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From theory to practice: A critical review and meta-framework for operationalising person-centredness, therapeutic alliance and empathy in pharmacist-led mental health consultations

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ABSTRACT

Despite their expanding patient-facing roles and increased involvement in mental health services, pharmacists' interactions with clients remain largely medicines-focused. This limitation is compounded by a reported lack of pharmacists' confidence and inadequate training in both mental health conditions and communication skills.

The interrelated concepts of person-centredness, therapeutic alliance, and empathy play a pivotal role in effective mental health consultations, positive client outcomes, and high-quality care delivery. Grounded in the interpretivist and pragmaticist paradigms, this critical review of the literature enabled the development of a meta-framework that unifies this triad. The resulting model conceptualises person-centredness across three interconnected levels: the Consultation (analogous to the therapeutic alliance), the Systems (focusing on multidisciplinary collaboration and leadership), and the Intrapersonal (encompassing the practitioner's intellectual, practical, and phenomenological attributes). Functioning as an integral, unifying component across the entire model, empathy is detailed as a three-stage process at the Consultation level between pharmacist and client, involving exploration, shared understanding, and optional therapeutic action.

Presented both as a conceptual model and comprehensive series of targeted recommendations, this work provides timely guidance, enabling pharmacists to deliver high-quality, holistic, and meaningful mental health care, with the aim of improving client outcomes and fostering effective interprofessional working relationships.

1. Introduction

Common mental health conditions, such as anxiety and depression, continue to show increasing global prevalence,[1,2] while simultaneously constituting a significant proportion of clinical encounters within primary care.[3] The contemporary management of these conditions is an increasingly multiprofessional endeavour, encompassing a range of practitioners delivering a variety of treatments and interventions.[4] Multidisciplinary teams are progressively incorporating pharmacists,[5] who are assuming advanced levels of practice and leadership positions, including at a consultant level.[6,7]

Despite guidelines positioning psychotropic medication as a secondary modality to non-pharmacological evidence-based treatment options,[4] antidepressants remain the dominant treatment in the management of common mental health problems.[1,8] Although antidepressants are widely regarded as efficacious in the treatment of depression and anxiety disorders, their real-world effectiveness has been a persistent point of contention since their adoption in clinical practice.[9–12] Indeed, a growing body of literature suggests that the observed therapeutic effects of antidepressants are primarily a consequence of non-specific (non-pharmacological) factors.[13–15] Scholarly efforts have been made to identify, classify and measure these effects, with mounting evidence for the critical importance of the practitioner-patient interaction.[9,16] These factors are exemplified by the clinician's capacity to provide person-centred care, foster a strong therapeutic alliance, and display empathy during consultations. This enquiry focuses specifically on these three core constructs, hereafter referred to as the triad.

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1.1. Person-centredness

The World Health Organization (WHO) identifies person-centred care as a fundamental tenet of healthcare provision.[17] It has been defined as: "*care approaches and practices that see the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health.*"[18] Several other definitions and descriptions exist, many of which incorporate notions such as personalised care, patient choice, shared decision-making, respect and dignity, compassionate and empathic care, enablement, and coordination of care, among others.[19,20] Within the United Kingdom (UK), this principle is enshrined as a core tenet of the National Health Service (NHS) Constitution.[21]

Rather than being merely an aspirational concept, person-centred care has been empirically associated with a multitude of positive outcomes from a variety of healthcare contexts and disciplines, such as improved emotional wellbeing; patient enablement and satisfaction; and specific clinical results including reductions in HbA1c, low-density lipoprotein, and systolic blood pressure as well as reduced readmission rates and improved medication adherence.[22–27]

1.2. Therapeutic alliance

The second concept under review, therapeutic alliance (also termed working alliance) constitutes the fundamental collaborative relational dynamic between a clinician (or therapist) and a patient (or client).[28] Indeed, it has been asserted that *"the alliance is the 'language' of mental health care"*.[28]

While originally a concept within the field of psychonanalysis,[29] its value in healthcare has been long established.[30] Numerous studies have reported associated positive outcomes, including clinical improvement, reduced duration of hospitalisation and rates of re-hospitalisation, and enhanced patient satisfaction[31]; as well as improved adherence to medication regimens.[32,33] Conversely, a compromised alliance has been linked to diminished therapeutic outcomes, including greater mental health symptom severity, increased involuntary psychiatric hospital admissions and violent behaviour during admission.[34,35]

1.3. Empathy

The final concept within the triad, empathy, originates etymologically from the German term *Einfühlung* ("to feel into"). This term was first articulated in 1873 by the art historian and philosopher Robert Vischer and subsequently translated into English as "empathy" by E.L. Hinman.[36]

The Cambridge Dictionary defines empathy as *"the ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation"*.[37] Another conceptualisation describes it as: *"A process for understanding an individual's subjective experience by vicariously sharing that experience while maintaining an observant's stance"*.[38] Although scholars vary in their conceptualisations and delineations of empathy within healthcare encounters (e.g., clinical empathy,[39,40] therapeutic empathy[36]), for the purposes of this discussion, empathy will be considered in its original, comprehensive sense, highlighting the central role of immediate lived experiences including emotions and affects in conjunction with the more widely endorsed cognitive-imaginative processes within healthcare encounters.

Empathy constitutes a central ethical and relational element in modern healthcare, underpinning compassionate and effective patient interactions.[41] A 2018 systematic review and meta-analysis of randomised controlled trials reported that heightened practitioner empathy and/or the conveyance of positive messages can yield patient benefits across a spectrum of clinical conditions.[42] Practitioner empathy in consultations is not only highly valued by patients,[43,44] but the provision of compassionate care has been associated with improved treatment adherence, greater patient satisfaction and well-being, as well as elevated levels of professional fulfilment, reduced rates of depression and a lower incidence of burnout among physicians.[45]

Empirical research has demonstrated a positive correlation between high-quality communication incorporating empathetic dialog and enhanced patient satisfaction, comprehension, self-management capabilities, and improved clinical outcomes, including adherence to treatment regimens.[46–50] A 2013 systematic review affirmed the unequivocal significance of empathic communication within general practice.[51] Within mental health, empathy has been identified as an instrumental component of care,[52] and further endorsed by the National Institute for Health and Care Excellence (NICE).[53]

1.4. Mental health pharmacy practice

Pharmacists are increasingly involved in patient-facing activities, including a range of mental health interventions that can benefit service-users.[54] Globally, typical pharmacist contributions encompass promoting mental wellbeing and preventing mental ill health, collaborating with specialist teams on issues such as substance misuse, and reconciling, dispensing, reviewing and optimising medications, as well as prescribing psychotropics in countries such as New Zealand, Canada and some jurisdictions of the United States.[54–67] Within the UK, pharmacists' expanding prescribing responsibilities,[68–70] coupled with impending changes within general practice and recent advancements in community pharmacy services to focus on the safe and appropriate use of antidepressants mean that the profession is assuming a progressively greater role in the management of common mental health conditions.[71,72]

Despite this evolution toward more clinical, patient-facing roles, research evidence indicates that pharmacist-client interactions have largely remained centred on the provision of medicines-related advice (commonly termed "patient counselling").[73,74] This conversational focus is further reflected in the continued dominance of traditional paternalistic communication styles, characterised by a passive patient role and active pharmacist control over information flow and decision-making processes.[75] A prevalent argument, particularly in the UK, is that patient counselling is a procedural, product-oriented (i.e., medicines-focused) practice that is incongruent with contemporary person-centred approaches.[76–78]

While the reasons for the persistence of this outmoded practice are not entirely clear, several studies have shown that pharmacists frequently find consultations with individuals taking psychotropic medications to be challenging. Pharmacists globally report a lack of confidence and discomfort during mental health consultations, along with inadequate training in mental health conditions and psychotropic medications, and limited awareness of non-pharmacological treatment options.[79–85] Moreover, emerging evidence highlights insufficient communication skills training during pharmacy education, further compounding these difficulties.[86]

While a prominent topic in pharmacy practice and education, person-centredness remains an ill-defined and abstract concept, as reported by recent pharmacy graduates in a 2020 Australian study.[78] Furthermore, a notable lack of empathy has been observed in the patient care provided by pharmacists,[76,87,88] with one study identifying work fatigue as a significant contributing factor.[87]

1.5. Review aims

Addressing these demonstrable deficits, therefore, is essential to ensure pharmacists effectively meet the relational demands of complex mental health care encounters. A comprehensive understanding of how the conceptual triad can be applied in everyday practice is crucial for preparing pharmacists across all settings for effective mental health consultations and high-quality care delivery.

To fulfil this need, this review synthesises and delineates the core concepts of the triad, whilst providing a series of evidence-informed recommendations to answer the following research questions:

1. What are the core attributes and the nature of interrelationships of person-centredness, therapeutic alliance, and empathy in the context of mental health care delivery?
2. How can these attributes be operationalised by pharmacists to improve the quality of their consultations with individuals managing common mental health conditions?

Throughout this review the terms "service-users" and "clients" will be used in preference to "patients", to align with contemporary recovery-oriented mental health service models and to emphasise client agency. In this context, "practitioner" and "clinician" are used interchangeably to denote pharmacists across a variety of settings.

2. Methods

This work is a component of a broader project that aims to synthesise evidence against a meta-framework that unifies the triad of person-centredness, therapeutic alliance, and empathy in the context of pharmacist-led mental health consultations (PROSPERO: CRD42025100073). In this paper, we present the development and final structure of this meta-framework as higher-order themes (levels, domains and dimensions) along with a series of focused practical recommendations within these, targeted specifically at pharmacists.

The meta-framework was constructed via a rigorous Critical Interpretive Synthesis (CIS) methodology,[89] with close links to the Framework Identification step outlined in the Cochrane-Campbell Handbook for Qualitative Evidence Synthesis.[90] While the latter specifically advocates for the adoption of a systematic approach to identifying components for a *de novo* organising system (i.e., (meta-)framework, model, or theory) for a subsequent framework synthesis, preliminary enquiries indicated this strategy was suboptimal. This was due to the conceptual complexity of the subject matter, characterised by a lack of universally accepted definitions and terminologies, a vast number of proposed frameworks for each individual concept, and the absence of a unified framework encompassing all three in the context of mental health care delivery.

