

RESEARCH ARTICLE

A mixed methods evaluation of a mentalising education programme for the community pharmacy workforce in Denmark – A promising way forward to deliver patient-centred counselling

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Abstract

Background: This article presents the results of the evaluation of a mentalising education programme for staff at community pharmacies as to whether it had made counselling more patient-centred. **Methods:** A mixed-methods design was chosen, combined with Kirkpatrick's four levels of evaluation. Twenty-eight participants from 11 community pharmacies participated. Data comprised qualitative reports at the end of the programme and measurements of Level of Emotional Awareness, Job Satisfaction, and Course Experience questionnaires. **Results:** The qualitative evaluation revealed three themes: "Awareness of emotions and communication skills is an important element when mentalising is the goal", "It's far more than a dispensing situation – I now tune into the patient", "I don't have to hide behind the screen any longer". The quantitative evaluation showed a significant increase in awareness of mental states, improvement in job satisfaction, and satisfaction with the programme. **Conclusion:** The results show promise in supporting the pharmacy workforce to adopt a patient-centred approach during counselling.

Introduction

One of the core activities at community pharmacies is counselling patients about prescription and over-the-counter (OTC) medication to support the implementation of correct use and contribute to health promotion (Herborg, Sørensen, & Frøkjær, 2007; Haugbølle & Herborg, 2009). At the same time, the workload of community pharmacies increased (Chui & Mott, 2012; Lea, Corlett & Rodgers, 2012; Berthenet, Vaillancourt, & Pouliot, 2016). At the global level, the average density of community pharmacies per 10,000 people is 2.75 (n=76 countries), while in Denmark, it is 0.88 (International Pharmaceutical Federation, 2021). Thus, the mean average population served by

community pharmacies is 8,940 per pharmacy (n=75 countries) globally. In Denmark, this number is 11,328 (International Pharmaceutical Federation, 2021), and on an annual basis, community pharmacy staff serve the majority of the Danish population (94%) (Hansen *et al.*, 2021), which, on average, corresponds to delivering 326 services daily per community pharmacy (n=524 community pharmacies) (Danish Association of Pharmacies, 2021). An increase in workload can contribute to increased job-related stress and decreased job satisfaction (Seston *et al.*, 2009; Hassell *et al.*, 2011).

Despite the juxtaposition between the desire for patient-centred counselling and managing a high

workload of dispensing tasks (Jalal *et al.*, 2020; International Pharmaceutical Federation, 2021), building a solid, balanced interpersonal relationship with patients at the community pharmacies is a way to mediate and accomplish both aims (Ilardo & Speciale, 2020). Patients who pick up medication at the community pharmacy may be emotionally affected due to their acute or chronic disease and their need for medical treatment. They may express sadness, frustration, anger, or insecurity or burst into tears, for example, when talking to staff (Fosgerau & Kaae, 2020), adding pressure on staff in an already challenging situation. Hence, dealing with patients appropriately is a way for staff to decrease their work stress.

However, although patients' emotional states may affect their medical adherence and reveal information relevant to staff when delivering counselling, studies show that patients' views are rarely engaged in the pharmacy encounter (de Oliveira & Shoemaker, 2006; Puspitasari, Aslani & Krass, 2009; Kaae, Mygind & Saleem, 2013; Kaae, Traulsen, & Nørgaard, 2014; Olsson *et al.*, 2014; Wolters *et al.*, 2017; Fosgerau & Kaae, 2020). One reason for staff not engaging with patients' feelings is that they find it inappropriate when patients disclose personal information. Another reason is that they do not know how to handle patients' emotions and their own (Fosgerau & Kaae, 2020; Fosgerau *et al.*, 2021). Thus, the interaction at the pharmacy counter widely consists of information transmission based on the workforce's agenda (Chong, Aslani & Chen, 2014; Koster *et al.*, 2015; Wolters *et al.*, 2017). However, patient-centred counselling comprises bringing forward patients' perspectives to provide counselling in line with patient needs and preferences (Wolters *et al.*, 2017).

Significant problems are solved every day at the pharmacies (El-Souri *et al.*, 2020), but pharmacy research has started focusing on how to bring the perspectives of patients into the desk meetings to enhance patient-centred counselling (Kaae, Traulsen & Nørgaard, 2012; Kaae & Nørgaard, 2012; Kaae, Mygind & Saleem, 2013; Kaae, Traulsen & Nørgaard, 2014; Koster *et al.*, 2015; Koster *et al.*, 2016). However, it still appears to be challenging to implement actual patient-centred counselling in community pharmacy settings (Gyllensten, Fuller & Östbring, 2022; Kaae *et al.*, 2022). Therefore, a new mentalising education programme for the postgraduate community pharmacy workforce has been developed in Denmark and tested in Denmark and the Netherlands to overcome these barriers (Fosgerau *et al.*, 2022). In the framework of mentalising, emotions play a prominent role; learning to understand, recognise, and regulate emotions is decisive to the personal development alongside the ability to engage, relate, and interact with others (Allen, 2003). Thus, the

mentalising education programme aimed to develop and increase the mentalising mindset of the pharmacy workforce, including targeting their awareness of their emotional states and those of patients in pharmacy encounters. Participants were taught a specific way of communicating to display the mentalising mindset in communication (Steinberg & Andresen, 1981; Orlando, 1990; Gordon & Kragh, 1999; Clabby & O'Connor, 2004; Zoffmann, Harder & Kirkevold, 2008) called mentalising communication, which includes mirroring, active listening, values clarification, and the use of communication models (Fosgerau *et al.*, 2022). Knowledge about traditional pharmacy practice was added to the mentalising education programme, and the teaching and training exercises were situated in a pharmacy practice setting to make the counselling patient-centred (Fosgerau *et al.*, 2022).

