A systematic literature review of the signals, barriers, and components of difficult conversations in the workplace

Rachel Smith and Colleen Addicott
University of Hertfordshire

Abstract

Difficult conversations are undertaken for a variety of reasons in the workplace, including performance, responding to change, or conflict. This research systematically reviews the literature to explore the signals a difficult conversation may be needed at work, the barriers to having the conversation, and the components of a difficult conversation in the workplace.

The review adopts the process recommendations from Daniels' (2019), using Scopus, APA, and Business Source Direct databases, alongside grey literature searches for policy and industry guidance. Keyword search terms initially identified 2388 articles and 36 grey literature references to difficult conversations. These were screened on title, abstract then full review. Inclusion and exclusion criteria, developed using a PECOS framework, were used and 44 articles were included in the study. The quality of each article was evaluated. There is very little primary data or evaluation data related to the topic. Only 8 articles were peer-reviewed studies, the rest were industry or practitioner sources.

Data integration involved theme analysis of the data extracted from the literature. Signals a difficult conversation was required were often assumed in the articles. The evidence for the barriers was clearer, with 4 themes (fear, competence, relational and emotional) discussed as barriers to having a difficult conversation. The evidence for the components was stronger, with three phases of a conversation identified (preparation, delivery, and transition).

The review highlighted the need for more empirical research relating to difficult conversations at work to support evidence-based recommendations and guidance. Practitioner advice is consistent and often practical, therefore designing and piloting difficult conversation training within an organisational context based upon this experiential advice is suggested.

Corresponding author:
Dr Colleen Addicott
c.addicott@herts.ac.uk

1. Introduction

Difficult or challenging conversations have been defined as: *"a discussion between two or more people where the stakes are high, opinions vary, and emotions are heightened. Often the participants of a difficult conversation will be emotionally connected to the subject and place a high level of importance on the subject, process, or outcome".* (Patterson et al., 2012).

Performance management is perhaps the most obvious workplace context where a conversation may be challenging, as it can require the delivery of negative feedback. Health and well-being discussions, return to work discussions, stress or other mental health concerns, bullying, harassment, long-term health conditions or absence are all examples, although not an exhaustive list of conversations within the workplace that could be considered difficult to have. Organisations and employees attempting to adapt to the pandemic, have found themselves managing unprecedented challenges and demands (Worley & Jules, 2020), providing a rich context for difficult conversations in the workplace.

Much of the research exploring difficult conversations come from the Medical and Healthcare sector, where it is more common to be dealing with sensitive, critical, and high-stakes situations such as 'breaking bad news,' 'having a difficult end-of-life discussion,' and 'advanced care planning' conversations. There are several existing reviews of advice and recommendations for difficult conversations in the medical field (Anderson et al., 2019; Aydin et al., 2020; Collini et al., 2020; Johnson and Panagioti, 2018; Albury et al, 2019). These reviews have included evaluation of a range of training interventions to up-skill practitioners in having difficult conversations and recommended frameworks for delivering difficult news.

Within healthcare, a range of interventions has been created to improve the confidence and communication skills of medical professionals in delivering bad or difficult news. Many of the interventions include elements such as role-playing or simulation, instructional videos, or group discussions (Johnson et al, 2018). Evaluations of short workshops, role-play scenarios, and group discussions have all provided evidence for self-reported improvement in the ability to conduct difficult conversations for medical staff (Griffiths et al., 2015; Bristowe et al., 2014). Findings from a review of interventions suggested these provided increased confidence and competency for having difficult conversations. In addition to those practical benefits, there were also some benefits to clinicians' well-being as there is less fear, stress, and anxiety associated with having to negotiate difficult conversations (Johnson et al., 2018).

Additionally, within the medical sector, there are several frameworks that have been created to assist clinicians in planning and conducting difficult conversations. In a review of suitable models for breaking bad news, Ahmady et al., (2014) discussed the value of five frameworks, highlighting their uses in different settings. The SPIKES model (Baile et al., 2000) is a six-step protocol that provides a

framework for health professionals to deliver bad news, considering: Setting up, Patient perception, patient's invitation, giving knowledge, addressing emotions, providing strategy & summary. The 'SCARS' acronym (Setting, communicate with kindness, Ask, Respond, and reflect and Summary and plan) is used as an aid to help navigate difficult conversations and forms part of a difficult conversations training programme. (Brighton et al., 2017). A more recent proposed protocol SHARE suggests that health care staff should follow four steps which include (1) create a supportive environment, (2) consider how to deliver the bad news, (3) discuss additional information that patients would like to know, and (4) provide reassurance and emotional support (Johnson et al., 2018). The FRAMES model was developed as a motivation-to-change strategy to guide brief interventions to reduce drinking (Sorocco & Ferrell, 2006). FRAMES (feedback, responsibility, advice, menu, empathy, and self-efficacy) is often used in GP brief interventions and research has demonstrated that interventions such as these are somewhat effective in assisting behaviour change, however the challenge appears to be the barriers to engaging individuals and opening the discussion in the first instance.

Limited comparisons have been made with contexts outside of healthcare. An exploratory literature review evaluating what it means to have difficult conversations in the workplace described how most of the literature surrounding difficult conversations from a management perspective mainly consists of self-help books (Kippist & Duarte, 2015). Only two-peer-reviewed papers were found, however one of these sources was focused on medical professionals and published in a medical journal. It is unclear if any specific guidance, frameworks, or training exist for difficult conversations within an organisational context.

The aim of this review is to systematically search current and existing literature relating to difficult conversations in the workplace, to synthesise and evaluate what is known and identify gaps in the knowledge and future research directions. Specifically, this review intends to identify the signals, barriers, and components of difficult conversations.

2. Methods

The systematic review adopted the processes and best practice recommendations from Daniels' (2019) guidance on conducting and reviewing systematic reviews (and meta-analyses) in work and organisational psychology. The protocol was developed and conducted in accordance with the "Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA1)". The electronic databases Scopus, APA PsychNet and Emerald were systematically searched using keywords, phrases, and Boolean operators for peer-reviewed published literature.

2.1 Search Terms

Google Scholar was used to explore the term "difficult conversations" and keywords arising from the results were used to perform a series of dummy searches using the electronic databases Scopus and APA PsychNet in February 2022 to assist the research team in refining the search criteria. After the dummy searches were complete the research team refined their research question and decided upon the final search terms: "Difficult conversations" / "Having difficult conversations" / "Hard conversations" / "Challenging conversations" / "Critical conversations" / "Professional conversations" / "Feedback conversations" / "Performance management conversations".

In addition to the academic database searches, Grey Literature searches were conducted as these were considered important sources of information for our search. We acknowledge that grey literature is difficult to search systematically and there is no standardised approach however we provide a description of our search methods. Grey literature, policy, industry guidance and recommendations were searched using the following sources: Harvard Business Review (HBR), Chartered Institute of Personnel and Development (CIPD), The British Psychological Society (BPS) and The Chartered Management Institute (CMI) using the same search terms used in these searches.

2.2 Study selection – inclusion and exclusion criteria

Inclusion was determined by a predefined criteria as outlined by the PECOS framework (Table 1). The authors also created a detailed exclusion criteria (Appendix 1) to ensure accurate and consistent rationale and decision making for exclusions. Specifically, given the prevalence of recent reviews of difficult healthcare conversations, papers relating to these contexts were excluded.