Therefore, a critical review of the literature was conducted, grounded in an interpretivist (i.e., focused on subjective meanings and social realities) and pragmaticist (i.e., aiming to provide practical solutions to research problems) philosophical stance, to identify a series of themes and subthemes as constituents of the meta-framework.

As delineated by Saunders and Rojon (2011),[91] critical reviews have nine fundamental attributes. Of these, the first principle is of critical importance, as it prioritises relevance over comprehensiveness, thus advocating for a broad, iterative literature search across numerous disciplines and contexts - a key distinction from traditional systematic reviews. This approach is also consistent with the view that a strictly systematic methodology is not suitable for qualitative enquiry, given the considerable epistemological challenges inherent in human sciences, particularly in contexts characterised by high conceptual complexity.[92]

2.1. Search strategy

Consequently, instead of a wholly systematic search, a hybrid approach to identifying the most relevant literature was adopted. This is supported by the work of Depraetere and colleagues (2020),[89] who specifically advocate for a broad searching strategy in addition to a more structured approach.

Our initial systematic search included three databases - APA PsycInfo (EBSCO), MEDLINE (EBSCO), and CINAHL Ultimate (EBSCO) - employing the following combined search terms: *"therapeutic alliance OR working alliance" AND "empathy" AND "patient cent* OR person cent*" AND "model OR framework OR theory"*. The selected relevant publications from this search were analysed by the primary author to identify key authors, core theories, seminal works, and core terminology thus serving as the foundation for a subsequent, extensive, iterative and purposive non-systematic search designed to facilitate a broader enquiry, following the principles of the CIS methodology.[89]

This second phase employed snowball sampling techniques (forward and backward citation tracking, author searches), supplemented by searches using Google Scholar and Research Rabbit, and a targeted review of the grey literature, with a primary objective of identifying seminal works pertinent to each individual construct or combinations thereof as well as their emerging constituent and related concepts.

2.2. Eligibility criteria and study selection

The selection criteria were kept flexible based on the relevance of the findings to the conceptual triad and its evolving constituent subthemes, as well as their direct applicability to the context of pharmacist-led mental health consultations.

The literature search was intentionally broad and was not restricted by methodology or disciplines, publication date or geographical location. Further, no studies were excluded on grounds of methodological quality, thus enabling consideration of a multitude of publications for integration, *"since papers considered to be methodologically weak may still provide relevant insights regarding the emerging theoretical framework"*.[89]

The primary author's background as a mental health pharmacist provided a theoretical and practical context that informed decisions on relevance and applicability, thereby guiding the conceptualisation and proposed operationalisation of the constructs under review. In addition, as recommended by Depraetere et al. (2020),[89] reflexivity constituted a central element of this process, incorporating considerations of the evolving mental health services landscape and the increasing professional skill mix. To understand and mitigate potential biases, a multidisciplinary team of researchers, which included - in addition to the primary author - two social scientists and an academic pharmacist, and clinicians from diverse backgrounds including psychiatry and psychology, alongside public contributors, was actively engaged throughout the process. The five public contributors were lay members of the public, representing diverse ages and ethnicities, with knowledge of common mental health conditions and/or experience of pharmacist consultations in the UK. Their inclusion was vital for incorporating service-user views and carers' perspectives, thereby enhancing the applicability and translatability of the research findings.

2.3. Framework assembly: thematic extraction, concept mapping and the critical interpretive process

The inclusion of relevant papers in the critical review facilitated the identification and extraction of themes. Thematic extraction and conceptual mapping were conducted by the primary author following an iterative process. Data were inductively coded to identify themes and subthemes related to three specific areas: operational or theoretical definitions, reported and/or measurable competencies/skills, and the practical application or implementation of the constructs. This thematic data was then mapped iteratively by the primary author, using constant comparison, to build the framework's hierarchical structure and serve as fundamental building blocks of the emerging meta-framework. The primary author was supported by the experienced supervisory team throughout this process with the aim to create a comprehensive model that is not purely theoretical but readily translatable to practice. Instead of offering generic principles to guide the application of the triad, we aimed to delineate conceptual definitions, detailed breakdowns of intricate ideas, and specific targeted recommendations to enhance applicability for pharmacists working across various mental health settings.

The iterative synthesis process occurred concurrently with the literature search. The search continued until inductive conceptual saturation was achieved,[89,93] signifying that no new concepts relevant to the framework's structure could be identified. Higher-order themes were refined, debated and represented diagrammatically with the assistance

of the public contributors. Subthemes were derived directly from the coded data on operational/theoretical definitions and practical application, and subsequently these were translated into the final pragmatic recommendations in consultation with the multidisciplinary team.

Throughout this process - informed by our own clinical practice and personal lived experiences, and with the help of clinicians and public contributors - we reflected on the evolution of Western mental health care across past centuries to fully appreciate and incorporate the many concurrent paradigms through which multicultural societies view wellbeing and mental illness. Postmodern philosophies and notions such as power dynamics – specifically within clinical and mental health encounters - are increasingly being recognised as instrumental,[94,95] and were therefore critically considered throughout the project. Our interpretive stance was informed by a commitment to modern humanistic value systems and an unrelenting pursuit of idealistic service provision, based on the fundamental values of human dignity, equity, personal autonomy, and relational support. This philosophical alignment with the UK's NHS and the recovery-oriented mental health movement is fully endorsed within this work.

3. Findings

3.1. Full texts included

The systematic search component yielded a total of 201 papers prior to de-duplication, from which an initial corpus of 13 relevant publications was identified. Following this, the iterative non-systematic search yielded an additional 192 included full texts. The final corpus of n = 205 publications was used in the assembly of the meta-framework including the focused recommendations (a list of all 205 full texts included in the analysis is available in Appendix 1; also see Prisma flow chart in Fig. 1).

The iterative search strategy facilitated the inclusion of studies representing heterogeneous clinical contexts (e.g., oncology, palliative care, nursing, psychiatry, psychology and psychotherapy) alongside diverse healthcare environments such as general practice, community pharmacy and hospital settings. Consistent with the principles of CIS,[89] the search encompassed both primary research and evidence synthesis methodologies, as well as theoretical works, relevant textbooks, guidance, and policy documents. The included texts covered a range of participant ages and clinical conditions, numerous treatment modalities, differing research fields and methodological approaches, and a spectrum of perspectives on illness and the broader human experience.

3.2. The meta-framework

In the following sections we present the topology of the triad within the meta-framework and provide pragmatic recommendations for pharmacists to support the operationalisation of these in the context of mental health service provision.

3.2.1. Person-centredness

Drawing on numerous previous conceptualisations and related literature, person-centredness is presented as a broad concept operating across three distinct yet interconnected levels within the meta-framework: the Consultation, the Systems, and the Intrapersonal. Therapeutic alliance is analogous to person-centredness at the Consultation level, while empathy holds a central foundational role within the model. A diagrammatic representation of the conceptual model is provided in Fig. 2.

The subsequent discussion will explore the overarching concept of person-centredness across its three interconnected levels, which are further delineated into distinct domains. Due to the close interrelationship among the constituting domains, some recommendations may have relevance to more than one; however, for the sake of clarity, each recommendation is listed only once, assigned to the domain where it held the greatest relevance.

3.2.1.1. Person-centredness at the Consultation level (therapeutic alliance). Person-centredness at this level is conceptualised as the therapeutic alliance formed between the practitioner (pharmacist) and the client. This established tripartite framework of the alliance was used to code and map relevant findings from the critical review and organise

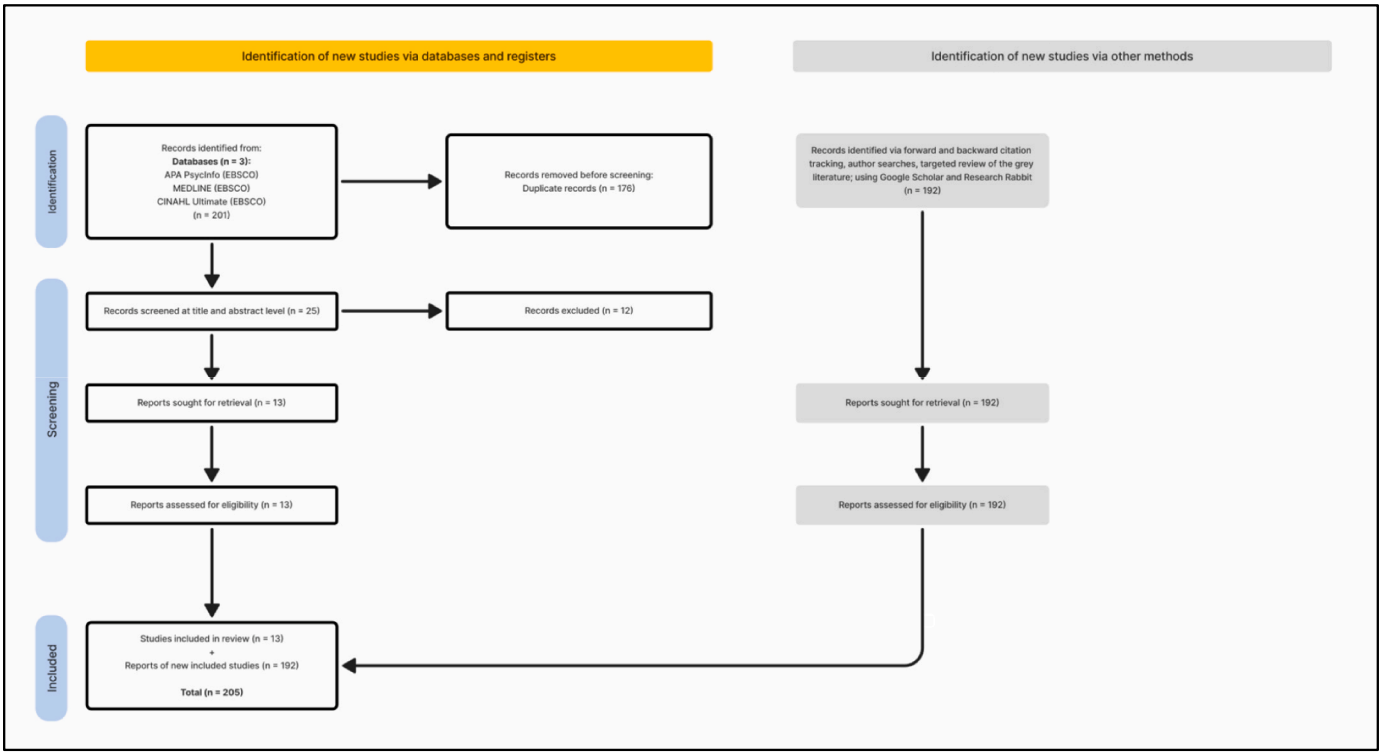

Fig. 1. Prisma flow chart.[96].