The programme lasted four months and combined physical attendance and online modules. Participants were also given practical homework between modules. Upon completion of the programme, participants were required to submit a qualitative written report that demonstrated their theoretical and practical understanding, knowledge, skills, and behavioural changes related to mentalising mindset and communication. This report helped assess whether participants had successfully acquired a mentalising mindset and were able to apply mentalising communication related to their community pharmacy practice (Fosgerau *et al.*, 2022).

This paper presents the results of an evaluation of a mentalising programme that was developed, adapted, and implemented in a community pharmacy context, which, to the best of the authors' knowledge, is the first of its kind. The primary aim was to evaluate whether this programme has resulted in a shift towards patient-centred communication in pharmacy counselling (Fosgerau *et al.*, 2022). Additionally, the paper discusses the participants' level of emotional awareness, generic mentalising abilities, changes in job satisfaction, and overall satisfaction with the programme.

Methods

Ethical considerations

According to Danish law, ethical approval is not required when conducting qualitative studies or collecting data using questionnaires (The Danish Ministry of Justice). However, ethical considerations were met, and the study was performed in accordance with the Helsinki Declaration (World Medical Association, 2022). Before

starting the educational programme, written and oral information was provided about the study, and written informed consent was obtained from all participants who were informed that data would be treated confidentially and anonymously in accordance with the EU General Data Protection Regulation ACT (GDPR) and that they could withdraw from the study at any time without further consequences.

Design

A mixed methods sequential design (Yu, 2009; Creswell & Plano Clark, 2011;), comprising a deductive qualitative evaluation of the mentalising education programme and quantitative measurements of the mentalising capacity, overall satisfaction with the programme, and impact on job satisfaction, was applied.

Participants

The mentalising programme was open to the entire workforce of Danish community pharmacies and was limited to a maximum of 30 participants. It was announced on the websites of the Danish Association of Pharmacies and Pharmakon (the Danish College of Pharmacy Practice). The only inclusion criterion was that there had to be a minimum of two persons from each community pharmacy. Those who fulfilled this criterion and registered first were given priority for the available places, and 30 people signed up for the programme. However, one community pharmacy (two participants) withdrew from the programme one week before it started due to a shortage of staff.

A total of 28 participants (one male, 14 pharmacy technicians, 13 pharmacists, and one pharmacy owner) from 11 community pharmacies across Denmark attended the education programme.

Evaluation approach and data collection

The educational programme (Fosgerau *et al.*, 2022) was evaluated using the four levels of Kirkpatrick's model, i.e., reaction, learning, behaviour, and results (Kirkpatrick & Kirkpatrick, 2009):

- 1) Reaction assesses the extent to which the participants find the learning experience favourable and relevant to their job;
- 2) Learning describes changes in the participants' understanding, knowledge, skills, and attitudes;
- 3) Behaviour describes whether participants change their behaviours and apply what they have learned when they are back on the job;

- 4) Results describe whether the learning had an impact on participants' emotional awareness and overall job satisfaction.

Evaluation of Level 1 (reaction): Overall satisfaction with the educational programme was assessed upon its completion. Data were collected using the validated Course Experience Questionnaire (CEQ), a generic 25-item instrument that seeks to establish participants' perceptions of the quality of the course they have recently completed (Curtis & Keeves, 2000). Twenty-four items in the instrument are statements that form five subscales: good teaching (six items, e.g., the teaching staff of this course motivated me to do my best work), clear goals and standards (four items, e.g., the staff made it clear right from the start what they expected from students), assessment of appropriateness (four items, e.g., the assessment methods employed in this course required an in-depth understanding of the course content), assessment of appropriate workload (four items, e.g., I was generally given enough time to understand the things I had to learn), and generic skills (six items, e.g., the course sharpened my analytic skills). The last item is a statement concerning general satisfaction with the course.

Participants expressed their opinions by selecting one of the five response options ranging from strongly disagree (1 point) to strongly agree (5 points), with higher scores representing higher satisfaction. The original English version of the instrument has been psychometrically validated. For the purpose of this study, it was translated from English into Danish and cognitively debriefed among five Danish users with pharmacy backgrounds, applying Principles of Good Practice for the Translation and Cultural Adaptation Process for Patient-Reported Outcomes Measures (Curtis & Keeves, 2000). Internal consistency Cronbach alpha of the scales in the Danish translation ranged from 0.47 (appropriate assessment scale) to 0.69 (good teaching scale).

Evaluation of Level 2 (learning) and Level 3 (behaviour):

A qualitative evaluation of knowledge and understanding of mentalising, as well as skills and competences related to the mentalising mindset and using mentalising communication in daily community pharmacy practice, was applied (Fosgerau *et al.*, 2022). Data consisted of participants' individually written reports comprising 36 qualitative open-ended questions, which were built on the theory that the educational programme was based upon (Fosgerau *et al.*, 2022).

The first part of the report required participants to describe the mentalising mindset and communication using their own words (one-third of the questions). One example of these questions is: Describe in your own words what it means to mentalise (Fosgerau *et al.*, 2022). In the second part of the report, participants had to

demonstrate their knowledge and understanding of the mentalising mindset and communication by applying it to fictive patient cases of desk meeting scenarios (one-third of the questions). Examples of these questions are: Rewrite the dialogue and imagine what the customer would answer; Use the mentalising communication model to determine the communication and reflection zones of the customer and the pharmacy employee (Zoffmann, Harder & Kirkevold, 2008). The last part evaluated participants' beliefs of how well they could apply mentalising skills and abilities to their community pharmacy setting (one-third of the questions). One example of these questions is: How do you use what you have learned in your daily work at the community pharmacy? Please provide examples (Illeris, 2016).

