

# Exploring the Comfort Model for Complex Communication for Physiotherapists in Neurorehabilitation: A Critical Review

Selma Pelaez\* and Michelle C Hall

School of Health Sciences, Clinical Sciences Building, City Hospital Campus, The University of Nottingham, Nottinghamshire, UK

## Corresponding author

Selma Pelaez, Msc, UNeurorehabilitation Service (Physiotherapy department), University Clinics (Clínica Universitària), University of Manresa (UManresa), 08242 Manresa (Barcelona), Spain. E-mail: [spelaez@umanresa.cat](mailto:spelaez@umanresa.cat).

Submitted: 30 Mar 2017; Accepted: 10 Apr 2017; Published: 16 Sep 2017

## Abstract

Literature has evaluated the level of accomplishment of the Patient-centred care (PCC) model from physiotherapists working in Neurorehabilitation. Reviewing the literature has revealed a lack of skills, confidence and training by physiotherapists to communicate difficult or complex information, such as poor prognosis or shared goal-setting, leading patients and families to complain about the need for more empathy, encouragement for patients to foster autonomy and rapport with physiotherapists. This problem is not unique to physiotherapists in neurorehabilitation and can be found in other medical disciplines. Many frameworks have been designed in order to teach how to successfully lead communication in stressful situations. However, the COMFORT model, which is an acronym for seven key principles of effective communication, is a grounded framework based on PCC ideals.

This study aims to review the evidence of the effectiveness of the COMFORT model used by other health care professionals (HCPs) to implement it for physiotherapists in neurorehabilitation to explore patients' multifactorial lives, break bad news (BBN) effectively, and manage the emotional labour implied in complex scenarios such as discharging or setting treatment goals. Numerous databases were electronically searched and through a critical realist approach, six studies that applied this communication framework in different medical specialities have been reviewed. Through the scope of the self-efficacy theory, the COMFORT model can be considered a suitable communication framework to be used by physiotherapists due to increasing their confidence, teaching how to approach the emotional dimension implied in neurorehabilitation and having the potential to change clinical practice. Recommendations are to conduct studies on physiotherapists working in Neurorehabilitation in order to display the effectiveness of the COMFORT curriculum but also, to design specific communication frameworks tailored for physiotherapists working in a challenging setting as neurorehabilitation.

**Keywords:** COMFORT, Model, Communication, Physiotherapists, Neurorehabilitation.

## Introduction

The biopsychosocial (BPS) model today is considered to be an inherent requisite in health care that takes its form in a patient centred care (PCC). BPS's main concern is attending to the health needs of patients by addressing the multifactorial aspects of health that include the biological, psychological, and social aspects [1,2]. Additionally, the philosophy of PCC is to facilitate an active engagement with the patient in the process of rehabilitation. Communication plays a crucial role in ensuring an effective implementation of the PCC based on building a provider-patient relationship by pursuing three goals: establish an interpersonal relationship, facilitate information exchange, and facilitate patient involvement in decision making [3,4]. The values, needs, and goals of patients taking importance over healthcare professionals' medical decisions [5-9].

In Neurorehabilitation a key aspect of PCC is the patients involvement in the setting of shared goals. Neurorehabilitation

aims to reduce the impact of disability and handicap, and improve the quality of life for 3 People who have a neurological disease or condition [10]. The complexities of neurological conditions can make it difficult to provide specific information regarding prognosis as well as predicting the degree of recovery [11]. This requires HCPs and specifically physiotherapists to deal with stressful situations such as communicating poor prognostic information or negotiating realistic rehabilitation goals that can be challenging in terms of delivering PCC [12-14]. Involvement of patients and their families in goal setting and the planning of treatment is considered a key part of neurorehabilitation and is also central to the concept of PCC [12,15,16].

Studies exploring patients' experiences and satisfaction in neurorehabilitation indicate that while physiotherapists successfully encourage and motivate patients during treatment they often fail to implement PCC entirely. For example, patients' fears are poorly addressed or rehabilitation goals do not match with patients' preferences to reach [12,17,18]. Research has indicated that physiotherapists are ill-prepared for the implied emotional endeavour attached to implementing a PCC and as a consequence,

---

there is still a biomedical discourse in clinical encounters [19-21]. Furthermore, many physiotherapists reported finding themselves at a juncture that communicating changes in treatment or delivering an unfavourable prognosis, may provoke a loss or diminishment of hope for families and patients and emotional issues resurface [22-24]. Therefore, psychology is essential to deal with all these issues from patients and emotional endeavour suffered by the physiotherapist, attached to PCC rehabilitation.

