: definition, scope, relevance

- Psychology = the scientific study of behaviour and mental processes — what people do, and the thinking, feeling and perceiving behind it.
 - Scope in health sciences: patient behaviour (adherence), provider–patient relationship, pain perception, stress and coping, health promotion, early mental-health screening at the pharmacy counter.
 - Why a pharmacist needs it: drugs treat the body, but behaviour decides whether the drug gets taken — you see patients far more often than the doctor does.
-

Branches of psychology with healthcare relevance

- Clinical psychology — assessment, diagnosis and treatment of mental disorders (spotting depression in a patient on long-term medication, referring onward).
- Health psychology — how psychological and social factors influence health and illness (counselling a diabetic patient on lifestyle change).
- Behavioural psychology — observable behaviour and how it is learned through conditioning (reminders and praise to reinforce regular tablet-taking).
- Developmental psychology — psychological changes across the lifespan (counselling a child's parent differently from an elderly patient with memory problems).

◆ Remember: Mnemonic for branches — CHBD

Clinical (mental disorders), Health (mind–health link), Behavioural (learned behaviour), Developmental (lifespan changes).

Sensation, perception and attention in clinical assessment

- Sensation = raw input (you see a patient sweating). Perception = the brain's interpretation (you conclude they may be anxious or in pain). Attention = selectively focusing on some inputs while ignoring others.
 - Types of attention: selective (focusing on the patient despite pharmacy noise), divided (billing while listening — risky, avoid during counselling), sustained (staying focused through a long interaction).
 - Practical tip: if a patient squints at a label, don't just repeat louder — perceive the real problem (poor vision) and adapt (larger writing, slower speech).
-

Learning and memory: reinforcement in health behaviour change

- Learning = a relatively permanent change in behaviour due to experience. Classical conditioning (Pavlov): learning by association — e.g., white-coat hypertension, where the clinic itself triggers anxiety and a BP spike.
- Operant conditioning (Skinner): behaviour shaped by its consequences. Positive reinforcement adds something pleasant (praise for bringing a BP diary); negative reinforcement removes something unpleasant (pain relief after taking the analgesic on time). Both increase the desired behaviour.
- Reinforcement is NOT punishment — scolding a patient for missed doses creates fear and avoidance, not adherence. Observational learning (Bandura): learning by watching — e.g., showing a video of correct inhaler technique.
- Memory runs encode → store → retrieve. Patients forget a large share of verbal instructions within days — so use small chunks, plain language, written + verbal advice together, and the teach-back method ("Can you tell me how you will take this tablet?").

Remember: Positive reinforcement = adds something pleasant; negative reinforcement = removes something unpleasant. Both build behaviour; punishment destroys trust.

Emotion and motivation in health contexts

- Emotion = feeling state with three parts: subjective feeling, bodily changes, behaviour. Three theories:
- James-Lange: bodily arousal first — "I am trembling, so I must be afraid."
- Cannon-Bard: arousal and emotion happen simultaneously and independently.
- Schachter-Singer (two-factor): arousal + how you label it = emotion — the same racing heart means fear in an exam hall, excitement on a cricket field.
- Health implication: anxiety raises heart rate and BP and can distort readings; fear of a diagnosis makes patients delay check-ups; a calm pharmacist gets more accurate information.
- Motivation: intrinsic (from within — "I want to be healthy") vs extrinsic (from outside — "my family insists"). Maslow's hierarchy: physiological → safety → love and belonging → esteem → self-actualisation; lower needs must be reasonably met before higher ones motivate.
- Counselling lesson: if a patient worries about medicine cost (a safety need), lecturing on lifestyle (a higher need) fails — address the cost first (generics, Jan Aushadhi), then the patient can hear the rest.

Very short questions (2 marks)

- 1 Define psychology.

- 2 Name the four branches of psychology with healthcare relevance.
- 3 Distinguish between sensation and perception.
- 4 What is the teach-back method?
- 5 State Maslow's hierarchy of needs in order.