Evaluation of Level 4 (results): Participants' mentalising abilities were measured using a Danish version of the validated instrument Level of Emotional Awareness (LEAS) to supplement the qualitative evaluation of Levels 2 and 3 (Lane & Schwartz, 1987). The LEAS is a performance-based tool that assesses informants' ability to be aware of mental states. Before and after the programme, participants were asked to describe in two to four sentences their anticipated feelings and those of another person in ten different scenarios, which involved various interpersonal situations, such as travelling and meeting people who criticise their country and receiving a massage from a colleague at work. Each scenario required the informant to answer these questions: How would you feel? How would the other person feel? Answers were scored according to a manual specifying structural scoring criteria that address their use of emotional words. Low scores suggest a lack of emotional awareness, while high scores reflect a heightened awareness of emotions and the ability to differentiate emotional experiences. Thus, LEAS assesses explicit aspects of 'self' and 'other' mentalisation.

Besides the qualitative evaluation at Levels 2 and 3, job satisfaction was measured before and after the programme. Data were collected using the validated Job Satisfaction Measure (JMS), which was developed to assess job satisfaction among community nurses (Traynor & Wade, 1993; Wade, 1993). It consists of 44 items, with the first 43 items forming seven subscales: personal satisfaction (six items, e.g., The feeling of worthwhile accomplishment I get from my work), satisfaction with workload (eight items, e.g., The time available to get through my work), satisfaction with professional support (eight items, e.g., The degree to which I feel part of a team), satisfaction with training (five items, e.g., The opportunities I have to advance my career), satisfaction with payment (four items, e.g., Payment for the hours I work), satisfaction with career prospects (six items, e.g., My prospects for promotion), and satisfaction with performed standards of care (six

items, e.g., The quality of work with patients/clients). The last item concerns the general satisfaction with one's job, where participants express their opinions by selecting one of the five response options ranging from very unsatisfied (1 point) to very satisfied (5 points), with higher scores indicating higher satisfaction. The original English version demonstrated good factorial, concurrent, discriminant validity, internal consistency, and test-retest reliability (Traynor & Wade, 1993). For this study, the English version was translated and cognitively debriefed in Danish, using the same methodology as for the Danish adaptation of the CEQ. Internal consistency Cronbach alpha of the scales in the Danish translation of MJS was calculated from baseline data before the programme and ranged from 0.64 (satisfaction with training scale) to 0.81 (satisfaction with pay scale).

Responses to the CEQ, LEAS, and JMS in this study were collected using the online survey system SurveyXact. Links to the questionnaire were sent to the participants by email.

The education programme was delivered in Danish, and participants were evaluated (with written reports and scales) in Danish.

Analysis

Qualitative analyses

Data from the final reports were uploaded to Nvivo software (QSR International Version 13 xx, QSR International Pty Ltd, Doncaster Victoria, Australia) to organise data and support the analysis process. Data were analysed using a six-phase thematic analysis as provided by Braun and colleagues (2019). The final reports were read and reread to gain an overview of the content (1. Familiarisation with the data). The transcribed data were deductively coded according to Kirkpatrick's learning levels two and three: knowledge, understanding, skills, and behaviour change (Kirkpatrick & Kirkpatrick, 2009; Johnston *et al.*, 2018) (2. Deductive coding). The coding process was subsequently discussed with one of the co-authors to develop the themes. Relationships between the codes were sought to generate subthemes and subsequent themes (3. Development of themes). Disagreements were resolved by consensus following discussion and with reference to the coded and original text. The text in the final reports was reviewed to ensure that the developed themes corresponded with the data and to improve the description of the themes (4. Reviewing themes). Each theme was given a name that captured the essence of its content, and the transcripts were revised to identify representative quotes to use in the written analysis (5. Defining themes). Theme descriptions and quotes were discussed and presented to all authors. A narrative of the

themes was written using quotes identified as illustrative evidence (6. Reporting).

Credibility was ensured by triangulating the researchers throughout the analysis with authors who have experience in the educational programme, qualitative research, or community pharmacy practice. The analysis included thick descriptions of the findings to address transferability. Dependability was achieved by providing quotes from participants' reports, and confirmability was provided by thoroughly describing the processes of sampling, data collection, and analysis (Guba, 1981).

Quantitative analyses

Descriptive statistics were used to analyse the CEQ and MJS data before and after the course. The means for each subscale were calculated by dividing the sum of item scores by the number of items comprising that subscale. The means of subscales in CEQ were calculated, and frequencies and percentages of overall satisfaction were reported to assess general satisfaction with the programme. Paired t-tests and Wilcoxon Signed Ranks Test were applied for normally and non-normally distributed scales, respectively, to assess the changes in MJS scores before and after the programme. One-Sample Kolmogorov-Smirnov Test was used to determine the type of distribution.

Two certified LEAS testers LEAS scored the data according to the LEAS manual. An expert certified tester was included to perform the scorings of ten informants to strengthen reliability. All discrepancies were discussed and solved. The means of the scores were calculated, and comparisons between before and after scores were made using a paired t-test. The mean and standard deviations were reported for means. A p-value of <0.05 was considered statistically significant.

IBM SPSS version 26 was used for all statistical analyses.

Results (qualitative)

All 28 participants completed the education programme during the autumn of 2021 and submitted the final written qualitative report by the end of January 2022.

Kirkpatrick Levels 2 & 3 – Findings from the thematic analysis

The findings are presented according to headings inspired by Kirkpatrick's Levels 2 and 3, with associated themes and subthemes. The analysis revealed three themes and related subthemes (Figure 1) and a distinction between knowledge and understanding at Level 2 and learning and behaviour change at Level 3.