Jevon and Johnston highlighted that minimal formal training in psychological theory or practice was provided by undergraduate physiotherapy programmes and represented less than five percent in Masters or in Postgraduate courses. Furthermore, Heaney et al. supported these findings reporting that the psychological content of these programmes was inconsistent, and Arvinen-Barrow et al. found that psychological interventions and their use in practice seemed not been integrated into previous physiotherapy training. This makes that physiotherapists are aware of their lack of formal training in psychology and may lead physiotherapists to avoid conversations with patients about progress or likely recovery, or physiotherapists giving ambiguous responses for fear of raising hopes and consequently, disappointment in their patients [25].

Competent communication requires skills that embrace being compassionate and empathetic [26,27]. The ongoing process of rehabilitation requires tackling whether delivering bad news or unfavorable prognosis with confidence [28-30]. Further challenges are responding to the patient's level of understanding either from health literacy levels or cultural differences and dealing with concerns and fears from either patients or relatives [12,31-34].

### Self-efficacy Theory

Research has reported that physiotherapists do not sufficiently know how to interpret reactions from patients, how to satisfactorily drive complex clinical encounters or explain discharge decisions without disrupting the rapport with the patient that is essential for goal-setting [12,13,14]. All these issues result in physiotherapists feeling unsure about their skills in managing these complex scenarios hindering the evaluation of one's own performances, the motivation to improve, suffering stress, anxiety and decreasing the quality of their emotional life. Hence, there could be a relationship between the actual concerns among physiotherapists in neurorehabilitation related to communication with patient/family and self-efficacy, defined as being confident in one's own abilities to carry out behavior effectively [35].

This theory supports the fact that stressful situations such as goal setting or delivering poor health outcomes generally elicit emotional arousal that might affect personal competency and thus, perceived self-efficacy in coping with such situations [35]. These factors tend to debilitate performance such as rejecting shared goal setting, avoiding an ongoing dialogue with patients and not building rapport between the physiotherapist-patient-family [35,36]. In front of this scenario, self-efficacy seems to influence one's motivation, efforts, goal-setting, and persistence thus, if more confidence is gained, more engagement in BBN conversations, and helping patients cope with adversities can be obtained as a result of [36,37,38]. Indeed, this concept may be an important component to lead effectively clinical encounters and neurorehabilitation objectives based on acquiring communication skills related to PCC and BPS models because individuals believe

in their behavioral abilities [36].

The current study employed a self-efficacy theory approach due to low confidence reported from many physiotherapists as an influential factor 6 in avoiding interaction with patients while establishing a biomedical discourse in the clinical encounters [28-30]. To clarify, when individuals feel confident about their abilities (self-efficacy), they are more likely to reach their goals [35,36]. Translating this theory to this study, if we provide tools to overcome physiotherapists' communication concerns, we will increase confidence resulting in improved shared goal setting and accomplishment of a PCC in the neurorehabilitation setting.

### The COMFORT communication curriculum

The complexities of shared goal setting in neurorehabilitation where physiotherapists can be assigned with delivering unexpected or unfavourable information can be likened to the complex communication required when breaking bad news (BBN) [39].

*“Bad news is any news that drastically and negatively alters one view of the future”* [40].

Frameworks for BBN have been developed for use in a range of settings where complex communication is required. Most notably in the field of oncology where the dilemma of giving hope in a bleak situation is obvious [36]. Of the numerous frameworks available including the SPIKES protocol, the SHARE model, the ABCDE mnemonic and the BREAKS protocol, the COMFORT model possibly aligns best with PCC in terms of neurorehabilitation [28,29, 34,41].

The COMFORT framework was originally designed to provide communication skill-building instruction for nurse practitioners in a 7 Palliative setting under the umbrella of BPS and PCC by using it concurrently and reflectively in the care of patients [42,43]. The effectiveness of this model lies mostly in holding up the allowance of time and opportunity for questions, clarifications and enabling an ongoing dialogue to resolve challenges and reiterate information by following the seven holistic principles (See Table 1):

1. Communication,
2. Orientation/ Opportunity,
3. Mindfulness,
4. Family,
5. Oversight,
6. Reiterative/ Radically Adaptive Messages,
7. Team.