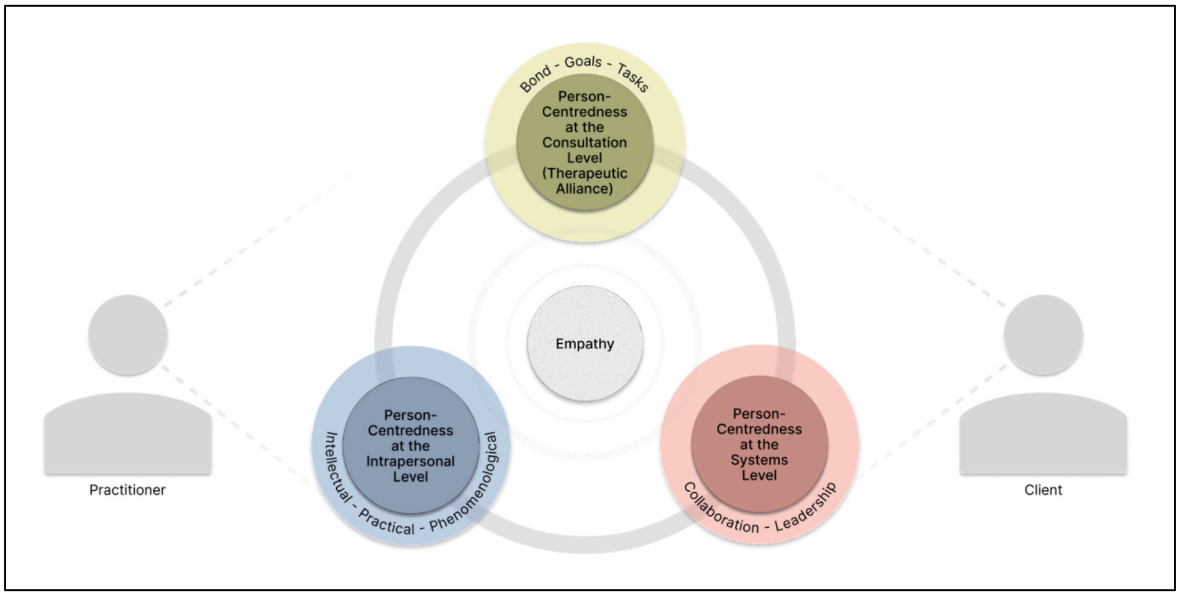

Fig. 2. The unified model of Person-Centredness, Therapeutic Alliance and Empathy in the context of mental health consultations.

them into subthemes (dimensions), which represent distinct areas of the alliance that may be relevant to pharmacists depending on their individual role and remit.

The three domains of the therapeutic alliance (Bond, Goals, and Tasks) are detailed in Tables 1–3. Each domain is enumerated into distinct yet interrelated dimensions, presented alongside their conceptual definitions and pragmatic recommendations for pharmacy practice.

3.2.1.2. Person-centredness at the Systems level. The second level of the framework is explicated as the Systems level, encompassing the intricate relationships and collaborative networks among various professionals (e.g., pharmacists, GPs, psychiatrists, mental health nurses) and organisations (e.g., secondary mental health services, social care, and the voluntary, community, and social enterprise (VCSE) sector) involved in care delivery. These networks may provide direct input into client care (both on a routine and an ad-hoc basis - such as during crisis interventions), support to their families and caregivers, and/or deliver advice, guidance, and professional support to the practitioner.

At this level, person-centredness also extends to the domain of Leadership. Recommendations listed here are expected to be of particular benefit to those in operational and strategic positions. As this area is not the primary focus of the present work, it will be addressed only briefly. The domains and respective recommendations for this level are presented in Table 4.

3.2.1.3. Person-centredness at the Intrapersonal level. The third and final area of person-centredness operates at the Intrapersonal level, that is, residing within individual practitioners. This dimension represents a synthesis of a practitioner's cumulative academic knowledge, professional experiences, requisite skills, foundational beliefs, and immanent core values. Collectively, these professional attributes together with relevant personal insights, facilitate the delivery of person-centred care and constitute a realm of ongoing professional and personal development. We categorised Intrapersonal person-centredness into three overlapping domains: Intellectual (knowledge), Practical (skills and behaviours), and Phenomenological (lived experiences; emotions, intuitions, attitudes, values and meaning-making). These domains along with their respective recommendations for targeted reflection, development and learning, are presented in Table 5.

3.2.2. Empathy

The final component of the conceptual triad, empathy, serves an integral, unifying function, effectively binding the entire model. Empathy occupies a central role with significant influence across all three levels of person-centredness. Given its complex, multifaceted nature, the present work will focus exclusively on empathy at the consultation level to support its enactment within the pharmacist-client dyad.

3.2.2.1. Empathy at the Consultation level. Drawing upon several seminal works, we propose the following three-stage temporal framework as a valuable heuristic for pharmacists operationalising empathy within consultations.

3.2.2.1.1. Stage 1: exploration. Empathy in healthcare encounters begins as a process of profound interpersonal engagement aimed at comprehending the service-user's unique perspective.[19,97,108,143,145,156] Maintaining an open mind and cultivating an attitude of "engaged curiosity" can be particularly beneficial, especially when the clinician lacks direct personal experience with the situation under discussion.[41,97,108,138,147]

Within this initial exploratory stage, scholarly literature often distinguishes between the cognitive and affective components of empathic understanding.[41,76,99,147,259] Cognitive empathy entails employing skills such as reasoning, imagination, theory of mind ("mindreading"), mentalisation (i.e., recognising mental states in others), and perspective-taking to establish understanding.[19,36,41,114,119,259–261] The role of perspective-taking, in particular, is reported to be critically important, as substantiated by both patient narratives and expert feedback,[262,263] and as such, encouraging the articulation of the service--user's perspective during this stage can be facilitative.[76,114,147,259] Fundamentally, however, one must acknowledge that this entire process is equally contingent upon the client's comfort and willingness to openly share their experiences, which is, in turn, typically predicated on the prior establishment of a trusting relationship.

In addition to the cognitive aspects, the phenomenological (i.e., deep first-person experiential) dimension and accompanying affects of the client can offer critical insights during this process, fostering a deeper understanding whilst also serving to strengthen the therapeutic bond.[41,99,244] The affective component of empathy requires practitioners not simply to characterise (and in certain cases, label) clients' emotions but also to explore their complexity and impact on the whole person.[41,255] Attentiveness to both verbal and non-verbal cues

Table 1
The Bond domain of therapeutic alliance.