Screening was first undertaken by title then abstract before the full text of articles were reviewed against the inclusion and exclusion criteria. The screening was conducted by one author (RS) with 10% double screened at each stage by an additional author (CA). Any disagreements were resolved through discussion and consensus. The screening process and results can be found in Figure 1.

Table 1. *PECOS Framework for including articles*

	Description for inclusion
Population	- Working age adults, >18 years of age - Any gender, ethnicity, location, organisations, business/sector/industry - Conversations between professionals (managers, employees & colleagues)
Exposure	- Having (or not having) difficult conversations on any topic considered sensitive or difficult - Any conversation between two or more (adult) parties on any topic - Work-based conversations / conversation that happen in the workplace
Context / Comparator Outcome	- Not Medical Conversations / Healthcare conversations - The signals of, barriers to, components of difficult conversation - Recommendations relating to having difficult conversations
Study Type / Design	- Any published quant, qual. or mixed methods, case study, large n study, peer-reviewed journal - Peer-reviewed journal articles including conceptual papers, intervention evaluation studies - Grey literature which includes Professional & Regulatory Body Policy and Best Practice guidance, recommendations, or research. Editorials or articles published in Industry or Professional Edited Magazines - Other grey literature may include PhD papers, other industry professional advice

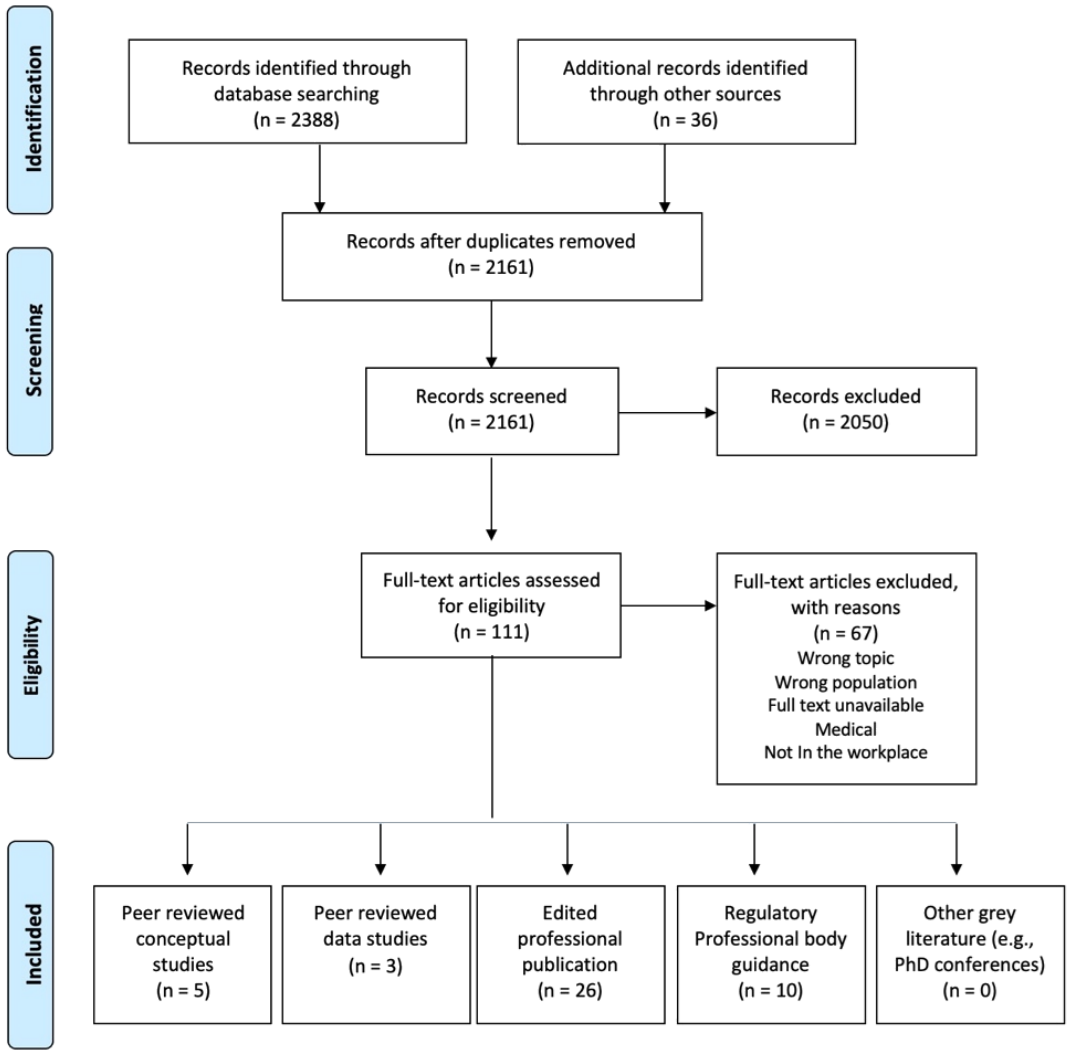

Figure 1 *PRISMA Flow Diagram*

2.3 Data extraction

A list of the included literature can be found in Appendix II. Data were extracted using a preformatted data extraction sheet. Study population data (sample size, demographic information, location) and study characteristics (authors, title, publication year, study design, measures used and analysis methods) were extracted for each data source. Results, conclusions, and recommendations were collected. Where possible, these were identified in terms of signals, barriers, recommendations and 'other information'.

2.4 Data evaluation

The data was assessed in terms of quality and strength. The quality of included literature was assessed independently by both authors using the criteria outlined in table 2. Any disagreements were discussed and agreed through consensus.

Table 2 *Evaluating the quality of evidence rating criteria*

Quality	**Definition for Peer-Reviewed Conceptual Evidence**	**Definition for Peer-Reviewed Data Evidence**	**Definition for Non-Research Evidence – Edited Professional Publication**	**Definition for Non-Research Evidence – Regulatory Professional Body Literature**
High	Synthesises a wide range of knowledge from previous work, presenting it to provide recommendations for future research to fill knowledge gaps. Does not include primary data but does present an original concept	Consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence	Synthesises a broad range of practitioner experiences, presenting clear recommendations for action and a structure for approaching a specific context. May not present data but does provide a range of real-life examples to illustrate recommendations	Expertise is clear. Uses primary data or research to support recommendations
Good	Builds on existing knowledge from previous studies / theoretical frameworks and highlights clear recommendations. Does not include primary data but does present recommendations based on previous work	Reasonably consistent results, sufficient sample size, some control, and definitive conclusions; reasonably consistent recommendations based on comprehensive literature review that includes some reference to scientific evidence	Uses evidence from practitioner experiences, presenting clear recommendations for action. Uses real life examples to illustrate recommendations	Expertise appears credible. May not include primary data or research, but uses real-life examples to illustrate recommendations
Low	Presents recommendations and highlights some links to existing theory	Little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn	Presents recommendations with limited or no reference to experience of examples	Expertise is not discernible or is dubious. Presents recommendations without reference to experience or examples

2.5 Data Themes

After data extraction and evaluation of the quality of each paper, the literature was interrogated for themes to identify any themes relating to the signals, barriers, and components of difficult

conversations in the workplace. The strength of the evidence for each of the themes was evaluated based on the criteria in table 3.