Hence, the COMFORT model is the object of study in order to evaluate if it has the potential for changing communication behaviours by raising awareness in physiotherapists about their own communication practices and key considerations to tackle while BBN [30,42].

**Table 1:** Description of the seven competencies of the COMFORT model adapted from Villagran (2010).

Seven principles of the COMFORT model	
Communication	Dialogue includes verbal and non-verbal messages, information sharing and questioning abilities.
Orientation and Opportunity	Provide orientation to the patient and their expectations with treatment options, diagnosis and reality of prognosis.
Mindfulness	HCP attuned to the interaction and their presence enhances interpersonal processes. This concept includes less self-talk by the HCP, avoids “scripts” and prejudice.
Family	Give opportunity for relatives’ involvement during clinical encounters.
Oversight /Ongoing	Ongoing discussions about care to ensure patient and family feeling of non-abandonment.
Reiterative messages	Repeating chunks of information to reinforce understanding and reframing where required.
Team	Aspects of effective team working such as good communication, team meetings and considering multiple perspectives.

### Rationale for this study

It is apparent that the communication issues faced by physiotherapists in neurorehabilitation are similar to those faced by other HCPs mandated with BBN [44]. Delivering prognostic information, shared goal-setting or also facilitating post-discharge care 9 planning in neurorehabilitation are complex; clinical predictions can be based partly on experience, however, each patient is unique [45,46,]. This process can be a source of stress and emotional difficulty for physiotherapists, requiring highly developed communication skills [46]. The COMFORT model for breaking bad news can be a useful framework for physiotherapists to use when approaching shared goal setting.

These critiques are aimed at informing physiotherapists practice(s) by examining the literature and identifying where the COMFORT model has been used and how it has been applied. Specifically, it critically analysed the utility of it in helping physiotherapists deal with these complex communication scenarios within neurorehabilitation in order to integrate a PCC approach.

### Methods

This study will use a critical realist approach in seeking to address the research question. Critical realism seeks to explore the mechanisms by which relationships happen between two events and why it works or fails, all within a determined setting or environment (context) [47-49]. This situation gives rise to new phenomena which would be the subject of interest and, the certain mechanism explored in order to discover its nature and the mechanism possessed by the elements [47,49]. For this review, the relationship between the physiotherapist and patient (the two elements or events) during shared goal setting in neurorehabilitation (context) is constructed through an effective communication model (the mechanism). Where the mechanism was effective, the results would be improved self-efficacy in physiotherapists around communication, successful shared goal setting, high level of

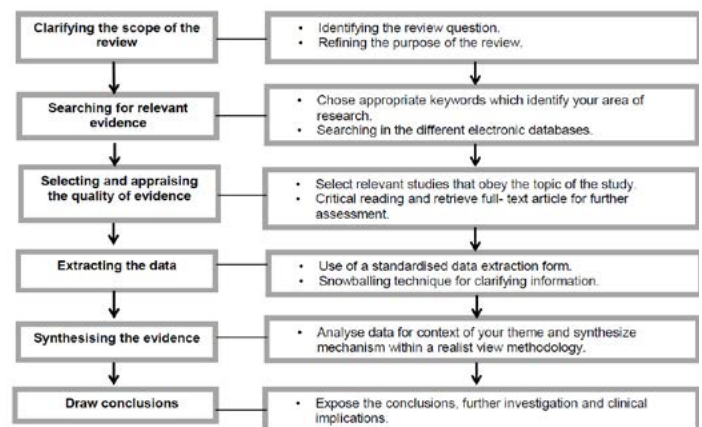
patient satisfaction and successful PCC. Due to the fact that there is not a communication framework tailored for physiotherapists in neurorehabilitation, the COMFORT model is going to be the focus of this review and as we put it under the scope to understand its functioning, procedures, and results of this communication framework. The contributions of change and improvements will be presented in order to display the clinical practice implications to physiotherapists in neurorehabilitation [50].

The objectives of this study will be to analyse the evidence-based publications and primary studies related to the COMFORT model application in different contexts, critique the content and extract the most useful information which addresses the review question:

1. Where COMFORT has been previously used and what methods were used to apply it?
2. Which outcomes did these studies obtain? And their importance in validating its utility.
3. Can the COMFORT model be used to aide complex communication scenarios in neurorehabilitation?

The findings will be discussed with the aim of highlighting how the model can be practically used to guide physiotherapists involved in shared goal setting within neurorehabilitation.