DIMENSION NAME	DESCRIPTION	RECOMMENDATIONS
Foundational Relational Postures	This dimension is defined by the underlying characteristics and attitudes essential for the operational structure and long-term viability of the relationship.	1. Create and maintain supportive relationships (bond) with clients,[21,53,97–106] built on the following characteristics: • Connectedness, reciprocity and partnership[107]; • Mutual respect,[97,99,102,105,108–110] authenticity,[103,111] congruence,[103,111] trust,[97,102,110,112–116] honesty and transparency,[97,99,117] accountability[99,104]; • Tolerance (non-discriminatory and non-judgmental attitudes and behaviours)[99,102,104,109,110]; • Practitioner's clinical competence and professional conduct[106,118]; 2. Discuss appropriate limits of confidentiality and circumstances of need to breach this (e.g., when risks to others are identified).[53] 3. Leverage the *alliance capacity*[29,112] [the inherent ability of a service-user and/or a practitioner to engage in, develop, and maintain a therapeutic alliance throughout the course of their consultation relationship]; continuously monitor and skilfully manage emergent *alliance ruptures*[103,112,119] [episodes of deterioration or strain in the quality of the working relationship]. 4. Actively solicit feedback on care delivery,[103,115,120–122] using this feedback to further reinforce the dyadic bond.
Affective and Relational Engagement	This is the dimension of skilled human interaction, combining the foundational concepts of emotional intelligence (EI) and the process of rapport-building. (Note that although empathy is considered a key constituent of EI, due to its foundational role within mental health consultations, it will be discussed in a later dedicated section).	**Emotional Intelligence: Self-focus** 5. Undertake internal self-assessment ("housekeeping") for psychological preparedness and physiological wellbeing before and after each consultation (i.e., mentally separating from the previous interaction to ensure optimal focus and emotional availability for the next, ensure not hungry, thirsty, or physically uncomfortable, etc.].[45,117,123,124] 6. Undertake introspective examination of own motivations.[125] 7. Consciously acknowledge and resolve any unintentional negative attitudes or biases held toward the client.[103,114] 8. Display warmth,[109,112,114,118,126] approachability,[127,128] courtesy,[99,129,130] humility,[131] friendliness,[127,129] and an optimistic disposition[99]; a caring attitude, compassion, and willingness to help.[29,99,112,115,117,126] Specifically, warmth and focused attention towards the end of a consultation while avoiding excessive optimism at the start may be beneficial.[130,132] 9. Continuously exercise self-awareness, self-monitoring and self-calibration.[99,114,133–135] 10. Act with authenticity whilst exercising judicious use of self-disclosure.[99,103,109,120,136,137] 11. Be open to adapting relational approach towards client[109,134,138,139] (e.g., by actively bridging perceived social distance[114,134,138–140]). **Emotional Intelligence: Other-focus** 12. Provide a psychological safe haven for and during each encounter.[141,142] 13. Maintain mindful presence and focused attention on client.[111,114] 14. Aim to adopt an *unconditional positive regard* [a non-judgmental stance of complete acceptance and support] toward client[103,143–145] and promote an environment of acceptance and understanding[99,102,109,112,127]; and dignity.[97,110,146,147] 15. Recognise, and respond appropriately to client's emotional states, and contain emergent negative affect (e.g., distress), employing affective regulation skills.[148] 16. Provide affirmations where appropriate [an affirmation is a statement recognising the client's efforts, strengths, or positive coping strategies, which validates their experience and encourages continued engagement].[103] 17. Continually anticipate affective responses (e.g., distress, disagreement) whilst ensuring readiness and psychological availability to address these.[149] 18. Recognise and resolve unhelpful or inappropriate transference and countertransference dynamics [Transference refers to the client's unconscious redirection of feelings from a past relationship onto the practitioner, while countertransference is the pharmacist's equivalent emotional response to the client, both of which can impair objectivity and the therapeutic process].[103] 19. Show willingness to adapt therapeutic approaches as needed.[29,150] 20. Foster active engagement and participation in client.[53,97,99,104,114,121,127,138,150,151] 21. Navigate sensitive information, conflict and complexity appropriately (e.g., vulnerabilities and safeguarding concerns, implicit communication impairments)[53,114,122,152–154] and psychological barriers (e.g., self-stigma, shame, preoccupations).[114,149,155] **Rapport-Building** 22. Initiate all interactions with a welcoming greeting,[108] introduce yourself by name.[156] 23. Employ active listening techniques throughout.[99,102,108,114,116,118,128,138,147,157] 24. Display pro-social behaviours through non-verbal communication; adopt appropriate body language with coordinated movements,[118,156,158] whilst considering the following[114,132,156,158–160]: • Mirroring body language; • Displaying mood-congruent gestures [mood-congruent gestures ensure that the pharmacist's non-verbal communication (e.g., facial expressions, tone, and movements) is aligned with the emotional content and therapeutic intent of the

(*continued on next page*)

Table 1 (*continued*)

DIMENSION NAME	DESCRIPTION	RECOMMENDATIONS
		interaction (e.g., displaying calmness during anxiety discussion or empathy when discussing distress)]; • Adopting a slight forward lean with direct body orientation towards the service-user; • Sitting with uncrossed legs and symmetrically uncrossed arms; • Making moderate amounts of less extensive eye contact; • Avoidance distracting movements such as fidgeting. 25. Aim for congruence[115] within the practitioner-client dyad during consultations; consider established ways of communicating agreement/approval[114,130,132,136,155,159]: • Validating (e.g., "It makes sense that you're feeling overwhelmed right now.") • Normalising (e.g., "Many people report similar anxieties when starting a new medication.") • Legitimation (e.g., "It's entirely justified to feel anger in response to being spoken like that.") • Backchanneling (nodding, or saying "Uh-huh", "I see") 26. Engage in social conversation (e.g., casual remarks, compliments and humour) judiciously.[130,132,138]
Deep Contextual and Humanistic Enquiry	This dimension focuses entirely on the content of exploration within the dyad: the rich lifeworld of the client, made up of specific biopsychosocial elements, beliefs, values, and other relevant personal and interpersonal aspects.	27. Invest dedicated time to understand the whole person.[53,97–99,138,151,161] Some salient client factors may include: • Individual and sociocultural identities[162] and affiliation needs[28]; • Lived experiences, opinions and relevant personal traits and attributes[120,151,161,163,164]; • Core values and deeply-held beliefs[114,165]; • Motivations[28,155] and aspirations[166]; • Socioeconomic context, including resources[28,114]; • Health beliefs and illness representations[98,108,114,127,162]; • Functional and social impact of symptoms; perceived locus of control[127,167]; • Ascribed meaning [the client's personal interpretation of their illness],[114,168] attributed teleology [the client's interpretation of the purpose of their condition][144] and aetiology [client's belief regarding the cause of their illness] of and own perspectives on condition[114]; • Attachment history and style [Bowlby's seminal attachment theory posits that individuals' early interactions with their primary caregivers shape their expectations of closeness, safety, and trust in later relationships].[28,103,168] 28. Employ a dynamic, dialogical approach for exploration and shared (intersubjective) meaning-making.[169] 29. Utilise psychotherapeutic inferential methods to guide appropriate timing and focus of exploration (e.g., observed affect, transference re-enactments [e.g., the pharmacist adopting a role that mirrors a significant figure from the client's past]).[168,170–172]
Instrumental Communication Skills	This dimension focuses purely on the technical-procedural skills necessary for clarity and eliminating errors in communication.	30. Proactively invite questions throughout the consultation.[99,108] 31. When asking questions, recognise that while open-ended questions are generally preferred, some clients may find these ambiguous and confusing.[122] 32. Use specific question types judiciously[76,105,114,152,157]: • Non-directive (e.g., "What would you like to discuss today?"); • Clarifying (e.g., "Could you tell me more about what you mean by 'feeling off'?"); • Probing (e.g., "And what did you do after you noticed your heart racing?"). 33. Continually review the client's information needs, receptiveness and knowledge deficits before imparting information.[53,99,104,108,114,121,122,147,149,152,153,158,173] 34. Continuously assess the client's comprehension, and consider the use of specific techniques, such as summarising, repetition, paraphrasing, chunking-and-checking, and the teach-back method, together with the provision supplementary written material to further aid their understanding.[53,99,105,108,114,127,130,138,153,174] 35. Communicate clearly all synthesised, complex information, adapting the message to the client, whilst addressing misinformation tactfully.[99,114,122,138] 36. Identify and repair communication breakdowns (self-repair, other-repair).[158,175] 37. Consider employing specific Communication Accommodation Theory (CAT) strategies: • Approximation [modifying one's speech (e.g., accent, rate, pitch, vocabulary) to become more similar (convergence) or more different (divergence) from the communication partner]; • Discourse management [careful selection of topics, the amount of talk, and the smooth sequencing of the conversation to ensure effective exchange and responsiveness to the partner's input]; • Turn-taking [managing the initiation, duration, and termination of speaking turns, using cues to signal when a listener should begin or when a speaker intends to continue, minimising awkward overlaps or silence]; • Face-maintenance [employing verbal and non-verbal behaviours to uphold one's own sense of dignity and self-esteem (self-face) and protect the positive image and reputation of the communication partner (other-face)]; and • Strategic emotional expression [the conscious regulation, suppression, or display of emotions to achieve a specific communicative goal, such as fostering trust, conveying empathy, or maintaining professional distance].[176]

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Table 1 (*continued*)

DIMENSION NAME	DESCRIPTION	RECOMMENDATIONS
Conducive Physical Context	This is the dimension of the external, physical setting necessary for a safe and focused consultation.	38. Cultivate a conducive therapeutic environment (safe, calm, private, confidential physical space) and carefully consider the appropriateness of others' attendance.[53,110,114,151] 39. Minimise interruptions and distracting environmental stimuli.[114,151,177] 40. Ensure functional technology and minimise reliance on devices during the consultation.[156,178] 41. Maintain effective time-keeping and manage task-related time appropriately (preparation, note-taking, documentation).[114,151,179–181]

indicating emotion and unspoken concerns can be as - if not more - significant than explicitly encouraging emotional expression verbally.[111,114,138,156–158,264,265]

Building upon this, McEvoy and colleagues (2012)[266] emphasise the unique importance of attending to service-users' ambivalent feelings, emotional dissonance (i.e., conflicting feelings), and unresolved internal conflicts through their concept of "empathic curiosity". They posit that the judicious interrogation of non-verbal disruptions in the client's flow of thinking, using curious questioning and encouraging verbalisation of thought processes, can facilitate a deeper investigation of previously unarticulated root problems. The authors do caution, however, that such in-depth exploration may also yield unintended consequences, such as excessive self-critical reflection and emotional distress, necessitating that clinicians possess the skills to promptly terminate the process and effectively redirect the focus to the present moment.

Cultivating an "empathic concern" towards the client, with a consistent compassionate approach (driven by the clinician's intrinsic motivation to enhance the service-user's wellbeing), further underpins this entire exploratory stage.[267]

Furthermore, the affective component of empathy specifically demands an openness on the part of the clinician to *experiencing* shared emotions.[19,36,41,244,267] This capacity can cultivate a strong emotional connection, which can function as a therapeutic agent in its own right.[124] Such a bond may be particularly valuable for individuals experiencing common mental health conditions, given their frequently reported sense of isolation and disconnectedness.[116]

During this process, self-calibration on the part of the practitioner is vital, specifically in the avoidance of over-identification with the client's emotional experiences. This is attained through the maintenance of appropriate professional boundaries and the application of affective regulation skills.[19,36,41,119,156,267]

Lastly, allocating sufficient time for this exploratory stage is imperative. The clinician must maintain a personal presence throughout and refrain from interrupting the service-user.[97,108,111,114,118,156] Premature progression to subsequent stages, such as venturing to validate a client's experiences too early, may be perceived as insincere or patronising, thus potentially proving counterproductive.[114]

A related point to consider here is the term "clinical empathy", which was introduced to distinguish between the professional's subjective experience of the service-user's emotions and the explicit acknowledgment of those feelings *without* sharing in this emotional experience.[39] This distinction demarcates the boundary between the aforementioned cognitive and affective components of empathy, effectively excluding the latter from the clinical setting. Proponents of pure clinical empathy in healthcare advocate for the communication of an understanding or appreciation of the person's experience, together with a clear motivation to provide assistance, over affective movements such as vicariously experiencing clients' emotions.[267–270] While they contend that excessive emotional empathy contributes to burnout and compassion fatigue,[267] this claim has been subject to numerous counterarguments.[271–274] Consequently, our model views the affective component as a vital element of effective and meaningful patient encounters.