Table 3 *Evaluating the strength of evidence for themes identified across the literature.*

Strength of evidence	**Criteria**
Very Strong	Predominately high-quality evidence sources including at least 2 high quality peer-reviewed source of evidence
Strong	Includes multiple high quality and good sources of evidence, includes at least one good quality or higher peer-reviewed sources of evidence
Moderate	Predominately high or good quality sources of evidence, but does not include any high or good quality peer-reviewed sources of evidence
Some	Predominately low-quality evidence sources, does not include any peer-reviewed evidence sources

3. Results

Our search resulted in a total of 2388 hits from the database, grey and alternative literature searches. A total of 44 sources were included in the final review having met the inclusion criteria. The sources of evidence fell within two broad categories, Peer-reviewed literature (n = 8), and Professional industry literature (n = 36). This included peer-reviewed conceptual studies (n = 5), Peer reviewed data studies (n = 3), Edited Professional Publications (n = 26), and Regulatory Professional Body guidance, policy, or research (n = 10), (figure 3). A summary table of all the included articles can be viewed in appendix 2.

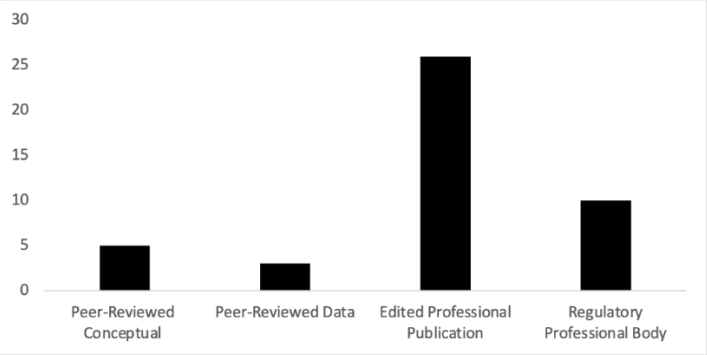

Figure 3. *Types of evidence sources included in the review*

The quality of evidence was assessed using a predefined criterion (table 3), resulting in the following quality ratings (Table 4). Of the five peer-reviewed conceptual papers, only one was rated high quality. Two of the three peer reviewed papers reporting data were rated high quality. 15 of the 36 grey literature documents included were rated as high quality.

Table 4 *Quality Ratings of selected sources of evidence*

Quality Rating	Peer-reviewed conceptual	Peer-reviewed data	Edited Professional Publication	Regulatory Professional Body
High	5	1, 8	10, 13, 16, 18, 22, 24	35, 36, 37, 38, 39, 40, 41, 43, 44
Good		4	9, 11, 17, 19, 20, 26, 27, 28,	42
Low	2, 3, 6, 7		12, 14, 15, 21, 25, 29, 30, 31, 32, 33, 34	

Numbers relate to the studies listed in the appendices

3.1 Theme analysis

3.1.1 Signals of a difficult conversation

Within the review there was extremely limited evidence relating to the signals of difficult conversations therefore, no main themes or subthemes were identified. A few articles alluded to the possible reasons why a difficult conversation might need to happen as well as some potential signs that a conversation may be needed. (Table 5)

Table 5 *Signals of a difficult conversation summary*

Signals	**Peer-Reviewed Conceptual**	**Peer Reviewed Data**	**Edited Professional Publication**	**Regulatory Professional Body**
Feeling stressed, nervous, angry, or upset	35, 54		15	
Changes in performance				44
Changes in behaviour			17	44
Conflict within the team			27, 31	
A loss of respect or trust			17, 27	

Numbers relate to the studies listed in the appendices

3.1.2 Barriers to having difficult conversations

Barriers are anything that prevents or delays a conversation, or the reasons individuals give for wanting to avoid such a conversation. Four main themes were identified: Fear, Competency, Relational and Emotional (Table 6)

Table 6 *Barriers of difficult conversations - themes, subthemes, sources and evaluation of evidence*

Barriers Subtheme and Summary Description	**Peer-Reviewed Conceptual**	**Peer Reviewed Data**	**Edited Professional Publication**	**Regulatory Professional Body**	**Strength of evidence**
Fear (Fear of uncertainty, conflict or of potential outcomes, consequences, or reprisals)	2, 5	1, 4	12, 24, 26, 27	41, 42, 43, 44	**Very Strong**
Competency (Feeling ill-equipped in terms of knowledge or skills required, a lack of training and guidance)		1, 4	24, 27	36, 37, 38, 39, 43, 44	**Strong**
Relational (Concerns about impact on relationships, breakdown in relationships, wanting to be liked and protect the feelings of others)	2, 5	1	18, 24, 25	43, 44	**Very Strong**
Emotions (Strong emotions such as anxiety, feeling overwhelmed and a build-up of stress, wanting to avoid emotional discomfort)	5		18, 19	43, 44	**Strong**

Numbers relate to the studies listed in the appendices

3.1.3 Components of difficult conversations

The articles and sources were examined to establish if there were any consistent components of difficult conversations. Specifically, the aim was to identify whether there was clear evidence of the stages of a difficult conversation or information relating how to structure a difficult conversation. There was a larger proportion of evidence for the components of a difficult conversation within the review, compared to the evidence for the signals and barriers. Three main themes were identified, the preparation phase, the delivery phase, and the transition phase. Within each of the main themes several subthemes were identified.

Components: Preparation Phase

This theme focuses on recommendations for how to prepare for a difficult conversation and discusses actions an individual may take before embarking on a difficult conversation. Within this theme, three subthemes were identified, Plan, Intentions & Goals, Practice, and Practical Considerations (Table 7)

Table 7. *Components: Preparation Phase - themes, subthemes, sources and evaluation of evidence*

Preparation Phase Subtheme and Summary Description	**Peer-Reviewed Conceptual**	**Peer Reviewed Data**	**Edited Professional Publication**	**Regulatory Professional Body**	**Strength of evidence**
Intentions & Goals (Planning for the conversation in advance, clarifying the intentions, goals, purpose and intended outcomes, creating agendas, and deciding upon key talking points ahead of conversations)	7	1	10, 13, 15, 16, 18, 19, 20, 21, 23, 25, 26, 27, 28, 29, 31, 33	42, 44	**Strong**
Practice (Practicing with trusted friends or colleagues, rehearsing conversations, anticipating possible reactions enabling consideration of possible emotional reactions or responses)	7	1, 4	20, 26		**Strong**
Practical Considerations (Considering the environment, location, and timing of the conversations to make participants feel as comfortable as possible)		1	10, 20, 23, 25, 26, 30	41, 42, 44	**Strong**

Numbers relate to the studies listed in the appendices

Components: Delivery Phase

The delivery phase focuses on the actual conversation and the considerations and actions that need to be taken during the conversation. There were 6 subthemes identified within the delivery phase outlined in Table 8.