**Figure 1: Flow chart of Pawson's Framework (Practical steps in realist review) [51].**



### Search for relevant evidence in the published literature

Pawson’s framework was adopted for searching the literature because it is an ordered methodological process that consists of a clear series of steps (See Figure 1).

The terms used evolve in line with the understanding of the relevant articles that fit our topic. The identification of relevant literature was conducted through the following seven databases: PUBMED; Ovid Medline 1946; Science Direct; Web of Science; PscARTICLES; Cochrane Library; and PEDro.

The keywords used in the search process were COMFORT, model, framework, curriculum, breaking bad news, communication, training, intervention, physiotherapy, rehabilitation. Grey literature was reviewed in terms of Google Scholar searches linked to the main databases, but other reports of this type of research were excluded, such as working papers from departments/ agencies, government documents, and evaluations.

---

## Selection of the articles

The process of selection began by screening titles and abstracts, followed by retrieving the full text papers to improve the accuracy of the articles and information provided by them [52]. A snowball effect was employed for the selection of appropriate studies. This technique is based on checking references from articles already found so as to include more relevant studies as well as, to collect significant information from the papers included [53,54].

## Appraisal of the findings

Critical reviews reject checklists and particularly, inclusion and exclusion criteria which act as an unfavourable barrier to remove or include a study [51]. Hence, the selection of articles is based on analysing each one in a critical manner so as to include those that expose relevant information. Once the issues are identified, being critical implies challenging one's own assumptions in order to make a potential change in the current knowledge [55]. It is also important to judge if an article is relevant to the topic in terms of addressing the research question under testing and if the research employed is sufficiently rigorous and credible to make a contribution to test the proposed theory [55-57].

## Data extraction

A data extraction form was designed with the following criteria: authors' names, year of publication, type of study, the context; the objectives and aims; intervention; results; conclusions (See *No se encuentra el origen de la referencia.*). The quality of the included studies in this CR was appraised following the Preview, Question, Read and Summarise (PQRS) strategy due to its clear steps that help to understand and judge if an article should be included and all the relevant information to fill the data extraction form [58].

## Synthesis of the findings

This study aimed to discover if the COMFORT model could be used to increase physiotherapists' self-efficacy or confidence in communicating difficult news during goal setting in neurorehabilitation. In this final stage, the procedures to adapt the COMFORT model will be displayed in order to modify the clinical practice of physiotherapists in neurorehabilitation and improve the rapport with patients-family.

## Results

From the literature, 6 studies were found from which three key themes were identified: perceived usefulness of COMFORT principles as an aid to communication, increased confidence in communicating skills and potential for changing communication practice. Overall, the studies have some similarities in that the principles of the communication framework were taught as separate modules using different resources to apply in the most practical way.

There were several post-curriculum evaluations to assess the effectiveness of the model in teaching how to deliver PCC messages. These were useful to gather the perceptions of HCPs working in different medical settings such as palliative care, nurse students, nurses undertaking a leadership role or entry-level physiotherapists to know if it fits to their requirements or necessities in communication. However, the included studies have diverse objectives related to the COMFORT model, based on whether it will work on their common communication issues,

increasing their confidence and future clinical practice.

## Perceived usefulness of COMFORT principles

Participants in the studies found the model to be a useful communication framework. It seemed to enhance HCPs' attitudes, skills, and knowledge about effective communication [36,42]. Research sought to determine which of the seven principles in the COMFORT model was more useful by ranking them (See Table 1) [42,59]. Nurses carrying out a leadership role aimed at determining the applicability of this framework to the common challenges identified by them. The difficulty of explaining prognoses and medical information in colloquial language, together with a feeling of insecurity when adapting themselves were reported as the most frequent challenges leader nurses face in their clinical encounters with patients from different backgrounds [42]. Though the authors did not report the context in which the 18 nurse participants were performing their role, they were more focused on the extent to which COMFORT could promote solutions to these communication issues. After a 90-minute education program about COMFORT, participants were asked to apply it to a specific communication scenario already identified by each nurse, and then rank each principle afterwards.

The results indicated that the Communication module was highest ranked, followed by the Family principle. Meanwhile, Team was seen as a resource to provide support while tackling stressful situations. As examples of the usefulness of this model, nurses identified the fact that certain verbal and nonverbal communication patterns can produce negative results. The COMFORT framework made them realize the many issues that require considerations when dealing with stressful situations including: culture and health literacy. Furthermore, the participants reported that they realized the importance of allowing enough time to dialogue and reiterate concepts, as well as to show how valuable it is to include as many family members as possible into the process of BBN. Understanding that a pivotal communication impacts many dimensions, for instance, memory of a family, or the work environment, the COMFORT content created awareness of participant' practices and provided potential tools to modify communication behaviours [42].