3.2.2.1.2. Stage 2: shared understanding. The second stage of empathy in our model begins with the clinician's communication of their initial understanding of the client's perspective and experiences back to the service-user.[19,36,41,97,104,127,143,264] Naturally, effective communication is a prerequisite for empathic encounters and directly influences the quality of the therapeutic relationship.[212] Research indicates that the timing of the practitioner's conveyance of this understanding is critical, requiring attentiveness to empathic opportunities signalled by the client through both direct and indirect conversational cues.[29,102,265] Effective communication of understanding relies on the clinician's capacity for emotional responsiveness,[29,102,244,265] with declarative questions (e.g., "That must have been quite worrying for you?") proving particularly useful in some scenarios.[275] Articulating the emotional dimension of understanding is particularly salient for establishing "affective resonance" with the individual; beyond verbal communication, this may also take the form of simple non-verbal cues, such as furrowing the brows.[276]

Following the clinician's indication of an initial understanding, an opportunity for refining this understanding through reciprocal communication commonly arises. Service-users reportedly value reflective communication that signals comprehension and provides an opportunity for clarification and correction.[118]

This interactive phase can demonstrate to the client the clinician's genuine desire to understand their perspective, acknowledge – and, in some cases, directly *feel* - associated emotions, and their willingness to invest effort in achieving a shared and accurate comprehension.[19,36,41,97,104,127,143,264]

3.2.2.1.3. Stage 3 (optional): therapeutic action. While some scholars consider empathic encounters to culminate in the preceding stages, others propose the concept of "therapeutic empathy" which extends to encompass an additional helpful (therapeutic) action.[19,97,99] Although the conveyance of understanding and subsequent two-way communication to refine this can inherently possess therapeutic value,[36,277] additional therapeutic interventions, such as offering emotional support (e.g., validation, legitimation, or reassurance) or practical/tangible assistance, may be appropriate and desired in certain contexts.[36,97,99,114,120,121,155,173] Thoughtful gestures and small acts of kindness may be particularly valued by some clients in states of distress.[118]

Conversely, particularly in more psychotherapeutically-informed interactions, resisting the inclination to offer immediate support can at times be more favourable, as such actions might, in some instances, impede the development of the service-user's internal resources and reinforce reliance on external support for managing unpleasant emotions and experiences.[140,170,278] To illustrate, instead of providing immediate reassurance or prescriptive advice, experienced practitioners may choose to encourage the tolerance of distress and discomfort and facilitate further exploration or collaborative problem-solving. Lastly, it is worth noting that the therapeutic benefit of seemingly simple interventions, such as affording service-users sufficient time to articulate their distress, could, in some cases, prove equally valuable.[124,149]

4. Discussion

The comprehensive model developed in this work establishes a unified conceptual meta-framework that integrates person-centredness, therapeutic alliance, and empathy, validating their synergistic and fundamentally interconnected role as integral to effective client

Table 2
The Goals domain of therapeutic alliance.

DIMENSION NAME	DESCRIPTION	RECOMMENDATIONS
Collaboration and Shared Decision-Making (SDM)[182]	This dimension emphasises the overall approach of working together towards agreed-upon therapeutic goals, integrating the concepts of consensus and shared decision-making.	42. Elicit the service-user's needs, concerns, expectations, wishes, and complaints before making all decisions.[103,110,114,127,158,183,184] Note that some clients may prefer being asked these in writing.[185] 43. Seek consent (implicit or explicit, based on judgment) before each decision; adopt an egalitarian approach throughout (e.g., set the agenda jointly).[114,184] 44. Respect individual service-user preferences regarding involvement, acknowledging that, in some instances (e.g., impaired mental capacity), a more paternalistic approach involving the provision of direct recommendations is warranted.[97,108,120,121,149,152,153,173,186,187] In such cases, justify deviations from shared decision-making principles.[109] 45. Support service-users' decision-making capacity[153,154,167,184]: • Provide sufficient information for making each decision[114]; • Consider using patient decision aids, together with formal and/or informal approaches (e.g., patient view elicitors (PVEs) [prompts used by clinicians to actively gather the person's subjective experiences, opinions and values][109,188]); formal approaches may include: o Three-talk model[189] [Team talk, option talk, decision talk]; o SHARE approach[190] [Seek participation, help explore and compare treatment options, assess values and preferences, reach a decision, evaluate the decision]; and o Purposeful shared decision-making framework[191] [Discuss alternatives and weigh up options ("Which is best for me?"); negotiate conflicting intra- or interpersonal points of view, desires, or agendas ("What do I want?"); resolve the problematic situation at hand ("How do we manage?"); help develop insight into the humanity or identity of individual faced with the dilemma ("What really matters?"). • Enlist the help of the client's own support networks in decision-making where appropriate (however, also consider factors such as caregiver burnout).[110,114,149,184] • Dynamically adapt consultation style to facilitate decision-making, offering reassurance and access to trained advocates as required.[53,114,122,140,153,154,167] 46. Explore and address conflicts between service-user values and clinical evidence: • Carefully balance challenging conflicting views with respecting the individual's values[97,121,152,173,184,192,193]; • Maintain a deontological commitment[97,98,184,193,194] to the service-user at all times, particularly when conflicts arise between nomothetic evidence and idiographic experience/values].[114,184] [This means prioritising one's ethical duty (deontological) to the individual, especially when standardised knowledge (nomothetic evidence) conflicts with the client's unique personal circumstances or beliefs (idiographic experience).]
Reciprocal Goal Alignment and Contracting	This dimension emphasises the fundamental therapeutic output: the establishment of goals. The concept of reciprocity underscores the necessary, two-way process of synthesising the client's individual goals with the practitioner's own agenda and expectations, which are formally documented within a treatment plan or therapeutic contract.	47. Cultivate a collaborative atmosphere during the exploration of therapeutic goals.[20,103,110,161,183,184] 48. Adopt inclusive language (e.g., "we" instead of "you") where appropriate.[149] 49. Adopt a recovery-oriented lens,[104] aligned with both the biopsychosocial model[195] and the personalised medicine approach.[162] 50. Consider the use of specific tools, such as DIALOG + [a process and technology-supported intervention that uses the DIALOG scale (a simple, validated, 11-item rating instrument assessing quality of life domains: mental health, physical health, employment, accommodation, leisure, friendships, partner/family, personal safety; and satisfaction with medication, practical health and consultations with mental health professionals) to structure communication, collaborative goal exploration and prioritisation, and to promote self-management and recovery].[181] 51. Establish appropriate and realistic individual goals based on both the client's capabilities and available resources.[114] Consider the following common recovery goals: • Connectedness[107]: Enhance social inclusion by mobilising personal support networks and utilising systems-level resources (including peer support).[20,114,116,120,147,152,173] • Positive Self-Identity: Work towards an enhanced self-worth and help dismantle self-stigma.[114,149,162] • Agency[99,114,121]: o Cultivate empowerment in the client in the form of permission and encouragement to take action,[99,114,120,162,196] self-advocacy[20,114]; ownership and self-help[99,105,121,162]; o Foster enablement through actively encouraging the acquisition and utilisation of specific skills, tools and abilities.[99,114,161] This is typically achieved by reinforcing the client's autonomy,[53,121,149] which represents the confluence of their self-efficacy and intrinsic motivation.[114,155] To evoke intrinsic motivation in the client, consider first exploring the state of ambivalence that maintains inertia (i.e., keeps the client feeling stuck), then negotiate viable options to achieve established goals, while consistently acting with inclusivity, initiative, and creativity, incorporating strength-based principles to promote sustainable recovery.[53,104,114,155,162,197] 52. Acknowledge that resistance commonly emerges during the process of setting goals, which can hinder overall recovery. Consider specific approaches: • Confront uncertainty and instil hope and positive expectations, whilst adopting a recovery orientation[103–105,112,114,127,140,149,150,155,162,183,198];

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Table 2 (*continued*)

DIMENSION NAME	DESCRIPTION	RECOMMENDATIONS
		• Convey realistic optimism, together with practical support toward the regulation of unpleasant emotions, strategies to alleviate fear and anxiety, and the fostering of hope through exercising compassion[105,149,183,198–200]; • Tactfully challenge maladaptive coping strategies, which can hinder goal-setting and subsequent progress, including avoidance and isolation, unhelpful cognitive distortions, externalised locus of control, and negative self-concept.[99,114,162,196,197] 53. Once goals are agreed upon, jointly determine the approaches and interventions to attain these (refer to Table 3 for a set of common interventions). Incorporate these into a jointly developed clear therapeutic contract or formal recovery care plan[20,104] by: • Establishing clear individual roles, boundaries and expectations for the collaborative approach to attaining these goals[102,114,127]; correct any misconceptions around these[138]; • Where appropriate, as part of this contract, co-develop a crisis and contingency safety plan.[117] 54. Throughout subsequent encounters maintain continuity of care and transparent communication about follow-up arrangements.[53,116,121,128,138,180] 55. Carefully manage service-user expectations through subsequent encounters, noting that misaligned expectations are a common cause of *alliance ruptures).*[28,104,114,127,183]

encounters, particularly those involving consultations about common mental health problems. Beyond a solely conceptual presentation, this robust synthesis yielded a total of 92 primary recommendations (alongside several additional subsidiary recommendations), specifically designed to support the operationalisation of these concepts. This dual focus directly addresses the identified gap, providing both a conceptual map and pragmatic guidance to facilitate the implementation of evidence-informed strategies in mental health care by pharmacists. Although many of the recommendations are closely aligned with principal elements of advanced pharmacy practice,[6] the universality of the triad ensures the model is sufficiently broad and adaptable for use by a range of healthcare professionals in a variety of settings. This universal applicability forms the foundation for the subsequent discussion of the meta-framework's key components.