Table 8. *Components: Delivery Phase - themes, subthemes, sources and evaluation of evidence*

The Delivery Phase Subtheme and Summary Description	**Peer-Reviewed Conceptual**	**Peer Reviewed Data**	**Edited Professional Publication**	**Regulatory Professional Body**	**Strength of evidence**
Listen (The importance of actively listening, with full attention, allowing time for processing and reflection)	3, 6		10, 12, 16, 21, 23, 25, 27, 29, 30, 34	35, 38, 41, 42, 43, 44	**Moderate**
Clarity (Ensuring information is articulated in a clear, direct, and concise way, being specific about the goals, intentions, and desired outcomes)	7		9, 10, 12, 15, 16, 18, 21, 23, 24, 26, 29, 30, 34	37, 38, 42, 43	**Moderate**
Collaboration (Emphasis on the conversation being a partnership, with participants invited to share their thoughts, feelings, and perspectives)	6, 7	1, 8	9, 14, 16, 25, 26, 27, 29, 30, 31	35, 38, 39, 41, 42	**Very Strong**
Emotional Awareness (The importance of self-awareness, emotional awareness, being able to recognise and respond the emotions and emotional reactions of self and others, demonstrating empathy)	3, 6, 7	1	14, 15, 17, 18, 19, 20, 21, 24, 30, 34	38, 41, 44	**Strong**
Mindset & Approach (Considering the approach, entering the conversation with an open mind, in a non-judgemental manner, avoiding assumptions and biases, demonstrating authenticity, care, concern and mutual respect, ensuring full transparency and honesty)	3, 5, 6, 7		9, 10, 15, 18, 20, 21, 24, 25, 26, 31	37, 38, 40, 41, 42, 43, 44	**Strong**

Numbers relate to the studies listed in the appendices

Components: Transition Phase

The transition phase refers to the end of the conversation and any period after the conversation has taken place where actions or behaviour change are expected. This phase was focused on just one area, the follow-up and next steps after the conversation has taken place (Table 9).

Table 9. *Components: Transition Phase - themes, subthemes, sources and evaluation of evidence*

The Transition Phase Subtheme and Summary Description	**Peer-Reviewed Conceptual**	**Peer Reviewed Data**	**Edited Professional Publication**	**Regulatory Professional Body**	**Strength of evidence**
Follow-up & Next Steps (Recapping the discussion, agreeing appropriate actions, checking understanding of actions, and ensuring and a follow-up schedule is in place for further review or discussion)	7		23, 24, 25, 27, 29, 30	38, 41, 42	**Some**

Numbers relate to the studies listed in the appendices

3.1.4 Summarising themes

A summary of the themes, illustrating signals, barriers and components of difficult conversations in the workplace and the strength of evidence for these themes can be found in figure 4. These themes were also compared with those identified in other reviews of difficult conversations in the medical field (as noted in the introduction). This comparison is found in Table 10.

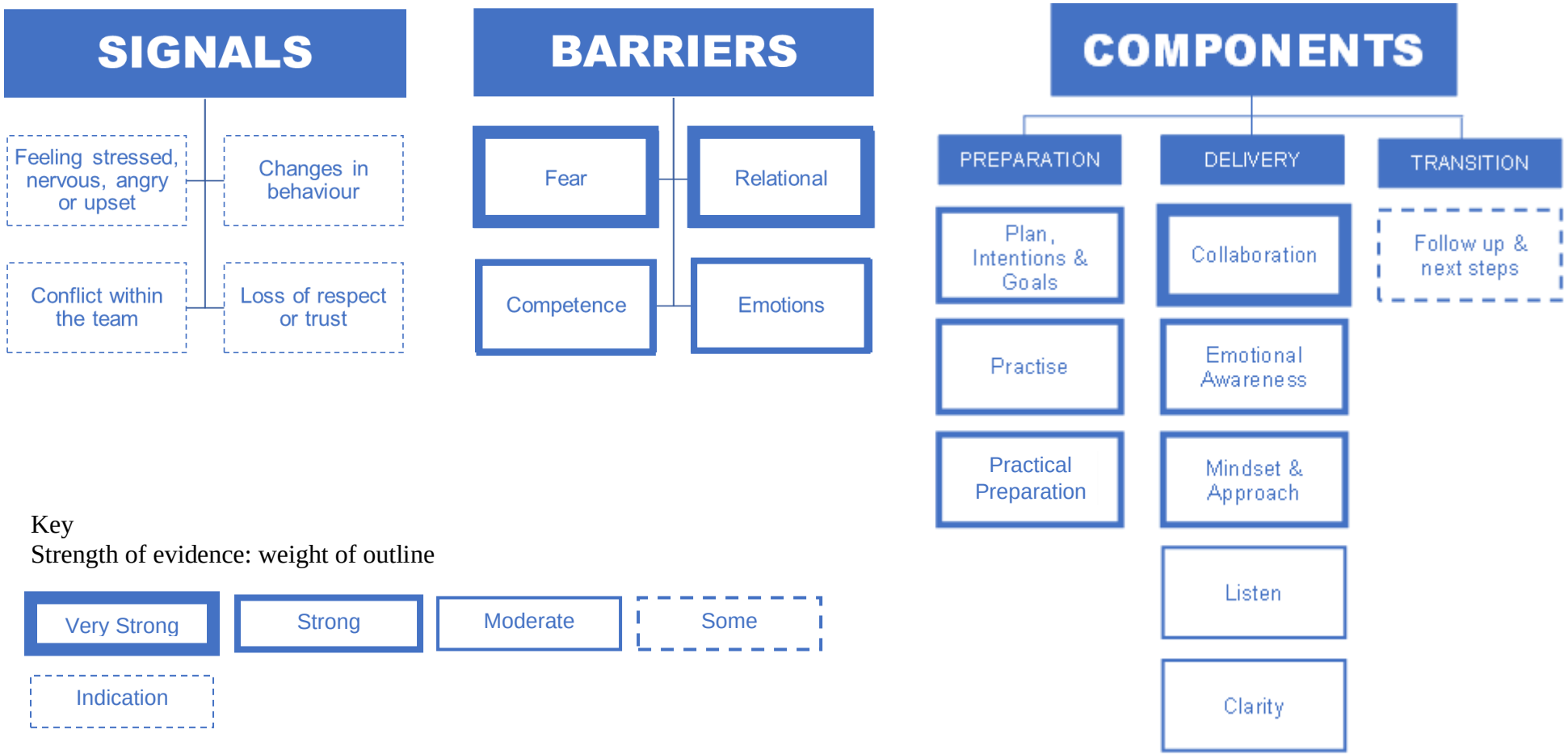

Figure 4. *Visual Summary of final themes and subthemes*

Table 10: *The signals, barriers, and components of difficult conversations: Summary*

	Themes from this review: difficult conversations in the WORKPLACE	**Evidence from other reviews: difficult conversations in the MEDICAL FIELD**
Signals	- Feeling stressed, nervous, angry, or upset - Changes in performance - Changes in behaviour - Conflict within the team - A loss of trust or respect	None identified – reviews relate to conversations between medical practitioner and patient; at diagnosis or delivering 'bad news' already identified
Barriers	Fear	*Bristowe et al. (2014)* Avoidance
	Relational	*Bristowe et al. (2014)* Limited support
	Competence	*Bristowe et al. (2014), Aydin et al. (2020)* Lack of Competence, Time, Training
	Emotions	*Collini et al. (2020)* Avoidance
Components	PREPARATION (intentions, practice, practical)	*Baile et al (2000)* SPIKES *Brighton et al (2017)* SCARS
	DELIVERY (Listen, clarity, collaboration, emotional awareness, mindset)	*Baile et al (2000)* SPIKES *Johnson et al (2018)* SHARE *Miller & Rollnick (1991,2002)* FRAME
	TRANSITION (Follow up & Next Steps)	*Brighton et al (2017)* SCARS

For reference:

SPIKES (Baile et al 2000) refers to: Setting up, patient perception, patient's invitation, giving knowledge, addressing emotions, providing strategy & summary.