At Level 2 (learning), participants showed knowledge and understanding of the theories on which the programme was based (Fosgerau *et al.*, 2022). At Level 3 (learning and behaviour), they could demonstrate their abilities to combine and apply theoretical knowledge in practice, i.e., combining understanding from Level 2 with practical knowledge, understanding, and skills, which led to behavioural changes, as shown by their rewriting of cases from real-life desk meetings (Fosgerau & Kaae, 2020). In addition, the participants reflected on and described in detail how they had achieved mentalising skills and had changed behaviour at desk meetings by providing examples with actual patients from the community pharmacy. That is why Kirkpatrick's Levels 2 and 3 are combined when presenting the findings, as illustrated in Figure 1.

Kirkpatrick Level 2 (learning): Knowledge and understanding

Participants demonstrated good knowledge and understanding of what they had been taught during the programme and training period. They reproduced and described in their own words what the mentalising mindset and communication consist of, and how to apply this knowledge and understanding to fictive scenarios in a community pharmacy setting.

Participants' levels of knowledge and understanding are presented below in relation to the themes and subthemes.

Theme 1: Awareness of emotions and communication skills are crucial elements when mentalising is the goal.

Participants demonstrated good knowledge and understanding of how a combination of a mentalising mindset and communication skills are important when mentalising is the goal for engaging with patients at the community pharmacy. They also exhibited knowledge and understanding of the different dimensions of mentalising and described the wheel of emotions and the three designated basic emotions, i.e., acceptance, serenity, and interest. They demonstrated knowledge and understanding of why and how these three basic emotions should be present as the foundation for establishing a safe and trustful relationship with a patient at the counter and how to use them to handle patients' emotions. Hence, participants exhibited high levels of knowledge and understanding of what mentalising communication comprises, how it operationalises into and concretises a mentalising mindset, and what mentalising means.

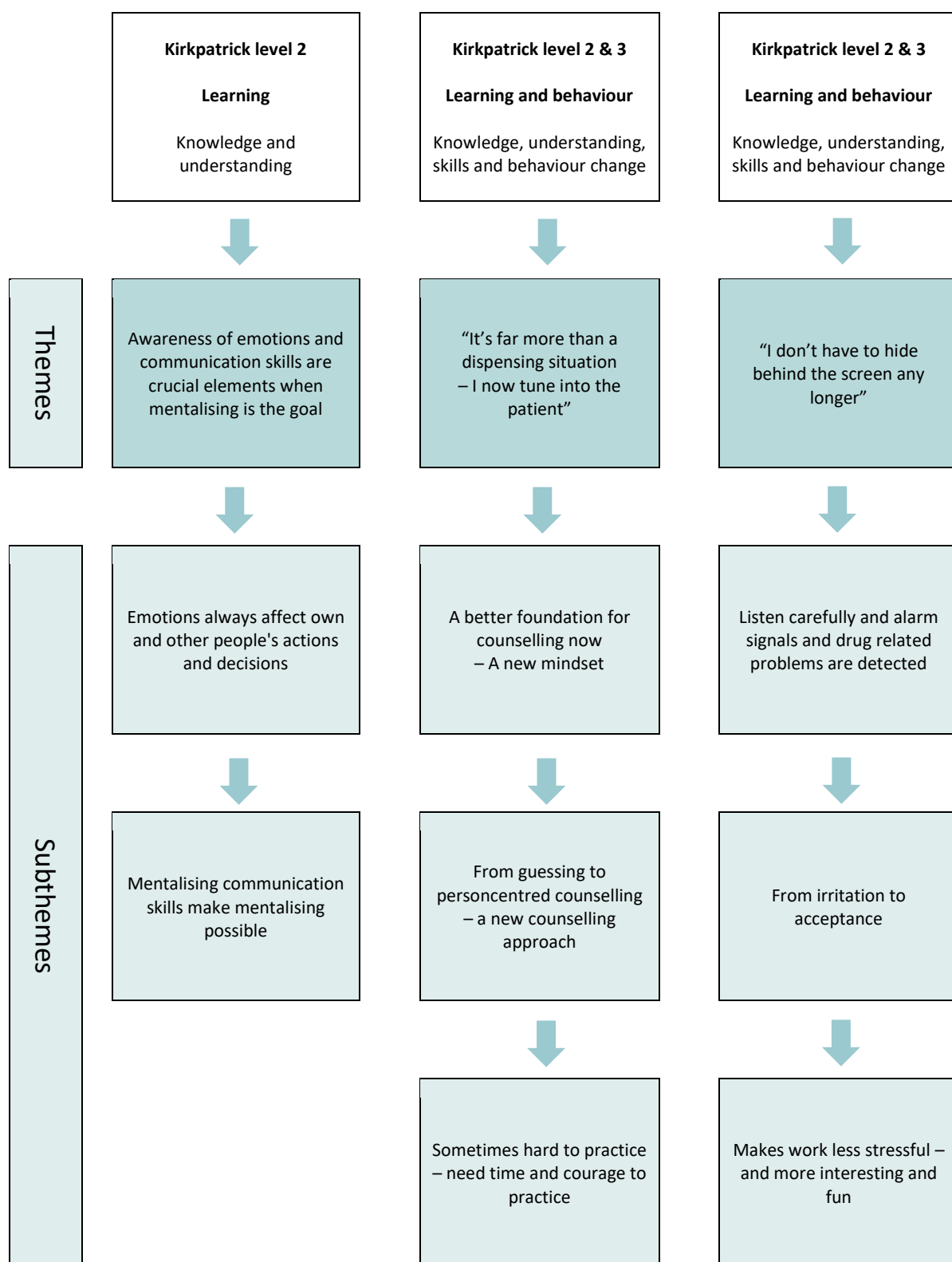


Figure 1: Overview of the themes and subthemes and how they correspond to Kirkpatrick's Levels 2 and 3

Subtheme: Emotions always affect own and other people's actions and decisions.