4.1. The meta-framework

4.1.1. Person-centredness

Person-centredness is conceptualised as the broadest, overarching concept of the meta-framework, spanning three distinct yet overlapping levels. We would like to acknowledge that much of the literature discussed herein employs the specific term “patient-centredness” - as distinct from “person-centredness” - thereby delineating the role of the individual primarily as a passive recipient of health interventions. Conversely, the term “person-centredness” encompasses broader identities and social contexts beyond the clinical encounter. The intellectual lineage of this latter term stems from the work of Carl Rogers, a foundational figure in the person-centred (also referred to as client-centred) psychotherapy movement with its central tenet of acknowledging clients in all aspects of their humanity.[143–145,279] Owing to its more encompassing definition, the term person-centredness has thus been adopted uniformly for the entirety of this work and as such we also opted to use the terms “clients” and “service-users” in favour of “patient” in this context to emphasise agency.

4.1.1.1. Person-centredness at the Consultation level (therapeutic alliance). Delineating the Consultation level - which in our analysis aligned precisely with the established concept of therapeutic alliance - was substantiated by an extensive body of evidence, allowing this level to be detailed through three domains and nine dimensions, resulting in 66 corresponding targeted recommendations. The recommendations pertaining to the various pharmacist activities were not intended to be exhaustive; it must also be noted that the implementation of certain interventions may necessitate specific training, the attainment of relevant competencies and advanced-level qualifications, and appropriate supervisory arrangements.

The choice of the therapeutic alliance as the core organising principle for this level is substantiated by its robust theoretical foundation. The alliance is underpinned by Edward Bordin's original framework (1979),[29] comprising three constituents: (1) the Bond, described as a trusting and authentic connection within the dyadic relationship; (2) the Goals, representing the overarching direction of the treatment/care trajectory; and (3) the Tasks, which encompass the specific actions and objectives designed to facilitate the desired change and improve overall wellbeing. Theoretically, the alliance serves as a crucial conceptual bridge, translating the pharmacist's person-centred intention (Intrapersonal) into tangible goals.

The alliance construct has undergone progressive refinement and adaptation across diverse care settings over several decades.[30,238,239] While a variety of instruments for measuring the therapeutic alliance are employed in research, this synthesis purposefully incorporated items from the Working Alliance Inventory (WAI),[280,281] which has been reported to be utilised in approximately two-thirds of studies examining the relationship between alliance and outcome.[28] Furthermore, we drew insights from psychotherapeutic disciplines (specifically, psychodynamic and person-centred approaches) not to propose that pharmacists provide psychotherapy, but to impart the relational perspective needed to understand and manage complex client dynamics (such as transference/countertransference or alliance ruptures) that may also impede pharmaceutical goals. We posit that such breadth and depth provide pharmacists with the necessary conceptual clarity and pragmatic guidance to bolster mental health consultations.

4.1.1.2. Person-centredness at the Systems level. While the initial scope of our enquiry, as framed by the research questions, endeavoured to dissect the triad primarily within the context of consultations, the comprehensive nature of this synthesis demonstrated that these concepts have a critical role reaching far beyond the practitioner-client encounter. As presented through several prior conceptualisations of person-centredness,[98,120,121,151,173,192,241] care delivery and client support increasingly extend to involve additional professionals within a complex system of organisations and care sectors, thus delineating a second level within the meta-framework: the Systems.

Explicating this level proved necessary as mental health was found to be an increasingly complex area of care frequently demanding interdisciplinary and cross-sector collaboration and leadership to achieve enduring improvements in client wellbeing. As articulated by the World Health Organization (WHO): *“Care should not […] be limited to the moment a patient consults nor be confined to the four walls of the consultation room. Concern for outcomes mandates a consistent and coherent approach to the management of the patient's problem, until the problem is resolved or the risk that justified follow-up has disappeared. Continuity of*

Table 3
The Tasks domain of therapeutic alliance.

DIMENSION	DESCRIPTION	RECOMMENDATIONS
Tasks of the Practitioner	This dimension encompasses the various interventions and evidence-based approaches commonly employed to attain therapeutic goals and recovery in the context of common mental health conditions.	56. When discussing a choice of available interventions, ensure the appropriate frame of these, for instance by adopting a *gain frame* to emphasise the benefits and intended outcomes.[158] 57. Promote treatment credibility through influencing and persuasion skills.[103,109,112,140] 58. Recognise when confidence in intervention success is unrealistic, exercising professional humility, reviewing available options and seeking second opinions as needed.[104] 59. **Psychoeducation** • Improve the client's health literacy, adapting information to the individual's circumstances (including beliefs) and addressing any emerging adverse impacts on their identity (e.g., consider attitudes towards diagnostic labels).[114,149,201,202] • Incorporate education on health promotion and disease prevention where appropriate.[127,179,184] • Co-develop self-management plans where appropriate.[99,114,184,203] 60. **Pharmacotherapy** • Involve the service-user, and where relevant and appropriate, their family and caregivers, in discussions about medications used in the management of common mental health conditions.[204] • Elicit the individual's beliefs about medication[98,121,152,167,184,204–207]; consider the use of the Beliefs about Medicines Questionnaire (BMQ), or the Necessity-Concerns Framework (NCF)[208] underpinning it, when discussing pharmacotherapy. Aim for coherence between the individual's beliefs, values, lived experiences and the professional guidelines and empirical evidence.[99,209] • Individualise all medication reviews, tailoring them to the client[99,152,184,210]: o Evaluate the appropriateness, effectiveness and suitability of medicines across multiple domains, sensitively navigating conflicts between evidence-based and values-based medicine[184,203–205,210]; always consider appropriateness in relation to other, including non-pharmacological, options – whether these are used alone or in combination with medication[211]; o Consider co-developing an individualised self-management plan tailored to the individual and their condition[110,184,203]; o Review and support treatment adherence non-judgmentally[152,155,184,204]; recognise that the practitioner-client relationship[212,213] and empathy[214,215] can both positively impact medication adherence. o Consider incorporating established frameworks for medication reviews, particularly those involving polypharmacy, e.g., 7-Steps Medication Review[216] [Aim: What matters to the patient; Need: Identify essential drug therapy; Need: Does the patient take unnecessary drug therapy?; Effectiveness: Are therapeutic objectives being achieved?; Safety: Is the patient at risk of Adverse Drug Reactions (ADRs) or suffers actual ADRs?; Efficiency: Is drug therapy cost-effective?; Patient-centred: Is the patient willing and able to take drug therapy as intended?]. • When considering medication change (whether acting in a prescribing capacity or through collaborating with a prescriber), recognise that the client's predilection has been shown to be a potent moderator of treatment response,[14] particularly in depression,[217] and that a mismatch between preferred and actual treatment may lead to attrition (e.g., non-attendance) and a diminished working alliance.[218] • On initiating medication (or when providing advice on new medication prescribed elsewhere), offer suitable information tailored to the individual.[152] Typically, at a minimum this should encompass dosage, frequency of administration, onset of action, potential side-effects and their management, expected treatment duration, and a general mechanism of action)[206,219]; avoid overly optimistic projections regarding medication effects.[16,170,220] • Review medicines at regular intervals and/or encourage seeking review by another professional if prescribed elsewhere.[4,219] 61. **Clinical Interview** • Adopt a collaborative approach when undertaking a clinical interview with the client,[104,114] prioritising their own ideas, concerns, and expectations,[108,127,155,158,172,221] and integrating these with the established process of psychiatric history-taking and mental state examination,[105] and third-party accounts.[105,184] • Evaluate individual risk status holistically, refraining from arbitrary stratification (e.g., low, medium or high risk).[222,223] Incorporate person-centred suicide risk assessment and management - such as Narrative Crisis Model (NCM) and Collaborative Assessment and Management of Suicide (CAMS).[222] • Avoid premature use of diagnostic labels.[149] 62. **Biopsychosocial Formulation** • Collaboratively synthesise a comprehensive case formulation that integrates subjective experiences and intersubjective accounts with clinical ("objective") observations; recognising that sharing formulations with clients possess inherent therapeutic value.[105,164]

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Table 3 (*continued*)