Wittenberg- Lyles conducted research on the utility of COMFORT by delivering the content through an online platform to a range of HCPs, including nurses, doctors, and other disciplines, working in a palliative setting [59]. Post-curriculum evaluation and knowledge quizzes were used to assess program effectiveness and with the different modules a variety of perceptions arose; for instance, the communication module made them aware of active listening techniques, which are important for collecting any type of information. The opportunity/orientation module discussed issues around cultural inclusion, and gave them encouragement for self-reflection on clinical communication, essential component to increase self-efficacy. The Team module understands that as a team member one should be available. The results represented a marked trend toward raising awareness of patients'-families' needs, self-reflection, adaption to diverse backgrounds, and reciprocal dialogue; however, this study contains a number of limitations. In the large sample of 177 HCP's some participants were not required to complete all modules available. Moreover, the pre- evaluation consisted of only participants self-reporting and did not account neither for actual enactment of communication skills or clearing

---

prior experiences working in a palliative care setting.

A study using a multidisciplinary stroke team for early discharge (STED) could be more useful as it is a context similar to the one applied in this study [60]. This stroke team composed of different HCPs, one of them a physiotherapist, undertook a consultation with a psychologist in order to identify and solve communication challenges. With the help of the psychologist and using the COMFORT model, the team solved issues mainly related to the balance between ideal and realistic expectations, yet enabling the person to retain hope. The team's members identified as important aspects of COMFORT the chance to reflect upon stressful situations, feeling reassured in how the team breaks bad news and reassurance of personal skills already acquired through experience.

This case example is probably the only one in which COMFORT was applied utilising a hands-on approach and a follow-up evaluation was performed to assess the impact of the model.

### Confidence in communicating skills

Patient's adherence to neurorehabilitation can come from different aspects involving the therapist, but one crucial ability of a physiotherapist is to build confidence and trust by demonstrating clinical listening and empathy [12,61]. It can be considered that HCPs who are already working are aware of this fact and therefore, the author of a study on entry-level physiotherapists aimed to explore the influence of training in the COMFORT communication curriculum [61]. Firstly, the participants received training via didactic lecture, video vignettes of real clinical encounters, and short activities that demonstrated COMFORT's communication concepts. After that, a reflective writing exercise was done with the aim of assessing practically physiotherapists' behaviour towards BBN in a palliative setting through understanding the content of the COMFORT curriculum. Secondly, participants were asked to identify appropriate content of verbal and non-verbal messages in three patient/family scenarios without further detail about them. Thirdly, they produced three, person-centred messages strategies and gave their own responses to each scenario.

64 students completed the curriculum and pre- and post-survey, and 41 students completed the reflective writing exercises (with only two students completing three of the six items). Authors analysed the level of COMFORT's influence by asking participants to identify comforting behaviours expressed through supportive messages that are also termed person-centred messages (PCMs). To achieve verbal clarity, one goal of COMFORT is to train physiotherapists to use PCMs, characterised by significant emotional support. An example of these comforting behaviours found in the study post COMFORT training was: "What do you mean exactly that "you don't know why you are going through this"? Do you have more specific questions about your care that I could answer? I'd be glad to take all the time we need to discuss these issues with you". The outcomes of this pilot training session were directed at increasing confidence levels and decreasing apprehension and anxiety to communicate. However, no changes regarding willingness to communicate with patients and families were found.

The Interprofessional Online Curriculum training reported differences in confidence between different HCPs. Nurses displayed the greatest confidence in communication that attempted

to recognize the individuality of patients with the least amount of confidence in talking with patients and families about treatment and with information beyond medical knowledge. However, physicians were more confident in helping patients to understand diagnoses than in understanding the patient's life [59]. The stroke team for early discharge (STED) requested a consultation with a psychologist due to the fact that they mainly lacked confidence to BBN consistently. A positive correlation was established between balance hope and realistic news, and increased confidence [60]. The STED complained that not enough time was allowed for the consultation. This grounded information can prove that for one to become more confident in their communication skills is a long process either for physiotherapists or trainers. Despite the good ratings from each STED component, the authors noted that the results may be less than desirable as they were conducted in front of the consulter.