Participants demonstrated that they have learned that all people are always emotionally invested and that it is crucial to be aware of your own emotions and reactions to mentalise, meet, and contain patients' emotions and, subsequently, provide adequate counselling at the counter.

"When I'm conscious about my own emotions, it's easier to see other people's emotions, patients' emotions, that is."

Participants demonstrated that they had learned the human ability to switch from one emotion to another whenever it was necessary. Also, they were able to account for and explain theoretically based reasons for not being able to move smoothly in and out of different emotions. They showed that they had learned the impact of using this knowledge of emotions when meeting patients, as illustrated by the following quote:

"Mentalising means that you try to understand other people's mental states – emotions, thoughts and needs – and use it in your communication with them. You use your observations to figure out what is important for the person in front of you and adapt your counselling to that. At the same time, you are also focused on your own emotions and how the meeting with the patient is affecting you."

They described an understanding of how patients' behaviour and mental state may be due to factors that are not connected to the counselling at the community pharmacy. They demonstrated knowledge and understanding of how the three basic emotions (acceptance, serenity, and interest) helped them handle and cope with their own and the patient's emotions and behaviour. They described how they discovered patients' emotions and how they studied their signals, taking particular care not to let patients' emotions influence their behaviour. Participants exhibited knowledge and understanding of how to regulate their own and patients' emotions if they were too 'noisy', as illustrated by the following quote:

"The main thing I learned at the course is to keep my feelings at interest, acceptance, and serenity. That allows me to understand and read the patient's body language without letting their emotions and behaviour affect me."

Subtheme: Mentalising communication skills make mentalising possible.

Participants demonstrated knowledge and understanding of how mentalising communication skills make mentalising possible and what it comprises

through rewriting fictive dialogues based on real-life community pharmacy cases. They explained how to communicate with the patients within a mentalising mindset, such as being aware of meeting the patients within the three basic emotions and incorporating the theoretical communication models (Steinberg & Andresen, 1981; Zoffmann, Harder & Kirkevold, 2008; Fosgerau et al., 2022) and appropriate body language and verbal communication, such as mirroring, active listening, response models, and value clarification responses, as illustrated by the following quote:

"Acceptance: Be friendly, forthcoming and accept the patient's emotions. Smile and greet them. Serenity: Be calm, take your time with each patient, and forget about the queue. Use calm language and body language. Take your time to listen and allow a second of quiet before you answer. Interest: Look at the customer, keep eye contact, be present, and listen. Ask questions and be curious."

Kirkpatrick Levels 2 and 3 (learning and behaviour): Skills in combination with behaviour

Participants demonstrated knowledge, understanding, and skills in mentalising combined with concrete examples of behaviour change. Self-reported answers provided in-depth descriptions and reflections on how participants have started a process and are on track to adopt a mentalising mindset and use mentalising communication as a conscious way to engage and counsel patients. They demonstrated that, already during the programme period, they began to apply what they had learned when they were back at work between modules. They showed confidence and commitment in using this new approach to their practice. This attitude may be related to the fact that mentalising training exercises with actual patients at their community pharmacies were part of the education programme (Fosgerau et al., 2022).

Participants' skills and behaviour changes are presented below in relation to themes and subthemes.

Theme 2: "It's far more than a dispensing situation – I now tune into the patient."

Participants demonstrated changes in their perception of what takes place at the counter. They were capable of combining knowledge and skills about how to practice a mentalising mindset in combination with mentalising communication when talking to patients at the counter. They demonstrated a shift in their attitude towards the patients and described how they were aware of the importance of tuning into patients' emotions and state of mind from the beginning of the dispensing situation. They described how this

behaviour change helped them understand patients' current situation and state of mind. Participants reported that they now know how to accommodate and manage patients' emotions and behaviour by being emotionally attuned to displaying acceptance, serenity, and interest towards patients and employing communication tools. This change made the dispensing situation more personalised and easier to manage because they collaborated with patients to identify potential challenges related to medicines.

Participants showed that they changed their perception of patients; they are now more attentive and able to help patients more effectively, which has resulted in significantly more positive dispensing situations.

Subtheme: A better foundation for counselling now – A new mindset.

Participants reported that they achieved a better foundation for counselling because they gained a theoretical understanding of how to act according to a mentalising mindset and mentalising communication, which has given them a new approach and perspective when interacting with patients, as exemplified by the following quote:

"Every day, I try to meet all patients with interest, serenity, and acceptance. That has given me a lot of eye-opening experiences and many more positive and successful counselling situations – situations where I believe I have made a difference for the patient – for the sake of the patient – and where I have also had a positive experience of the interaction with the patient myself. It has become much more than a dispensing situation."

Participants applied these skills to decode their own emotions and mental state and that of patients. They had not been previously aware of how their own emotions could influence the pharmacy encounter in a deconstructive or constructive manner for both parties. They now pay attention to patients' emotions and mental state and are aware of having to be in a mentalising mindset when engaging with them, as illustrated by the following quote:

"My awareness of the patient has been strengthened. I am much more aware of signals from the patients who express their emotions verbally and non-verbally. At the same time, I have become aware of my own emotions, thoughts, needs, and intentions. I know now that I have to be able to embrace patients' emotions and thoughts as well as my own."

Subtheme: From guessing to person-centred counselling – A new counselling approach.

Participants' perception of having achieved a better foundation for counselling was also related to their experiences of using mentalising communication. They declared they have stopped guessing and assuming what patients needed and how they managed to take their medication, for example:

"I used to tend to try to guess what the other person means."