Short questions (5 marks)

- 1 Explain the relevance of psychology to pharmacy practice.
- 2 Compare the three theories of emotion (James-Lange, Cannon-Bard, Schachter-Singer).
- 3 Distinguish positive and negative reinforcement with one pharmacy example each.

Long questions (10 marks)

- 1 Describe the scope of psychology in health sciences and explain why psychological knowledge is essential for a practising pharmacist.
- 2 Discuss learning and memory with reference to reinforcement, and explain how a pharmacist can use these principles to improve patient adherence.

How to approach these answers

- Very-short Q1: one definition + one example; don't write a paragraph.
- Short Q1: open with definition, then 4-5 relevance points in order, close with one line.
- Long Q1: structure — intro, main body under 3 subheads, labeled diagram, conclusion.

Unit II — Developmental and Behavioural Psychology

Human developmental stages and healthcare needs (Erikson)

- Erikson's eight psychosocial stages (1950), each with a core conflict and a pharmacy angle:
- Infancy (0-1): trust vs mistrust — caregiver must trust the pharmacist; demonstrate safe syrup measurement.
- Toddlerhood (1-3): autonomy vs shame — let the child choose a flavour where possible.
- Preschool (3-6): initiative vs guilt — praise cooperation during nebulisation.
- School age (6-12): industry vs inferiority — teach inhaler technique the child can master 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 busy work life; maternal health counselling.

- Middle adulthood (40–65): generativity vs stagnation — chronic disease (diabetes, hypertension) management and screening reminders.
- Late adulthood (65+): integrity vs despair — polypharmacy review, large-print labels, fall-risk counselling, patience with hearing issues.

Remember: Counselling is not one-size-fits-all — privacy for teens, simplicity plus family involvement for the elderly.

Personality theories and patient interaction styles

- Freud's psychoanalytic theory: the id (primitive desires — "I want it now"), the ego (realistic mediator), the superego (moral conscience) — behaviour is their negotiation.
- Big Five (OCEAN): Openness (curiosity), Conscientiousness (organised, dutiful — high scorers adhere better), Extraversion (sociable), Agreeableness (cooperative), Neuroticism (anxiety-prone).
- Practical mapping: anxious/high-neuroticism patient → reassurance + written backup; low-conscientiousness patient → reminders and pill organisers; sceptical/low-agreeableness patient → evidence, not orders; talkative/extravert patient → gently steer back to the point.

Psychological factors affecting illness perception and recovery

- Leventhal's common-sense model — patients carry five beliefs about illness: identity (what it is), cause (what brought it), timeline (how long it lasts), consequences (how serious), cure/control (can it be treated). Wrong beliefs break adherence ("BP tablets are only needed when I feel dizzy").
- Locus of control: internal ("my actions affect my health") vs external ("it's all fate") — internals generally adhere better. Self-efficacy: belief in one's own ability to follow treatment.
- Optimism, social support and low stress speed recovery; stress itself slows wound healing and worsens hypertension — so reducing patient anxiety is genuinely therapeutic.

◆ Mnemonic: Leventhal's five — IC-TCC

Identity, Cause, Timeline, Consequences, Cure/control.

Common psychological disorders: anxiety, depression, somatization

- Anxiety — excessive, hard-to-control worry with palpitations, sweating, restlessness, sleep disturbance. Pharmacy approach: calm tone, simple clear answers, avoid alarming

language; refer to a doctor if persistent. Note: some drugs mimic anxiety (salbutamol tremor, excess caffeine).

- Depression — persistent low mood or loss of interest (anhedonia), with sleep/appetite changes, fatigue, poor concentration, lasting weeks. A top hidden cause of non-adherence. A pharmacist gently screens (two questions on low mood/lost interest over two weeks) and refers — never diagnoses.
- Somatization — physical complaints (pain, fatigue, digestive issues) not fully explained by medical findings, linked to psychological distress. DSM-5 calls it somatic symptom disorder. Never say "it's all in your head" — acknowledge symptoms as real and coordinate with the doctor instead of repeatedly dispensing symptomatic medicines.