SCARS (Brighton et al 2017) refers to Setting, communicate with kindness, Ask, Respond, Summary.

SHARE (Johnson et al 2018) refers to: Supportive environment, consider how to deliver bad news, discuss additional information, reassurance, emotional support

FRAME (Miller & Rollnick 1991,2002) refers to: Feedback, responsibility, advice, menu, empathy, and self-efficacy.

4. Discussion

4.1 Limited peer reviewed evidence

The aim of this review was to explore the signals, barriers, and components of difficult conversations**.** Whilst there is an abundance of literature that focuses on difficult conversations or breaking bad news in the medical sector, there were no reviews regarding difficult conversations in the workplace. We systematically searched three electronic databases and several targeted professional websites with a range of search terms relating to the topic and 44 sources of literature were included in the final review. Most of the literature came from professional industry sources rather than peer-reviewed research. There were 5 peer-reviewed conceptual studies, 3 peer-reviewed data studies, 26 Edited professional publications and 10 Regulatory Professional body sources. This mirrors the scoping review conducted by Kippist and Duarte (2015), demonstrating that seven years after that review, there is still minimal peer-reviewed literature on the topic of difficult conversation in the workplace, with much of the literature still originating in healthcare.

The overall quality of the conceptual papers in this review were assessed as low, with four of the articles having limited or no links to existing theory or evidence. They provided a general background about the topic of difficult conversations and made some broad recommendations for structuring a difficult conversation in line with the industry guidance, however there was limited discussion surrounding how this knowledge could be used to develop understanding in this area.

The peer-reviewed data studies, whilst limited to only three, demonstrated the potential for adapting medical interventions and applying these within an organisational context. These studies highlighted that lack of confidence, skills and knowledge are the main reasons individuals struggle to have difficult conversations, much like clinicians or medical personnel (Marcus & Mott, 2014). They also provided an indication that interventions, such as bad news training and role play scenarios could be a valuable method of developing these apparent shortcomings, however due to the limited number of research studies exploring this within organisations, further research is recommended to truly evaluate the effectiveness outside of the medical sector.

Whilst the overall quality of the edited professional publication articles was variable, there was a great deal of consistency in the advice and recommendations provided for having difficult conversations, as such we feel it is important not to discount industry expertise. Industry professionals provide an additional level of insight that is not available from the limited peer-reviewed studies, providing lived experience examples upon which to base any future development of models of frameworks within and organisational context.

4.2 Signals a difficult conversation is required in the workplace

As the results chapter demonstrates, there was limited evidence for the signals of a difficult conversation (table 6). Whilst there were some short references to potential reasons why a difficult conversation may be needed, there was little information surrounding specific signals that someone might look out for to indicate a conversation may be needed. Whilst this may be a result of the nature of the evidence available, being focused on the having the actual conversation, it may also highlight a training need for managers and supervisors in being able to recognise the signs of a potential problem with an employee. An alternative explanation for the lack of evidence for the signals of a difficult conversation may be because different problems present themselves in different ways, and individuals facing issues may not display the same signals that there is something amiss.

4.3 Barriers to difficult conversations in the workplace

There was more evidence for the barriers (table 7), as these are perhaps easier for individuals to identify. There was very strong evidence that fear plays role in individuals avoiding difficult conversations – "*the reality, is that managers are often afraid of the consequences*" [24]; "*another constraint is the fear of the unknown, particularly when the individuals who have to engage in this sort of discussion are used to being the person in control*" [26]. There was also very strong evidence for individuals having concerns about the impact on relationships and wanting to protect the feelings of others: "*these conversations are tough because we don't want to upset the other person*" [18]. There was also strong evidence that people often avoid difficult conversations due to feeling ill equipped emotionally (emotions) and practically (lack of competence) to have them. Indeed, "*58% of those surveyed found the process stressful*" [58]. Individuals may not have adequate training or support in conducting difficult conversations, therefore choose to avoid them through fear and uncertainty, rather than tackling the challenging issues that arise: "*avoiding the situation feels less stressful than confronting it*" [27].

The barriers highlighted within the review share similarities with many of the barriers discussed in the medical literature (e.g. Albury et al, 2019; Kaner et al, 1999). Unlike the training and interventions trialled within the healthcare industry, there was limited discussion on methods for overcoming these barriers within the workplace, such as detailing training and development opportunities or introducing frameworks or models that could be used. Only one study (Richter, Manuela, Konig et al, 2017) evaluated the effectiveness of a training intervention within the workplace focused on the delivery of bad news. The findings of this study did provide evidence of positive benefits like those reported in the vast medical literature evaluating the effectiveness of training for delivering bad news (Clayton et al, 2013; Griffiths et al, 2015, Bristowe et al, 2014). However, additional research is required to truly understand the benefits of this training intervention in additional contexts.

4.4 Components of difficult conversations in the workplace

The components of difficult conversation were the focus of most of the evidence reviewed. The literature highlights recommendations around preparation, delivery and signposting next steps or follow up (transitions).

In terms of **preparation**, there was strong evidence for planning the conversation in advance, clarifying intentions, goals, intended outcomes. Advice included, "*your audience must understand and trust the purpose you have started for the meeting, list the outcomes you desire*" [10]. There was also strong evidence to recommend practising the conversation with trusted colleagues, anticipating possible reactions to help manage emotions and reactions. There was also strong evidence highlighting the need to attend to practical considerations for the conversation – advice included "be prepared to practice what you want to say in advance, but don't rehearse every word" [20]. Considering the environment, location and timing of the conversations to make participants feel as comfortable as possible were also recommendations – "*schedule the meeting, don't pop in. Ambushing people creates anxiety and breaks down trust*" [30].

The **delivery** themes (table 9) highlighted very strong evidence to recommend a collaborative approach and inviting individuals to share their thoughts, feelings and perspectives – "*treat the conversation as two people working together to solve a problem… this gives both sides ownership over the conversation and outcome*" [16]. There was also strong evidence for personal emotional awareness and "*the skill of regulating emotional responses in difficult conversations*" [18]. Here, the importance of self-awareness is highlighted whilst also being able to recognise and respond to the emotions of others by demonstrating empathy. This links with the strong evidence for taking a considered approach and managing one's mindset to "*avoid assumptions – making assumptions also limits our effectiveness because it prevents us from fully understanding the situation and narrows the range of solutions we consider*" [9]. Managing mindset also helps limit biases and maintains mutual respect and authenticity. Linked to these themes, there was also moderate evidence to recommend a focus on "*pausing your own agenda to really listen to the other person's side*" [16]. Being clear, direct and expressing oneself concisely is also noted as "*transparency helps facilitate productive conversations*" [9].

Ending the conversation and **transitioning** the conversation was the final phase of the components highlighted in this review. Here the evidence was limited to the grey literature. There was some evidence to recommend recapping the discussion, agreeing appropriate actions and checking understanding. This transition phase emphasised that these difficult conversations may not be one-

time events and are often the beginning of a longer-term solution: "*work towards what's next. Have a clear understanding of what kind of follow up is expected and agree on a time to talk or check in again*" [29].