Instead, they came to realise how patients' perspectives, needs, and wishes must be the starting point for the counselling instead of moving forward with standardised closed-ended questions. Participants described their experience of giving the patients enough time to explain and tell their side of the story and how they stayed interested by asking them open-ended questions, using mirroring, active listening, response models, and value clarification responses. This helped them identify patients' current challenges and get information that previously would not have been identified, which means that they now prioritise the content of counselling topics together with the patients, as illustrated by the following quote:

"I ask more open-ended questions, so that it does not become a guessing competition but more of an open dialogue between me and the patient. In several cases, this has opened up for important information that I wouldn't normally have gotten."

Participants acknowledged how the change of mindset and a helpful 'mentalising suitcase' provided them with skills to shift their counselling practice and their view of the patient's role in the dialogue. They reported having abandoned the current counselling model based on the exact product as the starting point for the counselling and replaced it with a person-centred approach. They described how surprised they were by the effect of using a mentalising mindset in combination with mentalising communication and how this approach opens for entirely different and more person-centred dialogues, as illustrated by the following quote:

"Overall, it has given me much better patient encounters and I feel that I have become much better at focusing on what is important for the patient instead of just rolling full steam ahead with my pharmaceutical information train – which is correct enough information but may not be what the patient needs or is able to take in, in a given situation. I have become better at reading the signals from the patients and reacting to them."

Subtheme: Sometimes hard to practice – Need time and courage to practice.

Although participants demonstrated knowledge, understanding, skills, and behaviour change by applying what they have learned to desk meetings, they were also humble about being able to practice a mentalising mindset and mentalising communication, especially when the pharmacy is busy. They conveyed that it takes time to practice but were aware of the benefits of letting old and sometimes superficial counselling habits go. They demonstrated different levels of behaviour change; some reflected on how specific counselling situations could have been performed differently and discussed this matter with colleagues, while others applied what they had learned more quickly. They all reported that it was hard work to incorporate the new theories and practices, and some were also reluctant due to a lack of courage to start a deeper conversation with the patients, as illustrated by this quote:

"I have to work on becoming braver at asking the patients more in-depth questions – for instance, if they use a word like 'unfortunately', I have to become better at catching that word."

Theme 3: "I don't have to hide behind the screen any longer."

The computer is an essential work tool at community pharmacies because this is where participants fill in their prescriptions. Participants reported how they have become aware that previously, they used the computer screen as a shield to hide behind to cope with both their own and patients' emotions – consciously and unconsciously. They stated that they now act differently due to the combination of emotional awareness of how to meet the patients in acceptance, serenity, and interest and the use of communication tools. They are now highly conscious about looking at the patients carefully, signalling calmness and readiness to listen and help them.

Subtheme: Listen carefully and alarm signals and drug-related problems are detected.

Participants reported listening more actively and showing interest in what patients say rather than staying focused on what information to convey to patients because they are no longer hiding behind the computer screen, as illustrated by this quote:

"I have started taking a step to the side so that I don't hide behind the screen when I call up a patient to the counter. I look up at the patients as they approach me. I smile and ask what I can help them with today. Only when patients have told me what they need do I go back to the computer."

This change resulted in increased attention and focus on the patient and the factual words used, such as cues and body language. Participants reported they are discovering things they would not have detected before, either because they were afraid of making the situation unpleasant and upsetting for both parties or because they lacked the mindset and communication skills to do so, as illustrated by this quote:

"I listen actively for small cues, expressions and look for body language that could be alarm signals. Things that I would have missed before or maybe was 'afraid' to follow up on because I thought it might make a situation worse."

Participants admitted that they do not mentalise every single patient but are aware of the potential to do it when counselling patients who collect medications regularly. They described how they previously asked in all directions without knowing where to detect alarm signals or drug-related problems. Now they feel they are able to identify different kinds of alarms signs that are of importance to patients, as illustrated by the following quote:

"I don't mentalise all patients, not at all. But I do it with a lot, and my communication and counselling have changed considerably, especially with patients who are picking up a medication that they have picked up many times before. I catch some completely different alarm signals now."

Subtheme: From irritation to acceptance.

Participants demonstrated their ability to operationalise basic emotion acceptance in practice when counselling patients whom they had previously avoided. This skill provided them with a surplus of mental resources, allowing them to investigate patients' perspectives with serenity and interest instead of blaming them without compromising their own emotions. As a result, they experienced fewer 'bad counselling situations' because their dialogues with patients became more engaging. Patients were even grateful when they left the pharmacy. Participants were conscious of their previous counselling patterns and are now aware that patients often need support, as illustrated by this quote:

"Before, I used to get irritated at patients who didn't follow the doctor's and my instructions, so I wasn't in the frame of mind to have a professional mentalising dialogue. I have learned to accept most patients and meet them with acceptance and serenity, so it has become much easier for me to accept their choices even if they don't follow instructions. That means that I can have better dialogues with exactly those patients, and they are often the ones who need to be seen, listened to, and counselled. It makes for really

interesting dialogues when I meet them with acceptance and ask about their choices with genuine interest."

Subtheme: Makes work less stressful, and more interesting and fun.

Participants conveyed that work has become more interesting, fun, and less stressful. They experienced changes in their mindset and communication behaviour, which, from their perspective, helped them manage busy days and kept them from focusing on the waiting times on the computer screen. They felt prepared to meet patients and were less vulnerable:

"I feel that I know myself better and feel stronger in my interaction with the patients."

Participants reported that they gained insight and understanding of how they can better integrate their professional and pharmaceutical knowledge to benefit the patients. They described their work as more interesting:

"... more differentiated counselling encounters, you never know what the next patient may need ..."