### Potential for changing communication practice

A follow-up evaluation is considered an effective procedure to measure the impact of change that an intervention has had in real practice. Only one study carried out a follow-up evaluation. The STED consultation study did a follow-up evaluation after 2 months post-consultation to assess the clinical implications of such performance [60]. The team reported having learnt in the consultation, for instance, the nature of BBN and the possibility that although the person may not choose to accept the delivered news and this is not indicative of incompetence on behalf of the clinicians. Furthermore, providing a space to acknowledge the nature of the bad message and reflecting upon past experiences were considered key aspects to overcome future complex situations but also, accepting that BBN "will never be easy". Therefore, changes included the following:

- a. Repeating the workshop periodically for new staff induction along with including and sharing workshop information and resources.
- b. Establish a communication system with local hospital clinics to facilitate consistent messages being given to patients from the STED.
- c. Revisit the approach to BBN in team meetings, and considerations for further development.

In the follow-up assessment, a senior physiotherapist mentioned that the staff who took part in the consultation felt reassured about their communication skills and confident to manage complex communication situations. COMFORT can be beneficial to all STED members increasing confidence perceptions and developing a special attention be given to future practice. Nevertheless, the study showed that over time consultees integrate the knowledge into their ongoing clinical practice. In the same direction, future applications from nurses in a leadership role are related to disseminate COMFORT as a curricular training program either for undergraduates or practitioners [61].

### Discussion

Physiotherapists seem to be close and attentive towards patients care by motivating and encouraging them in Neurorehabilitation [12]. However, research has shown a number of reasons why physiotherapists communication may not be successful, for example, in implementing effective goal setting or helping patients to find one's self-identity [11,62]. Managing patients and families

---

expectations and guiding patients towards making realistic goals implies an emotional labour for physiotherapists [11,63]. Listening to the patients and families, offering guidance on what to expect, and being a reassuring presence are linking actions that implies emotional labour to physiotherapists when applying a PCC approach.

This emotional labour, if misdirected, is displayed as low physiotherapist self-confidence, unwillingness to communicate, fear of making critical decisions, or communicating poor prognosis [44,46]. To overcome these stressful situations, competent communication requires skills that physiotherapists need to further develop such as negotiation, interaction, compassion and empathy with the ongoing process of healing [26,27].

From the articles included, most of them can be considered pilot studies because the COMFORT curriculum was delivered in terms of theory in order to mainly assess if the content had been understood and the extent of behavioural change from that learning. In general, it was found that participants understood the COMFORT principles and many considered to be important to receive training on this model. They also agreed that this framework reminds us as to what is critical when dealing in a communication process, such as including family or establishing a reciprocal dialogue, among others [59,60]. The online communication training was insufficient principally for delivering only 4 of the 7 principles to a sample composed by many different HCPs, most of them nurses and doctors [59].

A theoretical understanding of COMFORT can help physiotherapists understanding but does not necessarily have a direct link to an effective performance [61]. The removal of the Team and Mindfulness principles in the intervention could also make students unaware of the usefulness of COMFORT and this factor might have increased the confidence and willingness of the participants. Nurses in a leadership role and a huge variety of HCPs recognized the principle of Team as a resource to break bad news (BBN) successfully and that helps with the emotional labour inherent in any contact with patients and families [42,59,60]. Moreover, the Mindfulness principle might be viewed as the decisive concept that differentiates a PCC discourse from a biomedical “self-talk”. Hence, important key aspects were omitted with the consequence of affecting the results and the change of mind in those physiotherapists. Additionally, interprofessional interaction has not been done in this project and it is an important aspect to effective PCC.

Nurses reported more confidence in recognising the individuality of patients in contrast to physicians, who felt better at helping patients to understand diagnoses. Despite the importance of applying PCC in all medical disciplines, the results may lead one to consider that some HCP’s perceive that their clinical roles depend more with dealing with the psychosocial aspect of each patient’s life to perform their job in a complete and successful manner. Thus nurses and physiotherapists might need more help in tackling particular complex scenarios that involve giving support and assessing in a deeper manner the emotional issues and psychological dimensions around each patient [59].

Findings of the Goldsmith study investigating COMFORT application for physiotherapists in a palliative setting can be taken

as a supporting point for this CR. Goldsmith, critically highlighted the existing gap between skills training for physiotherapists whose careers despite having demonstrated complex interactions must complete for a successful rehabilitation setting [61]. The outcomes of this pilot training session were increased confidence levels and decreased apprehension to communicate. However, no changes regarding willingness to communicate with patients and families were found. Thus, it is supposed that participants, even seeming confident using COMFORT’s principles, will still avoid interaction and communication with families and patients.