Coping strategies, resilience and stress management

- Coping (Lazarus & Folkman, 1984) = efforts to manage stress. Problem-focused: tackling the cause (organising a pill box). Emotion-focused: soothing the feelings (deep breathing before a scary test result). Avoidant coping (denial, alcohol) is maladaptive.
- Resilience = bouncing back from adversity; it grows through social support, realistic optimism, self-care routines and past successful coping.
- Stress management techniques: deep breathing / 4-7-8 technique (teachable at the counter in 2 minutes), progressive muscle relaxation (tense then release muscle groups), time management, regular activity and sleep hygiene, seeking social support, professional referral when stress overwhelms.

Very short questions (2 marks)

- 1 Expand OCEAN and name the five traits.
- 2 Define id, ego and superego in one line each.
- 3 What is self-efficacy?
- 4 Name the two healthy types of coping.
- 5 What is the DSM-5 term for somatization?

Short questions (5 marks)

- 1 Tabulate Erikson's eight stages with one pharmacy-relevant point for each.
- 2 Explain Leventhal's common-sense model of illness perception.
- 3 Describe anxiety, depression and somatization and state the pharmacist's role in each.

Long questions (10 marks)

- 1 Discuss how personality theories help a pharmacist adapt counselling to different patient interaction styles, with examples.
- 2 Explain coping strategies and stress management techniques, and their relevance to patient care and to the pharmacist's own practice.

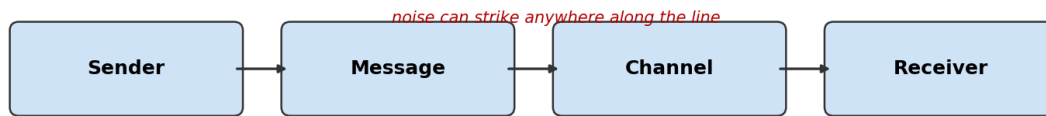
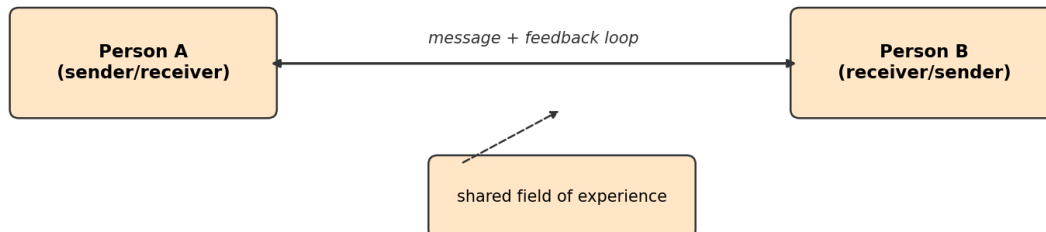
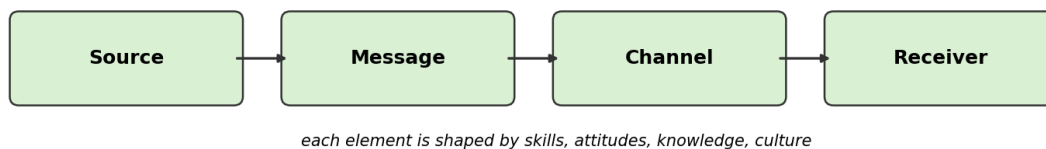
How to approach these answers

- Very-short Q1: expand the letters, one line per trait; nothing more.
- Short Q1: build a table with stage, conflict, pharmacy angle; close with one line.
- Long Q1: structure — intro, main body under 3 subheads, labeled diagram, conclusion.