They demonstrated a surplus of mental resources, wanting to test different ways of decoding patients' emotions and mental states and how to engage with the patients, as illustrated by this quote:

"I use it to make it much more fun for me to be at the counter – I challenge myself to become even better at reading the patients and having good dialogues. That gives me variation and great experiences. It is a success when the patients leave the pharmacy knowing more about themselves and their mediation."

Participants reported that they gained greater job satisfaction since they completed the mentalising education. They feel now more equipped to provide individual counselling based on their new mindset, active listening skills, and the ability to read patients' body language. Hence, their counselling is more individualised and relevant, leading to positive outcomes for both the patients and them. Participants described how this new approach helped them thrive at work more than before they completed mentalising education, as illustrated by this quote:

"I have become much better at hearing what my patients are actually saying and following up on the information they express verbally and non-verbally, which means I can give them the counselling they need here and now. It has also improved my job satisfaction because I feel that I have become better at counselling my patients at an individual level."

Results (quantitative data analysis)

Kirkpatrick Level 1

Table I displays participants' reactions to the educational programme measured by the CEQ. A total of 23 participants responded to the questionnaire distributed after the course. Of those, 48.8% agreed, and 39.1% strongly agreed that they were overall satisfied with the course. On average, the 'good teaching' and 'appropriate assessment' scales received the highest scores (means of 4.0 on a scale from 1 to 5), while the 'generic skills' scale scored the lowest (mean of 3.7 on a scale from 1 to 5).

Table I: Results of the Course Experience Questionnaire (CEQ)

	After the programme
Satisfaction with:	Mean (SD)
Good teaching	4.0 (0.47)
Clear goals and standards	3.6 (0.75)
Appropriate assessment	4.0 (0.45)
Appropriate workload	3.8 (0.43)
Generic skills	3.7 (0.49)
Overall evaluation	4.2 (0.79)
Overall, I was satisfied with the quality of the programme:	n (%)
Strongly disagree	0 (0%)
Disagree	1 (4.3%)
Neutral	2 (8.7%)
Agree	11 (47.8%)
Strongly agree	9 (39.1%)

SD – Standard deviation, n – number of participants choosing the response options. In total, 24 responded to the questionnaire except the overall satisfaction question where 23 responses were collected. Results are reported as means and standard deviation on the scale, ranging from 1=strongly disagree to 5=strongly agree; the overall satisfaction also is shown in numbers and percentage of participants choosing each response option.

Kirkpatrick level 4

Table II shows the results of the Job Satisfaction Measure questionnaire. In total, 24 participants responded to the questionnaire before and after the course. The average scores of all the subscales were relatively high already before the course, ranging from 3.7 for satisfaction with workload to 4.2 for satisfaction with professional support. Yet, the averages of all the scores, except overall satisfaction, increased after the course. Increases in satisfaction with payment, prospects, and standards of care were statistically significant.

Table II: Results of Job Satisfaction Measure (JSM) questionnaire

Satisfaction with:	Before the programme	After the programme	Significance of the difference
	Mean (SD)	Mean (SD)	t or z test (p-value)
Personal satisfaction	4.1 (0.40)	4.3 (0.49)	-1.911* (0.056)
Satisfaction with workload	3.7 (0.35)	3.8 (0.36)	-1.386 (0.179)
Satisfaction with professional support	4.2 (0.35)	4.2 (0.44)	-0.866 (0.395)
Satisfaction with training	4.0 (0.40)	4.2 (0.44)	-1.868* (0.062)
Satisfaction with pay	3.8 (0.41)	4.0 (0.34)	-2.346* (0.014)
Satisfaction with prospects	4.1 (0.39)	4.3 (0.47)	-2.034* (0.042)
Satisfaction with standards of care	4.0 (0.34)	4.3 (0.42)	-2.878* (0.004)

SD (Standard deviation), T (t – test, to compare difference in means for normally distributed data), Z (z test to compare difference in means for not normally distributed data). z tests marked with *, else t tests are reported.

In total, 24 participants responded to the questionnaire before and after the programme. Data are presented as means and standard deviation on the scale ranging from 1=very unsatisfied to 5= very satisfied.

Table III presents the results of the LEAS. In total, 23 participants completed the test before and after the educational programme. The mean of the 'LEAS SELF' subscale moved up by 0.5 (corresponding to an 18% increase). The 'LEAS OTHER' subscale score moved up by 0.7 points (corresponding to a 27% increase), and the 'LEAS TOTAL' scale increased by 0.4 points

(corresponding to a 13% increase). All differences between measurements taken before and after the educational programme were statistically significant ($p < 0.001$), demonstrating that participants increased their emotional awareness related to both self and others' mentalising.

Table III: Results of the Level of Emotional Awareness Scale (LEAS)

Subscales	Mean (SD)	Mean (SD)	t-test (p-value)
	Before the programme (N=23)	After the programme (N=23)	
LEAS SELF	2.6 (0.61)	3.1 (0.45)	-4.648 (<0.001)
LEAS OTHER	2.2 (0.55)	2.9 (0.43)	-5.337 (<0.001)
LEAS TOTAL	3.0 (0.47)	3.4 (0.48)	-3.720 (<0.001)

SD (Standard deviation), t-test (to compare difference in means for normally distributed data).

In total, 23 participants completed the test before and after the program. Data are presented as means and standard deviation on the LEAS scores calculated according to the coding manual for level of emotional awareness

Discussion

The aim of developing the mentalising educational programme was to increase participants' awareness of mental states and communication during pharmacy counselling to ultimately centre the interaction around the patients' perspectives.