A study that did not follow this methodology was performed by a multidisciplinary stroke team (Phillips et al., 2013)[60]. This study can be considered effective in how to help directly HCPs related to a neurological field, like Neurorehabilitation, with an expert in explaining and guiding team members successfully apply COMFORT. The results were the same as the other articles (acknowledgement of the different aspects to tackle when communicating with patients, though they required more theoretical teaching). Additionally, the authors could demonstrate that this manner of delivering the COMFORT model in fact had clinical implications. In a 2-month follow-up evaluation, the authors could witness the changes in the staff and team’s performance based on repeating the workshop periodically, revisiting the approach to BBN in team meetings, and making specific guides for that. Without a doubt, a follow-up evaluation will be the best feedback after an intervention since it objectively demonstrates that this has made a change in the practice, and the results have lasted over time. This study can be seen as the first study that did something close to a hands-on approach.

Without omitting the importance of teaching physiotherapists the content and theory behind the COMFORT curriculum, it will be crucial to approach the complex cases that they face in a direct and practical manner by having an expert in the field teach how to deliver messages, create PCC messages, or get a better team rapport. Moreover, physiotherapists in neurorehabilitation should establish periodical follow-up evaluations or audits in order to assess if the new practice is performed properly and if there are further concerns to solve.

Self-efficacy is defined as being confident in your own abilities to behave effectively. Steckler found that participants attained the knowledge for BBN, but did not attain self-efficacy, nor did their attitudes on communication skills improve after receiving the instruction of COMFORT’s communication module. The author stated that self-efficacy and confidence are heightened through repeated practice and the study did not permit to repeat a behavioral practice followed by reflective evaluation and reinforcement. This gap in the study could have distorted the outcomes, resulting in no change. The author tried to explain the inconsistency of the findings with the fact that participants were nursing students who supposedly do not have enough perception of the importance of BBN and what it implies in clinical practice.

In contrast, the study involving physiotherapists showed positive outcomes regarding self-efficacy though research on skills improvement is needed. Physiotherapists need to communicate with a variety of patients, taking into account cultural differences and levels of health literacy; probably, because they require help with these issues. Principles such as Orientation and Mindfulness

teaching them how to tackle and explore them effectively, fortify the communication role of physiotherapists. The Self-efficacy theory makes sense with the findings of this study due to the use of the COMFORT model will increase physiotherapists' confidence in BBN. The results of which changed practice within the PCC model, in physiotherapists rapport with patient-family and successful goal setting or balancing hope and poor prognosis or health outcomes [36]. Hence, repetition of the COMFORT model, PCC and BPS models content-practice will fix the desired behavioral change in physiotherapists. Additionally, as the COMFORT model holds, reflective evaluation and reinforcement of the new-learned practice will increase self-efficacy and confidence that directly result in better coping strategies and reduced stress level.

### Limitations

There are some limitations in this CR as follows: firstly, the studies found were limited in terms of teaching the COMFORT model. Most of them were focused on delivering theoretical modules of the different principles of this model but they did not evaluate its change in practice with real case studies or daily complex scenarios. Although it can be considered a proper first step when applying something new in a different setting, it lacked studies assessing the real clinical implications that this model presumably has. Secondly, this review may not find all the literature available regarding applying this model in various medical settings. Other communication frameworks might be equally suitable to help physiotherapists in this task of BBN effectively, though time limitations made to choose that line of research.

Finally, this paper has looked at the Self-efficacy theory through a lens but future studies may look at it from the viewpoint of other social theories like feminism for instance, which would potentially provide an alternative valuable perspective.

### Recommendations and Further Research

This CR has demonstrated the value of this communication model for physiotherapists in neurorehabilitation who are usually involved in complex communication scenarios. Further research is needed to conduct studies on physiotherapists working in neurorehabilitation in order to display the effectiveness of the COMFORT curriculum to overcome the already identified communication issues. It is also suggested that along with this training, a greater impact on the emotional preparedness may be gained by gradual immersion via clinical neurorehabilitation placements. Longitudinal studies and follow-up assessments would shed light on the most suitable procedure for assessing the correct applicability and utility of the COMFORT model and the clinical implications of this model in practice, respectively.