The medical literature presents several frameworks designed to assist clinicians in having difficult conversations with patients, often focused on how to deliver bad news: SPIKES, SCARS, SHARE, FRAMES. Many of the reviewed articles suggested similar approaches for having a difficult conversation at work. Neither the number of steps recommended nor one framework was referenced more than once. This highlights a lack of standardisation in the approach to tackling difficult conversations in the workplace. We acknowledge that due to the vast nature of potential topics for difficult conversations within the workplace, it may be difficult to create a 'one size fits all' approach to navigating difficult conversations. There is however evidence that clinicians benefit from having standardised frameworks upon which to frame these difficult conversations, reporting more confidence in their ability to deliver bad news (Ahmady et al, 2014). This indicates potential for synthesising the vast recommendations for approaching difficult conversations at work to create a similar framework or guidance for industry professionals.

The very strong theme of collaboration in this review distinguishes difficult conversations in the workplace from difficult conversations in a healthcare setting. Whilst both settings encourage listening and asking questions, the workplace context requires less focus on telling an individual what to do or making conclusions and judgements. A greater focus is required on working in partnership and encourage sharing of views and perspectives.

The main similarities with the extensive medical literature were found in the preparation phase, whereby several authors alluded to the benefits in practicing or rehearsing the conversation in advance. There were no formal training recommendations discussed in the literature as with the medical literature, as such it would be useful to draw upon the evidence from the reviews of training interventions involving role-play scenarios with patients (Johnson et al, 2018) to see whether similar activities would be beneficial for training managers within organisations in having difficult conversations. Within the delivery phase, much of the discussion was around the approach taken, listening skills and emotional awareness. Whilst there were multiple recommendations that individuals having difficult conversations need to 'have these skills' there was no indication from authors on how one might develop them, suggesting a gap in the current literature. The obvious lack of a framework such as those used within healthcare presents challenges for managers in how to enter a difficult conversation, how to structure it and how to utilise the skills mentioned in conversations.

The most obvious observation from the review is the need for training and standardised guidance for having difficult conversations. The themes demonstrate there are clear and consistent recommendations for having a difficult conversation based upon industry professionals' own experiences. However, there are no examples of any frameworks or models within an organisational space that encompass the range of recommendations and provide clear processes to be used.

4.5 Limitations

Whilst this study followed a systematic approach, we acknowledge that there are limitations to systematically searching grey literature and findings are restricted by the sources available within the search parameters. There were limited peer-reviewed articles in the final review, with most of the evidence coming from grey literature sources. Whilst we view industry and professional expertise as a valuable contribution to the findings of this review, much of this literature is based upon individual opinion and experience as such we acknowledge that further research is necessary to support the recommendations outlined in this review.

Many of the grey literature sources were published in Harvard Business Review (HBR) which may have created some bias in the findings of the review, and this should be considered. What these limitations highlight is the gap in peer-reviewed research exploring the concept of difficult conversations, which can be used to inform future research.

4.6 Future directions

Future research should look to **design and pilot difficult conversation** training within an organisational context. The clear benefits associated with such training interventions within healthcare, demonstrate the potential to alleviate many of the skills, competency and emotional barriers that prevent managers from being able to have successful difficult conversations. Brighton et al (2017) showed that short workshops and role play scenarios increased self-rated ability in conducting difficult conversations, and the practical benefits of training include increases in confidence and competency which created additional benefits in reducing fear, anxiety, and stress, leading to improvement in the well-being of those having to have a difficult conversation (Johnson et al, 2018).

Developing a formal model and framework, potentially adapting those used within the medical sector may assist in the development of training interventions, or at least provide managers with some form of guidance in how to approach a difficult conversation, rather than entering them with uncertainty and fear. It would provide an opportunity to synthesis all the advice given in the multiple sources, books or magazines and journal articles for the components of a difficult conversation, to create a helpful structure for planning and having difficult conversations, thus reducing the barriers.

The lack of evidence for the **signals of difficult conversations** from the review demonstrate an additional and perhaps important avenue for future research. If managers are not skilled in identifying the signs and signals a difficult conversation may be needed, then opportunities to implement their training in having these discussions may be missed. If there is a wider understanding of the signals that may warrant a difficult conversation, it may in fact lend itself to earlier intervention with problematic workplace issues, ultimately reducing the difficulty of the conversation when it does indeed take place.

References

ACAS, www.acas.org.uk

Ahmady, A. E., Sabounchi, S. S., Mirmohammadsadeghi, H., & Rezaei, A. (2014). A suitable model for breaking bad news: Review of recommendations. *JMED Research*, *2014*, 1-15.

Albury, C., Hall, A., Syed, A., Ziebland, S., Stokoe, E., Roberts, N., ... & Aveyard, P. (2019). Communication practices for delivering health behaviour change conversations in primary care: a systematic review and thematic synthesis. *BMC family practice*, *20*(1), 1-13.

Anderson, R. J., Bloch, S., Armstrong, M., Stone, P. C., & Low, J. T. (2019). Communication between healthcare professionals and relatives of patients approaching the end-of-life: a systematic review of qualitative evidence. *Palliative medicine*, *33*(8), 926-941.

Aydin, O. A., Bastarcan, C., & Kaptanoglu, A. Y. (2020). Breaking bad news in palliative care: literature review. *Folia Palliatrica*, *1*, 19-29.

Annual Reviews: Difficult conversations made easier. (2017). *Human Resources Magazine*, *22*(1), 30–31.

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. *The oncologist*, *5* (4), 302-311.

Bradley, G. L., Campbell A. C. (2016). Managing difficult workplace conversations: Goals, strategies and outcomes, *International Journal of Business Communication, 53* (4), 443-446.

Brighton, L. J., Selman, L. E., Gough, N., Nadicksbernd, J. J., Bristowe, K., Millington-Sanders, C., & Koffman, J. (2018). 'Difficult Conversations': evaluation of multiprofessional training. *BMJ supportive & palliative care*, *8*(1), 45-48.

Bristowe, K., Shepherd, K., Bryan, L., Brown, H., Carey, I., Matthews, B., ... & Murtagh, F. E. (2014). The development and piloting of the REnal specific Advanced Communication Training (REACT) programme to improve Advance Care Planning for renal patients. *Palliative Medicine*, *28*(4), 360-366.

Chartered Institute of Personnel and Development (CIPD) – www.cipd.co.uk

Chartered Management Institute (CMI), www.managers.org.uk

Collini, A., Parker, H., & Oliver, A. (2021). Training for difficult conversations and breaking bad news over the phone in the emergency department. *Emergency Medicine Journal*, *38*(2), 151-154.

Conduct Difficult Conversations with Ease. (2017). *Volunteer Management Report*, *22*(6), 5. https://doi.org/10.1002/vmr.30667

Daniels, K. (2019). Guidance on conducting and reviewing systematic reviews (and meta-analyses) in work and organizational psychology. *European Journal of Work and Organizational Psychology*, *28*(1), 1-10.

Difficult conversations over Zoom: 8 tips for success. (2021). *HR Specialist*, *19*(10), 6.

Farrell, M. (2015). Difficult Conversations. *Journal of Library Administration, 55*(4), 302–311. https://doi.org/10.1080/01930826.2015.1038931

Federer, D. P. (2014). Having the Difficult Conversation. *On Wall Street, 24*(2), 37–38.