DIMENSION	DESCRIPTION	RECOMMENDATIONS
		• Recognise that formulations evolve dynamically over time – be sure to update these at appropriate intervals.[105,164] 63. **Psychosocial Approaches and Interventions** Listed below, in no particular order, are a set of established psychosocial approaches and interventions utilised in the management of common mental health conditions.[4] It is important to note that this compilation is not intended to be exhaustive, but rather reflects the dynamic evolution of evidence-based practices and service provision in the UK. Interventions that receive national recognition are typically endorsed by relevant NICE guidelines and other guidance documents. • Support based around transtheoretical model of change: This approach customises interventions to meet individuals at their current state of readiness for change, moving them sequentially through precontemplation, contemplation, preparation, action, and maintenance.[224] • Health coaching: A client-centred, collaborative partnership where the coach supports the client in identifying health goals and developing self-management strategies for sustainable behaviour change.[184,225,226] • Motivational Interviewing (MI): A directive, non-confrontational communication style designed to resolve client ambivalence and strengthen intrinsic motivation for positive change by exploring and resolving discrepancies.[155,167,225,227] • Social prescribing: A holistic approach that connects individuals with non-clinical sources of support within their community, addressing social, emotional, or practical needs that affect health and well-being.[20] • Behavioural Activation (BA): A structured, brief psychological intervention that aims to increase engagement in positive, rewarding, and goal-directed activities to counteract patterns of avoidance and withdrawal associated with depression.[4] • Cognitive-Behavioural Therapy (CBT): A time-limited, goal-oriented psychotherapeutic approach that helps clients challenge and modify dysfunctional thoughts, emotions, and behaviours by focusing on their reciprocal relationships.[109,114] • Attachment theory-based approaches: Interventions that explore and address how early relational experiences shape current patterns of attachment, influencing emotional regulation and interpersonal functioning in order to foster secure relating to others.[141] • Trauma-informed approaches: A framework for service delivery that recognises the high prevalence of trauma and integrates knowledge about its profound effects into practices to prevent re-traumatisation and promote safety.[228] 64. **Psychodynamic Psychopharmacology** This approach integrates psychodynamic principles with pharmacotherapy to gain a deeper understanding of unconscious processes and motivations which may impact on medicine effects. It is considered particularly useful where traditional evidence-based pharmacological treatment algorithms may fall short, for instance in the management of refractory depression.[168,229–231] • Examine own motivations for prescribing.[125,232] • Explore the client's ambivalence about recovery together with secondary gains which perpetuate inertia.[168,229–231] • Assess the influence of transference and countertransference.[168,229–231] • Address resistance from/to medication.[168,229–231] • Explore the meaning attached to psychotropic medication by the client (e.g., medication perceived as beneficial, harmful, symbolic of weakness, or influencing interpersonal relationships) • Consider the symbolic significance of the practitioner/prescriber (e.g., whether seen as the healer), and the act of prescribing itself.[125,168,196,229,231–233,233–237]
Tasks of the Service-User	This dimension encompasses the active responsibilities and efforts the service-user is required to undertake, including adherence to therapeutic activities and self-monitoring, which are essential for achieving positive treatment outcomes.	65. Once the client's individual tasks have been assigned, support their attainment continually through: • Monitoring progress and seeking feedback[30,110,114,238,239]; • Cultivating accountability and ownership[99,104]; • Encouraging and/or assisting the service-user in completion of their own assigned tasks, whilst applying flexibility to the overall approach as needed[114,140]; 66. If there is a lack of progress[114,140]: • Review challenges and adapt approach as appropriate; • Review the domains of Bond (Table 1) and revisit the Goals (Table 2) as needed; • In certain situations, particularly when core relational factors like empathy face an impasse, consider seeking external input (e.g., feedback from family, caregivers and/or professionals).

care is an important determinant of effectiveness, whether for chronic disease management, reproductive health, mental health or for making sure children grow up healthily."[17] Consequently, the emphasis on practitioners effectively harnessing resources for optimal service-user outcomes became a critical constituent of the meta-framework and we provided 12 recommendations to specifically enhance Systems-level working for pharmacists. This detailed understanding is anticipated to strengthen pharmacists' collaboration and leadership within multidisciplinary and cross-organisational settings primarily through enabling them to engage effectively with the shared theoretical principles and terminological language used by other service professionals. This focus on systemic support and organisational change theoretically aligns the model with the principles of recovery-oriented mental health care.[150,162]

While the maxim that *"leadership is everyone's business"* underscores

Table 4
Domains of person-centredness at the Systems level.

DOMAIN	RECOMMENDATIONS
Multiprofessional and Cross-Organisational Collaboration	67. Foster effective working relationships with colleagues from diverse professional backgrounds in multidisciplinary teams.[97,120] 68. Regularly seek out supervision, and learning and development opportunities through working with others.[104,153,184] 69. Share your expertise and professional experiences, both with professionals (e.g., in multidisciplinary case reviews), and directly with service-users under the care of colleagues, where appropriate.[53,97,104,121,154,180,184,240] 70. Ensure familiarity with available local and national services, their respective remits, and the wider health and care system.[20,53,184] 71. Liaise with professionals from other organisations for referrals, signposting, specialist interventions and opinions, integrating care from other providers and comprehensive care coordination.[104,113,114,120,121,147,152,173,184,241,242] 72. Ensure consensual access to health records, adhering to robust information governance frameworks (e.g., accurate documentation, information-sharing, timely completion of sensitive tasks such as risk assessments).[104,184]
Person-Centred Leadership	73. Prioritise client safety within organisations (e.g., identifying, reporting, and learning from safety incidents).[203] 74. Embed innovation, positive risk-taking, integrating positive team values (e.g., power-sharing), and creating health-promoting environments.[20,53,104,110,121,124,192] 75. Improve equitable access to services, integration of cultural competence and inclusive practices, neurodiversity and autism awareness, fostering an environment free from stigma, prejudice, and discrimination.[53,104,113,122,138,147,163,184,243] 76. Ensure effective communication channels for identifying and resolving service gaps, enhancing availability and timely responsiveness of support, and ultimately optimising clinician time for the delivery of person-centred care.[110,113,124,150,244] 77. Recognise the vital role of emotional intelligence skills, particularly empathy, for effective systems-level work; utilise these effectively for delivering compassionate leadership.[110,244,245] 78. Foster a positive workplace culture, an attitude of positive role modelling, and supportive collegiate relationships.[110,124,192,244]

that leadership is not exclusively restricted to formally designated roles, since this area is not the primary focus of the present work, we only briefly addressed it. Nevertheless, a comprehensive strategy for implementing a person-centred workforce has, however, been articulated through the 2017 collaborative work of Health Education England, Skills for Health, and Skills for Care, which produced a freely available core skills education and training framework.[20]

4.1.1.3. Person-centredness at the Intrapersonal level. In line with some previous scholarly work identifying essential practitioner characteristics and prerequisites that facilitate the adoption of a person-centred approach,[120,151,192] we intentionally explicated a third crucial level of person-centredness: the Intrapersonal. This inclusion ensures comprehensive attention to the clinician's internal world, a focus which aligns directly with the consideration of practitioners as individual human beings (possessing motivations, values, and purpose) identified in established literature, including the 'Doctor as person' dimension in Mead and Bower's model.[151] We deem this emphasis to be necessary because we posit that effectively operationalising the triad requires an in-depth, experiential, first-person appreciation of the complex ideas, transcending traditional theoretical comprehension (knowledge) and

Table 5
Domains of person-centredness at the Intrapersonal level.

DOMAIN	RECOMMENDATIONS
Intellectual Domain	79. Acquire a comprehensive understanding of person-centred practices, whole-person approaches and evolving holistic paradigms, and integrate these into your own practice.[246] Ensure familiarity with relevant contemporary concepts such as: • Multidimensional model of wellness[247]; • Biopsychosocial model of illness[195]; • Maslow's hierarchy of needs[248–250]; • Trauma-informed care[228,251]; • Established consultation models[117,184,252]; • Communication skills[253]; • Shared decision-making frameworks (Three-talk model,[189] SHARE approach[190] and the Purposeful shared decision-making framework[191]) and informal approaches (e.g., patient view elicitors, PVEs[109,188]); • Recovery-oriented approach.[162,197] 80. Develop deep understanding of how modern conceptualisations of health and wellbeing inform conceptualisations of mental ill health and its management.[4,164,254] 81. Acquire an understanding of prevalent psychotherapeutic and psychological theories and approaches, such as cognitive-behavioural including third-wave CBT approaches (e.g., dialectical behaviour therapy (DBT), acceptance and commitment therapy (ACT), mindfulness-based cognitive therapy (MBCT), etc.), psychodynamic psychotherapy, schema therapy, solution-focused approaches) and their respective formulation methodologies.[99,109,114,140,144,164] 82. Learn about and develop cultural competence, disability and neurodiversity awareness, and an understanding of the tenets of equity, diversity, and inclusion (EDI), including an acute awareness of marginalised groups and ways to challenge stigma.[53,104,122,138,147,163,184,243] 83. Maintain acute awareness of pertinent policy, guidelines, codes of conduct and key legislation.[246] 84. Ensure up-to-date clinical knowledge through continuous professional development, including self-directed learning.[246]
Practical Domain	85. Actively develop the skills essential for delivering person-centred care. Recognise that mastery of person-centred practice necessitates practical proficiency, as theoretical knowledge acquisition alone is insufficient for competence; this is particularly relevant for honing skills such as facilitative interpersonal communication, collaboration, emotional intelligence, and conflict management.[42,53,99,104,134,192,255] 86. Continually strengthen your own person-centred practice through specific educational and/or developmental methods: • Actively engage in participatory communicative behaviours with clients and colleagues[102,104,112,138]; • Continually reflect on and refine own facilitative interpersonal and social cognitive competencies; • Solicit and act on service-user feedback[103,115,120–122]; • Formal educational programmes (many of which incorporate simulated patient scenarios and role-play) (e.g., developing empathy[256]); • Interprofessional learning opportunities (e.g., clinical supervision with seniors, observation of other professionals ("shadowing"), being observed by colleagues, reflective practice, Balint groups, Schwartz rounds).[20,184,240] 87. Maintain a clear understanding of one's limits of competence, practise within own scope,[257] and demonstrate professional humility.[131,184]

(*continued on next page*)

Table 5 (*continued*)

DOMAIN	RECOMMENDATIONS
	88. Acquire proficiency in delivering specific skill-based person-centred interventions, relevant to one's own practice, such as: • Person-centred medication reviews[210]; • Health coaching[184,225,226]; • Motivational interviewing[155,167,225,227]; • Behavioural activation[4]; • Generic suicide prevention and crisis management (e.g., Mental Health First Aid[258]); • Person-centred suicide risk assessment and management - such as Narrative Crisis Model (NCM) and Collaborative Assessment and Management of Suicide (CAMS).[222]
Phenomenological Domain	89. Cultivate essential core values and attitudes that underpin person-centred care (e.g., the importance of affording dignity, respect, and compassion without judgment; collaboration and co-production, etc.)[20] 90. Engage in critical self-reflection to identify and manage personal biases (e.g., commission bias, omission bias, fundamental attribution error, visceral bias) and areas of personal discomfort.[99,120,157,184,192,193] 91. Incorporate into practice insights and wisdom gained through personal growth and development. 92. Consider seeking psychotherapeutic/psychological support specifically to address one's own attachment insecurities, where appropriate, in order to enhance own mentalisation and relationship-building capacity.[137,141,148]

simple skills-based application: a twofold distinction commonplace in contemporary healthcare professional education and development.[282] Far from being unique to the pharmacy profession, such limitations have drawn critique across disciplinary boundaries: *"Of course, nurses need to be trained in the technical knowledge and skills necessary to perform safely and competently, but they also require an education in what it is to be fully human, an education which […] is far broader in content and scope than what is currently being offered"*.[283]