Unit III — Foundations of Health Communication

Elements and models of communication

- Elements of every communication act: sender → encoding → message → channel → decoding → receiver, plus feedback (confirms understanding), noise (anything distorting the message — literal noise, jargon, anxiety) and context (a rushed counter vs a counselling room).
- 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 in a feedback loop, needing a shared field of experience (a common language/background).
- Berlo's SMCR (1960) — Source-Message-Channel-Receiver, each element shaped by skills, attitudes, knowledge and culture; the quality of each element decides the outcome.

Shannon-Weaver (1949) — LINEAR: one-way transmission; noise is the enemy**Schramm (1954) — INTERACTIVE: sender and receiver swap roles; feedback loop****Berlo (1960) — SMCR: the quality of each element decides the outcome**

Shannon-Weaver, Schramm and Berlo communication models compared

Remember: Linear = Shannon-Weaver (1949); Interactive + feedback + field of experience = Schramm (1954); SMCR with quality factors = Berlo (1960).

Types of communication in healthcare

- Interpersonal — one-to-one: counter counselling ("take this after food, twice daily"). The core of pharmacy practice.
- Group — one-to-many in person: a diabetes education session, an asthma awareness camp in a village.
- Mass — reaching the public: posters, radio spots, newspaper ads, social media campaigns (antibiotic-awareness week).
- Telehealth communication — remote care: video consultations, phone follow-ups, telepharmacy for distant patients; grew sharply after COVID-19 and is now a standard skill.

Barriers to effective communication in clinical settings

- Physical: noise, no private counselling space, long counter distance. Physiological: hearing loss, pain, drowsiness from medicines.
- Psychological: anxiety, fear of diagnosis, distrust, preconceived notions. Semantic/language: jargon ("take tds pc"), language mismatch (English label, Hindi-speaking patient).
- Cultural: gender norms, religious beliefs, deference to elders. Organisational: time pressure, staff shortage, no follow-up system.
- Beat them with: plain language, confirm understanding (teach-back), privacy where possible, and never rush a confused patient.

Active listening, questioning techniques and empathy

- Active listening = listening to understand, not just to reply. SOLER (Egan): Sit squarely facing the patient, Open posture, Lean slightly forward, Eye contact (culturally appropriate), Relax.
- Add verbal skills: paraphrasing ("So the tablet makes you dizzy in the morning?"), reflecting feelings ("That sounds frightening"), summarising, minimal encouragers ("hmm", "go on").
- Questioning: open-ended invites explanation ("How have you been taking your BP tablets?") — best to start; closed confirms specifics ("Did you take today's dose?"); probing digs deeper; funnel technique = open → probing → closed. Avoid leading questions ("You took it correctly, right?") — they push the answer you want, not the truth.
- Empathy vs sympathy: empathy understands feelings from the patient's perspective ("It must be hard managing all these tablets alone") and builds trust; sympathy pities from your own perspective ("Oh, poor you") and creates distance.

Mnemonic: SOLER — Sit, Open, Lean, Eye contact, Relax. Question funnel: open → probe → close; never lead.

Culturally appropriate and inclusive communication

- Use the patient's language where possible; otherwise simple words, pictures and demonstrations — never complex English on a label alone.
- Respect preferences: some women prefer a female pharmacist for certain issues; some elderly patients want a family member present. Don't assume literacy — pictorial schedules (sun = morning dose) work where text fails.
- Person-first language: "person with diabetes", not "diabetic"; "person with depression", not "mental patient". Be disability-inclusive: face hearing-impaired patients when speaking, write key points down, allow extra time.

Very short questions (2 marks)

- 1 List the elements of the communication process.
- 2 Expand SOLER.
- 3 Distinguish empathy from sympathy in one line.
- 4 What is person-first language? Give one example.
- 5 Name the three communication models with their years.

Short questions (5 marks)

- 1 Describe the elements of communication with a pharmacy example.
- 2 Tabulate barriers to communication in clinical settings with one example for each type.
- 3 Explain questioning techniques: open-ended, closed, probing and the funnel approach.