Fernandez, C. P. (2008). Managing the difficult conversation, *Journal of Public Health Management and Practice, 14* (3) 317-319

Gabbey, A. E. (2018). How to Prepare for Difficult Conversations. *Volunteer Management Report, 23* (11), 3. https://doi.org/10.1002/vmr.31028

Gallo, A. (2015). How to Make Sure You're Heard in a Difficult Conversation. *Harvard Business Review Digital Articles*, 2–5.

Gallo, A. (2016). How to Mentally Prepare for a Difficult Conversation. *Harvard Business Review Digital Articles*, 2–4.

Gallo, A. (2017). How to Control Your Emotions During a Difficult Conversation. *Harvard Business Review Digital Articles*, 2–4.

Garfinkle, J. (2017). How to Have Difficult Conversations When You Don't Like Conflict. *Harvard Business Review Digital Articles*, 2–4.

Grenny, J., & Cullimore, D. (2021). How to Have Those Difficult Return-to-Office Conversations. Harvard Business Review Digital Articles, 1–6.

Griffiths, J., Ewing, G., Wilson, C., Connolly, M., & Grande, G. (2015). Breaking bad news about transitions to dying: a qualitative exploration of the role of the district nurse. *Palliative medicine*, *29*(2), 138-146.

How to Have a Difficult Conversation. (2012). *Nonprofit World*, *30* (5), 28.

How to have those 'tough talks' with employees: 10 tips. (2019). *HR Specialist*, *17*(12), 6.

Johnson, J., & Panagioti, M. (2018). Interventions to improve the breaking of bad or difficult news by physicians, medical students, and interns/residents: a systematic review and meta-analysis. *Academic Medicine, 93* (9), 1400-1412.

Jones, K. (2016). The Work Conversations We Dread the Most, According to Research. *Harvard Business Review Digital Articles*, 2–7.

Kippist, L., & Duarte, F. (2015). What Does It Mean Having Difficult Conversations in the Workplace? An Exploratory Literature Review. *Employment Relations Record, 15* (2), 61–74.

Ladika, S. (2020). CAN WE TALK? Difficult conversations have become tougher than ever, as HR professionals factor in physical and mental health issues, economic uncertainty, and struggles employees face working from home. *HR Magazine, 65* (4), 46-51.

Le Fervre, D.M., & Robinson, V.M.J. (2015). The interpersonal challenges of instructional leadership: principals' effectiveness in conversations about performance issues. *Educational Administration Quarterly, 51* (1), 58-95.

Levine, E.E., Roberts, A.R., & Cohen, T.R. (2020). Difficult Conversations: navigating the tension between honesty and benevolence, *Current Opinion in Psychology, 31*, 38-43.

Marini, T. (2018). Good Leaders Have the Difficult Conversations: Talking to someone about their work performance or behavior is never easy, but it must be done. *Modern Machine Shop*, *91*(1), 44–46.

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2012). *Crucial conversations tools for talking when stakes are high*. McGraw-Hill Education.

Patton, B. (2000). Difficult Conversation. *Executive Excellence*, *17*(10), 13.

Priftanji, D., Hill, J.D, & Ashby, D.M. (2020). Managing difficult conversations, American *Journal of Health-System Pharmacy*, *77* (21), 1723-1726.

Rabbetts, J., & Jones, P. (2014). Difficult conversations. *Training Journal*, 28–31.

Richter, M., Konig, C., Kopperman, C., & Schilling, M. (2016). Displaying fairness while delivering bad news: Testting the effectiveness of organisational bad news training in the layoff context. *Journal of Applied Psychology*, 101 (6), 779-792.

Rimm, A. (2013). To Guide Difficult Conversations, Try Using Compassion. *Harvard Business Review Digital Articles*, 2–4.

Rowland, D. (2016). What's Worse than a Difficult Conversation? Avoiding One. Harvard Business Review Digital Articles, 2–4.

Segal, J. (2016). That Difficult Conversation. *HR Magazine*, *61*(3), 74–75.

Sorocco, K. H., & Ferrell, S. W. (2006). Alcohol use among older adults. *The Journal of general psychology*, *133*(4), 453-467.

Tips for Navigating Difficult Conversations. (2017). *Volunteer Management Report*, *22*(8), 7. https://doi.org/10.1002/vmr.30719

Tjan, A. K. (2010). How Good Are You at Critical Conversations? *Harvard Business Review Digital Articles*, 2–4.

Valcour, M. (2017). 8 Ways to Get a Difficult Conversation Back on Track. *Harvard Business Review Digital Articles*, 2–5.

White, N. (2014). Having Difficult Conversations with Borrowers: Dispute Resolution Skills for Success. *Banking Ireland*, 121(1), 16–17.

Wilkie, D. (2015). How to Handle Difficult Conversations. *HR Magazine*, *60* (7), 12.

Worley, C. G., & Jules, C. (2020). COVID-19's uncomfortable revelations about agile and sustainable organizations in a VUCA world. *The Journal of Applied Behavioural Science*, *56*(3), 279-283.

APPENDIX I – EXCLUSION CRITERIA

	Description for Exclusion
Title Screen	• Identified Duplicates • Any title's that do NOT mention any of the keywords *(difficult, hard, challenging, critical, feedback, performance, professional, performance management, mental health)* AND (*conversation, communication, discussion)* • Titles that include an evaluation of a medical training programme, intervention or teaching for communication skills within a medical setting (see previous reviews and introduction for justification of exclusion) • Medical conversations e.g., end-of-life care, chronic illness, cancer prognosis, advanced care planning, death and dying (see previous reviews and introduction for justification of exclusion) • Conversation with or between medical professionals, patients, and relatives (see previous reviews and introduction for justification of exclusion)
Abstract Screen	• Any additional duplicates • Non-Accessible Sources (E.g., not open access) • Books, Book Chapters or Book Reviews • Any source where the abstract does not describe / mention a 'conversation' between two or more parties • Any source where the population criteria is not met (conversations with children or young adults <18 years of age) • Any source that is an evaluation of a medical training programme, intervention or teaching for communication skills within a medical setting (see previous reviews for justification of exclusion) • Medical conversations E.g., end-of-life care, chronic illness, cancer prognosis, advanced care planning, death and dying (see previous reviews and introduction for justification of exclusion)
Full Text Screen	• Any additional duplicates • Non-Accessible Sources (E.g., not open access) • Full Text Unavailable • Any source that does not address the topic of 'difficult conversations' • Any source that does not highlight any of the specific outcomes (signals, barriers, or components of difficult conversations -articles needs to have at least one outcome discussed to be selected)