Drawing parallels with Bloom's taxonomy's threefold classification of learning,[284] we categorised Intrapersonal person-centredness into three overlapping domains: Intellectual (knowledge), Practical (skills and behaviours), and Phenomenological (lived experiences; emotions, intuitions, attitudes, values and meaning-making). Crucially, our framework places a special emphasis on the latter, thus grounding the model in humanistic psychology and phenomenology by shifting the focus from purely professional competencies to the practitioner's own being and experience. While pharmacists may be more familiar with the traditional rationally-informed ("gnostic") intellectual-cognitive and technical-behavioural aspects of their practice through their undergraduate (and postgraduate) education, the affective-phenomenological ("pathic") dimension is increasingly being considered critical,[283,285] particularly in the provision of mental health care. As the esteemed phenomenologist, Max Van Manen so eloquently articulated: *"Psychologists, nurses, physicians, and other professionals need to be able to create a conversational sphere if they want to reach the trust and inner lives of their patients. This kind of insightful knowledge has more to do with thoughtfulness and tact than with rules, techniques, and external competencies."*[286] Completing this framework, a further 14 recommendations were offered to promote intrapersonal self-reflection and professional development.

4.1.2. Empathy

While we dedicated an entire section to the exploration of empathy in a mental health consultation setting within the meta-framework, we must also acknowledge its foundational role across the entirety of the model. At the Systems level, empathy involves fostering relationships among professionals and between leadership and frontline staff - fundamental aspects that are primarily within the purview of organisational psychology and thus will not be detailed here. At the Intrapersonal level, empathy is conceptualised as a learnable skill and an adoptable character trait - a view that is increasingly prevalent in healthcare and professional education.[274]

As a key constituent of emotional intelligence, empathy forms the cornerstone of all person-centred encounters, particularly those involving the discussion of mental health concerns and difficult - often distressing - personal experiences.[97,99,102,103,114,116,128,133,138,147,155,158] The clinician's adeptness at utilising empathy effectively is crucial for achieving sustained positive outcomes.[42] At the Consultation level empathy creates the foundation for an effective working relationship between practitioner and client whilst cultivating human connection.[287]

Empathy is frequently contrasted with the closely-related concepts of compassion and sympathy,[288] which have been jointly defined as *"an other-oriented motivation congruent with the perceived welfare of someone in need"*.[267] They are characterised by feelings of warmth, concern, and care for the other, as well as a strong motivation to improve their wellbeing.[289] Some scholars have articulated sympathy specifically as the emotional experience of *"sorrow or concern for another"*, wherein the individual is affected by the other's experience to such an extent that the experiential focus shifts from the other to the self, thus rendering this concept as typically less desirable in clinical encounters. Some authors seek to differentiate further between sympathy and compassion, proposing that the former implies being moved by another's plight,[290] while the latter, in addition, emphasises a sensitivity to suffering together with a propensity for action towards reducing or preventing it.[291] In our pragmatic account of the empathic process such strict distinctions are not made in favour of articulating processes shown to reinforce the pharmacist-client bond and support client wellbeing.

Drawing upon several seminal works, including those of 20th-century phenomenologist Edith Stein (through secondary sources),[260,292,293] and recent conceptualisations of therapeutic empathy articulated by Hardman and Howick (2019),[19] Howick et al. (2025),[36] and closely aligned in theory with the CARE (Connecting, Assessing, Responding and Empowering) approach[294] and the Framework for Compassionate Inter-Personal Relations,[244] we not only introduce the concept of empathy through a pan-theoretical lens, but also provide a detailed three-stage temporal framework to improve its enactment with service-users.

4.2. Implications for pharmacy practice and education

The comprehensive, three-level structure of this model provides a pathway for the professional development of pharmacists and the further evolution of pharmacy practice toward autonomous, client-facing clinical roles. Although the model is specially suited to mental health care, many of the guiding principles remain applicable across several clinical pharmacy contexts, including in the management of many chronic physical health problems. This extended applicability is warranted because these conditions, akin to common mental health problems, are frequently characterised by prolonged psychological distress, chronic uncertainty, and the absence of curative interventions, thus necessitating a focus on relational support and holistic wellbeing, rather than a purely biomedical approach. Therefore, our model - owing to the universality of its constituent concepts - is expected to be of utility to pharmacists even beyond mental health care.

The recommendations presented in this work bolster the direct use of pharmaceutical expertise, extending far beyond simply providing medication counselling to service-users or advice to multidisciplinary teams. Notably, effective operationalisation of the model necessitates a fundamental theoretical shift in the consultation paradigm. Traditional pharmacy encounters are frequently medicines- and problem-focused, centring on disease or medication adherence issues; however, the structured integration of the triad supports a confident move toward relationship-focused engagement. This shift aligns with the recovery-oriented mental health movement, which crucially emphasises solution- and strengths-based approaches rather than a sole focus on client

deficits.[162,196] Such advanced practice requires not only high-level clinical skills but also the critical integration of pharmacists into the wider system of health (and social) care professionals. This, in turn, demands increased theoretical and practical focus on the discipline of social pharmacy, recognising the fundamental link between an individual's unique context, values, and mental wellbeing within today's increasingly multilayered society.

In addition, the model's novel emphasis on the Intrapersonal level highlights a deficiency in traditional pharmacy undergraduate education, which often limits instruction to theoretical comprehension (knowledge) and skills-based application. To effectively foster the experiential, first-person appreciation necessary for operationalising the triad, educational curricula must be redesigned. Akin to the intentional development of humanities curricula for medical education,[295] modern pharmacy education should undertake a theoretical re-balancing: this requires moving beyond a disproportionate reliance on postpositivist values and attitudes to include interpretivist and pragmaticist paradigms to effectively address the complexity of the social world. This integration is crucial for preparing future pharmacists for person-centred practice, where understanding human complexity and context requires theoretical foundations beyond those offered by the natural sciences alone. As such, our recommendations necessitate increased commitment to varied teaching methodologies that cultivate relational competence and self-awareness, specifically: reflective practice and supervised patient consultations; humanities-informed modules (e.g., philosophy, sociology, anthropology, literature, and art to cultivate a deeper appreciation of the lived experience of health and wellbeing, distress, suffering and illness); structured role plays (for practising complex relational dynamics); and group discussion formats such as Balint groups (for discussing the emotional content of client encounters and relationships) and, later, Schwartz rounds (for fostering clinician wellbeing and relational awareness).

4.3. Limitations

While the CIS method was deemed to be suitable for this project for reasons described earlier, we acknowledge the limitations of this approach relative to highly systematic evidence synthesis methodologies. We endeavoured to present our method as clearly as possible to improve transparency and trustworthiness by providing detailed descriptions on how the synthesis was performed. Although the lack of strict, fixed inclusion criteria and the omission of methodological quality assessment of included studies likely introduced bias to the selection process, we aimed to mitigate this through ongoing discussions with external experts and lay persons outside of the core research team.

We acknowledge that another limitation of this study is that the literature search, thematic extraction and initial assembly of the meta-framework were undertaken by the primary author alone, albeit with ongoing supervision from and discussion with experienced researchers and guidance from the multidisciplinary team but without formal voting or consensus procedures.

Due to the interpretive methodology and its alignment with modern humanistic value systems, we acknowledge that our model may not be compatible with service delivery in all contexts, particularly where legal frameworks or clinical urgency may infringe upon individual liberties (e.g., acute severe mental illness, neurocognitive disorders, or forensic psychiatry); it is instead deemed to be particularly suited to the management of common mental illness, primarily in community (outpatient) settings.

Lastly, we acknowledge that the pan-disciplinary nature of the synthesis means many findings were not drawn directly from the pharmacy literature and may therefore not always be readily translatable into practice without bespoke adaptations, targeted educational initiatives, and commensurate organisational support.

4.4. Future research

To support pharmacists in embedding these recommendations into practice, further research is necessary to explore both facilitators and barriers to their adoption. Our subsequent project will utilise this meta-framework to gauge the breadth of person-centredness in reported pharmacist activities in relation to common mental health conditions globally. We posit that qualitative studies exploring the pharmacist-mental health client consultation and the phenomenological intrapersonal domain of pharmacists would also prove beneficial, and the resulting insights could in turn be utilised to propose targeted education and training to aid the delivery of humanistic pharmaceutical mental health care.

5. Conclusion

This critical review and meta-framework of the conceptual triad aim to provide pharmacists with a blueprint for approaching clients holistically, particularly in the context of care for common mental health conditions. Presented as a robust set of pragmatic recommendations, this paper offers pharmacists an enhanced understanding of high-quality care centred on the individual service-user. Our model is pioneering, not only in its elucidation and unification of the triad, but also in its specific application within a humanistic, recovery-oriented mental health context, in consideration of the evolving role of the pharmacist. Crucially, this work is designed to be of value across a range of roles and levels of practice, including those with indirect client care responsibilities, formal leadership and educational positions, and those seeking opportunities for self-reflection and continuous professional development.

CRediT authorship contribution statement

Balazs Adam: Writing – review & editing, Writing – original draft, Visualization, Software, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Kinda Ibrahim:** Writing – review & editing, Supervision. **Fiona Stevenson:** Supervision. **Geraldine Leydon:** Writing – review & editing, Supervision.

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Declaration of interest

The authors declare no conflicts of interest.

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Appendix A. Supplementary data

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