Long questions (10 marks)

- 1 Compare the Shannon-Weaver, Schramm and Berlo models of communication, with a labelled diagram of any one model.
- 2 Discuss active listening and empathy in patient counselling, and how culturally appropriate communication improves outcomes in the Indian setting.

How to approach these answers

- Very-short Q1: list the nine elements in order; nothing more.
- Short Q2: table with barrier type and pharmacy example; close with one line.
- Long Q1: structure — intro, main body under 3 subheads, labeled diagram, conclusion.

Unit IV — Professional Communication in Healthcare Settings

Communication with patients, caregivers and interdisciplinary teams

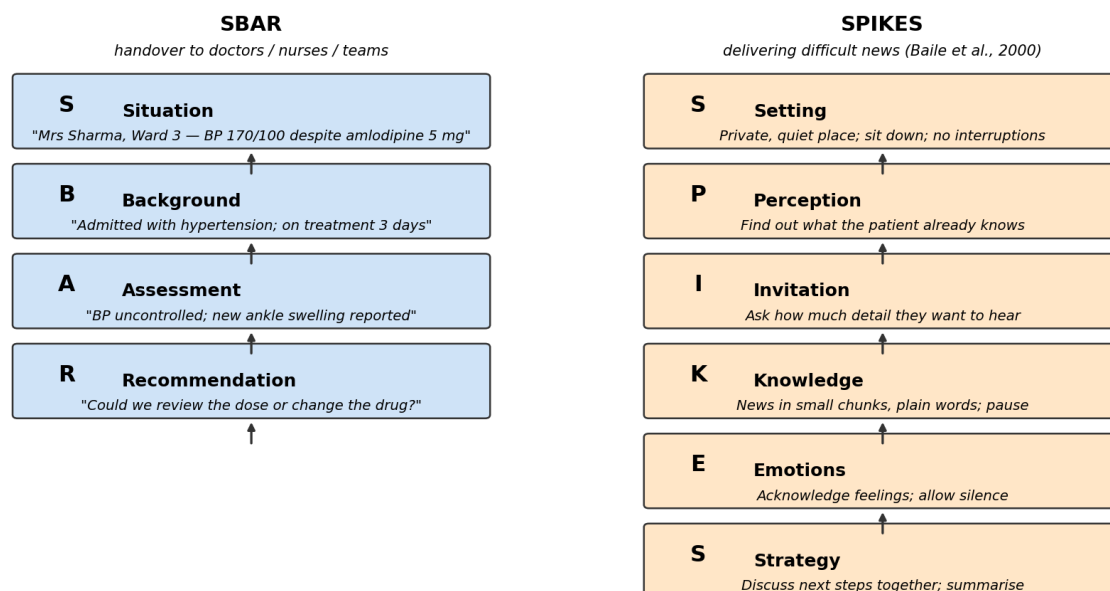
- With patients: follow a counselling flow — greet warmly, assess what the patient already knows, explain in plain language, demonstrate (inhaler, insulin pen), check understanding with teach-back, invite questions. Stay unhurried even when the queue is long.
- With caregivers: involve family for children, elderly and seriously ill patients — with the patient's consent where they are competent. Brief caregivers on dosing schedules, warning signs and storage, since they supervise the actual medicine-taking at home.

- With interdisciplinary teams (doctors, nurses, lab staff): keep communication structured and factual — state facts, not opinions. Use SBAR: Situation ("I'm calling about Mrs Sharma in Ward 3..."), Background ("...admitted with hypertension, on amlodipine 5 mg..."), Assessment ("...BP still 170/100 with ankle swelling..."), Recommendation ("...could we review the dose or drug?"). SBAR stops the vague, rambling calls that cause errors.