APPENDIX II – INCLUDED LITERATURE

Study	Type of source	Title	Author / Year	Design / Methods	Population
1	**Peer-reviewed** Data Study	Managing difficult workplace conversations: Goals, strategies, and outcomes	Bradley & Campbell (2016)	Study 1 – Qualitative Semi-structured interviews, analysed using Content Analysis	Study 1 – n = 24 nurse managers, 23 female, 1 male, age range 35-60+
				Study 2 – Quantitative E-survey with items relating to the content and context of a difficult conversation and level of satisfaction with this conversation. The electronic survey included several open-ended questions asking participants to recall a recent conversation in which they had received negative feedback from a superior regarding performance or behaviour, Analysed Using single step regressions	Study 2 - n = 137, (80% female), age range 17-59 (M = 23.4) recruited via convenience sampling.
				Study 3 – Paper Questionnaire which included a version (one of 8) of a difficult conversation scenario, and measure of 3 dependent variables: Conversation satisfaction, likely withdrawal behaviours and likely retaliatory behaviours. Analysed using ANOVAs	Study 3 – n = 204 undergraduate students (71% female), age range 17-54 (M = 22.0)
2	**Peer-reviewed** Conceptual Study	Difficult Conversations	Farrell (2015)		
3	**Peer-reviewed** Conceptual Study	Managing the difficult conversation	Fernandez (2008)		
4	**Peer - reviewed** Conceptual Study	Difficult conversations: navigating the tension between honesty and benevolence	Levine, Roberts, Cohen (2020)		
5	**Peer-reviewed** Data Study	The Interpersonal Challenges of Instructional Leadership: Principals' Effectiveness in Conversations About Performance Issues	Le Fevre & Robinson (2015)	Both studies involved standardized scenarios written scenarios, followed by an actor playing the role of complaining parent (study 1) and a teacher about whom complaints have been made (study 2) for a 7-minute conversation. 1. Research Questions: How effective are principals when discussing parental complaints about teacher performance?	Randomly selected representative sample of principals from a cohort of 156 principals enrolled in the FTP (First time principles) program. N = 27, 16 Female, 11 Male, Age range 31-51+

				2. To what extent do principals' patterns of interpersonal behaviour differ across conversations with teachers and with parents? Participants were given 5 minutes to review the scenario before the conversations but were purposely not given time to rehearse the conversation. Analysis – Conversations were rated on the basis of six skills using a coding book developed by the authors. Statistical Analysis was used, paired t-tests, Pearson correlations. Qualitative analysis was undertaken for transcribed conversations and skills were rated for further quantitative analysis	
6	**Peer-reviewed** Conceptual Study	You can't win by avoiding difficult conversations	Patton (2017)		
7	**Peer-reviewed** Conceptual Study	Managing difficult conversations	Priftanji, Hill, & Ashby (2020)		
8	**Peer-reviewed** Data Study	Displaying fairness while delivering bad news: Testing the effectiveness of organizational bad news training in the layoff context.	Richter; König, Koppermann & Schilling (2016)	Study 1 – Designed to test the overall effectiveness of organizational bad news training. A training group was provided with complete training consisting of bad news delivery and the fairness components and was compared with a no training control group. Training intervention - Classroom training consisted of a half-day workshop comprised of 5 learning modules	Study 1 – N = 51 (30 females, 21 males) with mean age 27.18 years.
				Study 2 – Was designed to identify the specific impact of the two components, bad news delivery and fairness components of organisational bad news training. Three experimental groups were needed. A) training group provided with both components of training. B) a basics group provided with the bad news delivery component only. C) a control group that received neither of the components.	Study 2 – N = 75 young adults (46 females, 29 males) with a mean age of 23.49 years.
9	**Edited Professional Publication** Harvard Business Review (HBR)	8 Ways to Get a Difficult Conversation Back on Track.	Valcour (2017)		

10	**Edited Professional Publication** Harvard Business Review (HBR)	How Good Are You at Critical Conversations?	Tjan (2010)	
11	**Edited Professional Publication** Harvard Business Review (HBR)	How to Control Your Emotions During a Difficult Conversation.	Gallo (2017)	
12	**Edited Professional Publication** Harvard Business Review (HBR)	How to Have Difficult Conversations When You Don't Like Conflict.	Garfinkle (2017)	
13	**Edited Professional Publication** Harvard Business Review (HBR)	How to Have Those Difficult Return-to-Office Conversations.	Grenny & Cullimore (2021)	
14	**Edited Professional Publication** Harvard Business Review (HBR)	How to Make Sure You're Heard in a Difficult Conversation.	Gallo (2015).	
15	**Edited Professional Publication** Harvard Business Review (HBR)	How to Mentally Prepare for a Difficult Conversation.	Gallo (2016)	
16	**Edited Professional Publication** Harvard Business Review (HBR)	The Work Conversations We Dread the Most, According to Research.	Jones (2016).	
17	**Edited Professional Publication** Harvard Business Review (HBR)	To Guide Difficult Conversations, Try Using Compassion.	Rimm (2013)	
18	**Edited Professional Publication**	What's Worse than a Difficult Conversation? Avoiding One.	Rowland (2016).	

	Harvard Business Review (HBR)			
19	**Edited Professional Publication** Human Resource Magazine	Annual Reviews: Difficult conversations made easier.	Annual Reviews (2017)	
20	**Edited Professional Publication** HR Magazine	CAN WE TALK? Difficult conversations have become tougher than ever, as HR professionals' factor in physical and mental health issues, economic uncertainty, and the struggles employees face working from home.	Ladika (2020)	
21	**Edited Professional Publication** Volunteer Management Report	Conduct Difficult Conversations with Ease.	Volunteer Management Report (2020)	
22	**Edited Professional Publication** Executive Excellence	Difficult Conversation.	Patton (2000)	
23	**Edited Professional Publication** HR Specialist	Difficult conversations over Zoom: 8 tips for success.		
24	**Edited Professional Publication** Training Journal	Difficult conversations.	Rabbetts & Jones (2014)	
25	**Edited Professional Publication** Modern Machine Shop	Good Leaders Have the Difficult Conversations: Talking to someone about their work performance or behaviour is never easy, but it must be done.	Marini (2018)	
26	**Edited Professional Publication** Banking Ireland	Having Difficult Conversations with Borrowers: Dispute Resolution Skills for Success.	White (2014)	

27	**Edited Professional Publication** On Wall Street	Having the Difficult Conversation.	FEDERER (2014).		
28	**Edited Professional Publication** HR Magazine	How to Handle Difficult Conversations.	Wilkie (2015)		
29	**Edited Professional Publication** Non-profit World Magazine	How to Have a Difficult Conversation.			
30	**Edited Professional Publication** HR Specialist	How to have those tough talks with employees: 10 tips.			
31	**Edited Professional Publication** Volunteer Management Report	How to Prepare for Difficult Conversations.	Gabbey (2018)		
32	**Edited Professional Publication** HR Magazine	That Difficult Conversation.	Segal (2016)		
33	**Edited Professional Publication** Volunteer Management Report	Tips for Navigating Difficult Conversations.			
34	**Edited Professional Publication** Sales Insider	To minimize stress, PLAN your response to difficult conversations.			
35	**Regulatory Professional body guidance** CIPD	Performance Reviews - Appraisals Factsheet			
36	**Regulatory Professional body guidance** CIPD	Drug and alcohol misuse at work - Training scenarios			
37	**Regulatory Professional body guidance** CIPD	Managing drug and alcohol misuse at work - A guide for employers			

38	**Regulatory Professional body guidance** CIPD	Managing drug and alcohol misuse at work - Guidance for line managers on providing support and dealing with disclosures	
39	**Regulatory Professional body guidance** CIPD	Managing and supporting employees with long-term health conditions - guide for people professionals	
40	**Regulatory Professional body guidance** CIPD	Mediation at work - Mediation fact sheet	
41	**Regulatory Professional body guidance** CIPD	People Managers' guide to mental health	
42	**Regulatory Professional body guidance** ACAS	Challenging conversations and how to manage them	
43	**Regulatory Professional body guidance** CMI	Challenging conversations and how to manage them	
44	**Regulatory Professional body guidance** CMI	Handling difficult conversations checklist	