Mentalising and mentalising communication to improve patient-centred counselling

The qualitative evaluation showed that the participants gained knowledge, understanding, and skills regarding the mentalising mindset and mentalising communication in pharmacy encounters. It also showed that participants changed their behaviour and applied a patient-centred counselling approach to desk meetings when they went

back to work. The results of the Level of Emotional Awareness Scale (LEAS) showed that participants' emotional awareness increased significantly, suggesting that after having attended the mentalising education programme, participants returned to their pharmacies to engage in patient-centred counselling (Wolters *et al.*, 2017). This result is paramount, as patient-centred counselling has been recommended as a way forward to deliver high-quality health care and as being essential to identifying drug-related problems (Wolters *et al.*, 2017; Langberg, Dyhr & Davidsen, 2019). The qualitative evaluation showed, among other things, that participants were surprised by how they were now able to identify alarm signals and drug-related problems, which they could not previously. However, studies in community pharmacy practice have described challenges in delivering patient-centred counselling

(Koster *et al.*, 2016; Guillaumie *et al.*, 2018; Fosgerau & Kaae, 2020). A possible reason is that the concept of patient-centred counselling is too abstract to apply to practice without a robust theoretical framework and practical training; such obstacles have also been identified in other professions (Zoffmann & Lauritzen, 2006; Husted *et al.*, 2014). The evaluation shows that developing a theory-driven educational programme – with a focus on establishing a mentalising mindset in combination with learning how to practice this mindset by using mentalising communication through practical and concrete communication training – seems to have paved the way for becoming actual patient-centred in counselling patients. The significant results of the LEAS complement the qualitative findings and show that participants had indeed increased their awareness of their own emotions and their ability to detect the emotions of others, corresponding to patients in a pharmacy counselling setting. The high post-educational LEAS scores indicate that participants are capable of experiencing and differentiating their own feelings from those of the patients and are also more capable of understanding patients' needs and experiences without being affected and disturbed by their own mental states, an ability that seems essential to perform patient-centred counselling. It is well-known that communication is a core and complex skill affected by attitudes, emotions, and knowledge (Silverman, Kurtz & Draper, 2013), which was accounted for in this educational programme.

Mentalising and mentalising communication to improve stress and high workload

The qualitative analysis showed that counselling was less stressful, more interesting, and more valuable, suggesting that a mentalising mindset and mentalising communication skills may be the key to reducing stress and burnout. This result can be further substantiated by studies demonstrating a correlation between aspects of emotional abilities such as emotional awareness and burnout. Hence, recent studies show that more than 60% of pharmacists experience high levels of burnout, with the community pharmacy workforce reporting one of the highest burnout rates among healthcare professionals (Balayssac *et al.*, 2017; Protano *et al.*, 2019; Padgett & Grantner, 2020). Psychologically-informed education programmes such as the mentalising programme in combination with advanced communication skills training seem to influence job satisfaction and make the interaction with patients more engaging and less stressful, as shown in the present study (Fosgerau *et al.*, 2022). This finding was supplemented by the job satisfaction quantitative results, which revealed that essential elements in job satisfaction significantly increased after participants

applied mentalising mindset and communication in their workplace; satisfaction with the standards of care was particularly affected. Thus, when participants used the acquired mentalising knowledge and mentalising communication skills, they achieved more interest in their daily work and probably developed more professional integrity and pride and felt that the care they provided to the patients was of higher quality. Another qualitative result supplementing positive changes in job satisfaction was that participants could reach out to patients whom they previously avoided. The ability to understand the meaning of other people's behaviours seems to promote one's experience of well-being, which may protect healthcare professionals from the impact of distressing events and positively affect their job satisfaction (Schwarzer *et al.*, 2023).

Finally, the results of the CEQ measurement showed that the vast majority of participants (87.9%) agreed or strongly agreed that they were satisfied with the educational programme, corroborating the findings of the qualitative evaluation, where participants showed engagement toward the mentalising educational programme (i.e., all completed the programme and submitted the written report) and reported that they found it relevant. Further, participants demonstrated that they could relate education to their daily work in community pharmacies, suggesting that the content and teaching accommodated the participants' level and learning needs.

Strengths and limitations

The strengths of this study lie in its mixed method design which enhances the validity of the findings, as the qualitative results can help interpret and distinguish the quantitative data (Creswell & Plano Clark, 2011). Additionally, only validated instruments, rigorously translated into Danish with good reliability, were used in this study.

This study has some limitations. The assessment of whether participants' communication has become more patient-centred relied on self-reported written reports rather than video recordings of pharmacy encounters or interviews with patients. However, the use of the LEAS, which measures mentalising capacities, supports the participants' self-reported improvement in abilities. Another limitation is that job satisfaction and mentalising abilities were assessed only before and after the programme; including a control group could have accounted for other factors that participants may have been exposed to during the period between measurements. For example, the increase in pay satisfaction reported by participants may have been influenced by bonuses given at the end of the year rather than solely by the programme.

Additionally, the participants increased satisfaction with their job (more engaging, fun, and less stressful) may have influenced their higher satisfaction with the pay; thus, finding their job meaningful may have affected their level of pay satisfaction.

Conclusion and practice implications

This study showed that this mentalising education programme designed for the pharmacy workforce in Denmark increased participants' awareness of relevant mental states and communication in community pharmacy settings, enabling them to put patients' perspectives as the centre of their interactions. The programme was theory-driven and rooted in the humanities; it adapted the mentalising framework and mentalising communication to the community pharmacy context. Combining this framework with pharmacy practice perspectives is a novel approach in pharmacy postgraduate courses. Both qualitative and quantitative results are promising and suggest the potential for the pharmacy workforce to offer actual patient-centred counselling at desk meetings while also preventing or reducing job-related stress and burnout. In Denmark, the programme is now available to the entire pharmacy workforce.

Conflict of interest

The authors declare no conflict of interest.

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