Delivering difficult news and handling emotionally charged situations

- SPIKES (Baile et al., 2000, from oncology) for difficult news: Setting (private, quiet; sit down; no interruptions), Perception (find out what the patient already knows), Invitation (ask how much detail they want), Knowledge (news in small chunks, plain words; pause), Emotions (acknowledge feelings explicitly; allow silence), Strategy/Summary (discuss next steps together; summarise).
- Handling angry or weeping patients/relatives: stay calm, never match their volume; acknowledge the emotion before the facts ("I understand you're upset — let's sort this out"); move to a private corner; listen fully before explaining; offer concrete next steps; call a senior or security if needed — your safety matters too.

Structured communication tools: SBAR & SPIKES



SBAR for team handovers and SPIKES for delivering difficult news

Legal and ethical issues: confidentiality and consent

- Confidentiality: patient information — prescriptions, diagnoses, even the fact of a pharmacy visit — must not be disclosed without consent. Don't discuss one patient's

medicines within earshot of the next in queue; keep records secure; never share patient details on social media or WhatsApp groups.

- Informed consent: before any procedure, treatment or data sharing, 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 beyond their care.

Remember: The syllabus names only two — confidentiality and consent. Guard information; explain before you act.

Writing patient records, reports and discharge summaries

- Good documentation is factual, concise, dated and timed, legible, with no confusing abbreviations — it is both a legal record and a communication tool.
- SOAP notes (Weed, 1960s): Subjective (what the patient reports — "dizziness every morning after amlodipine"), Objective (what you measure — "BP 150/95, pulse 88"), Assessment (your judgement — "possible amlodipine-related dizziness; adherence good"), Plan (next steps — "counselled on rising slowly; advised to report to doctor; follow up in 3 days").
- Reports: ADR (adverse drug reaction) reports to the Pharmacovigilance Programme of India (PvPI) — what happened, which drug, dose, timing, outcome. Accurate reporting by pharmacists protects other patients.
- Discharge summaries: medication list with doses and timings, duration, warning signs, follow-up date and lifestyle advice — written so both the patient and the next provider understand the plan.

Technology and digital communication in healthcare

- Telehealth/telepharmacy: video or phone consultations and remote counselling — essential for rural and distant patients. EHR (electronic health records): shared digital histories 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 apps for quick interaction checks at the counter.
- Cautions: protect patient data (passwords, no public computers for records), never diagnose or prescribe over a casual message, and remember digital tools support — but never replace — face-to-face counselling.

Very short questions (2 marks)

- 1 Expand SBAR.
- 2 Expand SPIKES.

- 3 Expand SOAP.
- 4 Where do pharmacists in India report adverse drug reactions?
- 5 Name the two legal-ethical issues in the syllabus.

Short questions (5 marks)

- 1 Explain SBAR with a pharmacy example.
- 2 Describe the SPIKES protocol step by step.
- 3 Write a sample SOAP note for a patient complaining of dizziness after starting a new antihypertensive.

Long questions (10 marks)

- 1 Discuss how a pharmacist should communicate with patients, caregivers and interdisciplinary teams, using SBAR and the counselling flow.
- 2 Explain confidentiality and informed consent in pharmacy practice, and describe the documentation a pharmacist must maintain (patient records, ADR reports, discharge summaries).

How to approach these answers

- Very-short Q1: expand the four letters with one line each.
- Short Q1: expand SBAR, then one example flowing through all four steps.
- Long Q1: structure — intro, main body under 3 subheads, labeled diagram, conclusion.

Unit V — Health Psychology and Behavioural Interventions

Health belief models and illness behaviour

- The Health Belief Model (HBM) (Rosenstock, 1966; Becker, 1974) explains why people do — or don't — take health action. A person acts when these line up:
- Perceived susceptibility — "Could this happen to me?" ("I could develop drug-resistant TB if I stop early")
- 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, clinic travel, lost wages)
- Cues to action — triggers that prompt action (ASHA worker's visit, a reminder call)
- Self-efficacy — "Can I actually do it?" ("I can manage six months of tablets")
- The pharmacist's job: raise perceived benefits, lower barriers (simpler regimens, cost solutions), supply cues to action (reminders, follow-up calls).

- Illness behaviour (Mechanic) = how people perceive, evaluate and act on symptoms — including delay in seeking care and self-medication, extremely common in India where the chemist shop is the first stop. Parsons' "sick role" (1951): the sick person gets two rights (exemption from normal duties, not blamed for the illness) and two obligations (seek competent help, cooperate with treatment). Non-adherence = failing the sick role's obligations.

◆ **Remember: HBM's six — SSBBCSe**

Susceptibility, Severity, Benefits, Barriers, Cues to action, Self-efficacy.

Psychosomatic illnesses and the mind-body connection

- Psychosomatic illnesses = physical conditions significantly influenced or worsened by psychological factors — stress, anxiety, emotional conflict. Classic examples: hypertension, IBS, migraine, asthma flare-ups, eczema, 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 (studied by psychoneuroimmunology).
- Pharmacy angle: when an IBS or migraine patient also reports heavy stress, medicines alone may underperform — stress management (Unit II techniques) is a legitimate adjunct. And crucially: psychosomatic does NOT mean fake — symptoms are real; psychology is part of the cause, so it is part of the treatment.

Behaviour change theories: CBT and TTM in treatment adherence

- CBT — Cognitive Behavioural Therapy (Beck): 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 (examine the evidence — "long-term studies show this dose protects kidneys in hypertension") and behavioural experiments (small tests — "try the morning dose for a week, 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 — Precontemplation ("I don't need to quit smoking") → Contemplation ("maybe I should...") → Preparation ("I'll set a quit date") → Action (doing it) → Maintenance (sustaining it). Relapse is normal — it returns the patient 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 plan for relapse triggers). Ask "Have you thought about quitting?" before handing over nicotine-gum advice.

◆ **Mnemonic: TTM stages — PCPAM**

Precontemplation, Contemplation, Preparation, Action, Maintenance.

Psychological first aid and crisis communication

- Psychological First Aid (PFA) — WHO's framework — 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 safety and urgent needs — injured, in shock, alone?
- Listen: approach calmly, listen without pressuring them to talk, acknowledge feelings.
- Link: connect to practical help — family, medical care, helplines — and share accurate information.
- Crisis communication: be honest about what you know and don't know, stay calm, speak clearly and simply, avoid speculation and rumours, repeat key safety information. In a crisis (drug-shortage panic, adverse-event scare), the pharmacist is often the trusted local voice — accuracy matters more than speed.

Mental health promotion and stigma reduction through communication

- Mental health promotion = building the conditions for psychological wellbeing: awareness, early help-seeking, supportive environments — not just treating illness. Stigma (shame and discrimination) is the biggest barrier to mental-health care in India.
- Communication reduces stigma through: person-first language ("person with depression", never "mental"/"psycho"/"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, usually treatable), and visibility (pharmacists as accessible first-contact professionals displaying helpline numbers and discussing 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 under severe stress, not committing an offence). Knowing this helps you respond to a distressed patient lawfully and humanely.

Very short questions (2 marks)

- 1 Name the six components of the Health Belief Model.

- 2 List the five stages of the Transtheoretical Model.
- 3 Expand PFA and name its three actions.
- 4 What does psychosomatic mean? Is the illness fake?
- 5 Name the Act that established the right to mental healthcare in India, with the year.

Short questions (5 marks)

- 1 Explain the Health Belief Model with a pharmacy example.
- 2 Describe the TTM stages and how counselling must match each stage.
- 3 Explain CBT's core principle with one pharmacy application to adherence.

Long questions (10 marks)

- 1 Discuss the Health Belief Model in detail and explain how a pharmacist uses it to diagnose and correct non-adherence.
- 2 Describe psychological first aid and crisis communication, and explain the pharmacist's role in mental health promotion and stigma reduction.

How to approach these answers

- Very-short Q1: list the six components in order; nothing more.
- Short Q1: open with definition, then each component with a short example, close with one line.
- Long Q1: structure — intro, main body under 3 subheads, labeled diagram, conclusion.