Furthermore, it would be interesting to broaden the research on this model. None of the studies included here looked at patients' perceptions and whether training in the COMFORT model resulted in better engagement and rapport in HCP patients. Thus, looking at patients' perceptions and problems with training COMFORT being applied by the two sides specifically practitioners and patient, the hands-on experience may be the most valuable dynamic research. At the same time, it would be vital to design a specific communication framework for professionals' concerns that affect them particularly and give importance on providing more tools and training for either physiotherapists or undergraduates.

### Conclusion

Communication is identified as a core skill needed in order for patient-centered neurorehabilitation to be achieved. Physiotherapists working in neurorehabilitation lack the confidence and ability to deal with complex scenarios such as goal setting and delivering poor prognosis, successfully. More education and training are required in physiotherapist communication and it needs to be explicitly inclusive of psychosocial engagement [59].

Even though the application of the COMFORT model in the included studies was mainly theoretical, the use of the model has demonstrated an increase in confidence by HCPs, and also the potential to change clinical practice by renewing the content and making practitioners more aware of the key concepts that must lead communication no matter the context. Through the scope of the self-efficacy theory, COMFORT has established its utility in improving practice learning for interprofessional disciplines such as palliative care, nursing, and physiotherapy. The COMFORT communication curriculum can be considered a suitable communication framework to be used by physiotherapists in neurorehabilitation due to increasing their confidence and transmitting the 24 dimensions to deal with clinical encounters with more satisfactory results for all parties [64].

### References

1. Wittenberg-Lyles (2010) The COMFORT initiative: Palliative nursing and the centrality of communication. *Journal of Hospice & Palliative Nursing*, 12: 282-292.
2. Engel G L (1989) the need for a new medical model: a challenge for biomedicine. *Holistic Medicine* 4: 37-53.
3. Ledford CJ (2010) "Practicing medicine": Patient perceptions of physician communication and the process of prescription. *Patient education and counseling* 80: 384-392.
4. Arora N K 2003. Interacting with cancer patients: the significance of physicians' communication behavior. *Social science & medicine* 57: 791-806.
5. Smith R C, Fortin A H, Dwamena F, Frankel R M (2013) An evidence-based patient-centered method makes the biopsychosocial model scientific. *Patient Educ Couns* 91: 265-270.
6. Care C (2012) Patient-centred Care. *Nursing Standard / Ren Publishing* 27: 48-50.
7. Engel G L (1977) The need for a new medical model: a challenge for biomedicine. *Science* 196: 129-136.
8. Sinclair S, Norris J M, Mcconnell S J, Chochinov H M, Hack, et al. (2016) Compassion: a scoping review of the healthcare literature. *BMC Palliat Care* 15: 6.
9. Escorpizo R, Bemis-Dougherty A (2015) Introduction to Special Issue: A Review of the International Classification of Functioning, Disability and Health and Physical Therapy over the Years. *Physiother Res Int* 20: 200-209.
10. Dworzynski K (2013) Rehabilitation after stroke: summary of NICE guidance. *BMJ* 346: f3615
11. Conneeley A L (2004) Interdisciplinary collaborative goal planning in a post-acute neurological setting: A qualitative study. *The British Journal of Occupational Therapy* 67: 248-255.
12. Luker J, Lynch E, Bernhardsson S, Bennett L, Bernhardt J (2015) Stroke Survivors' Experiences of Physical Rehabilitation: A Systematic Review. *Lutz, B. J. & Young, M. E. 2010. Rethinking intervention strategies in stroke family caregiving.*

Rehabil Nurs 35: 152-160.

13. Jevon S M, Johnston, L H (2003) The perceived knowledge and attitudes of governing body chartered physiotherapists towards the psychological aspects of rehabilitation. *Physical Therapy in Sport* 4: 74-81.
14. Van Weel-Baumgarten E M, Brouwers M, Grosfeld F, Hermus Fj, Van Dalen J, Bonke B (2012) Teaching and training in breaking bad news at the Dutch medical schools: A comparison. *Medical Teacher* 34: 373-381.
15. Horak B J, Welton W, Shortell S (2004) Crossing the quality chasm: implications for health services administration education. *J Health Adm Educ* 21: 15-38.
16. Dwamena F, Holmes-Rovner M, Gaulden C M, Jorgenson S, Sadigh G, et al. (2012) Sikorskii, Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev* 12: CD003267.
17. West E, Barron D N, Reeves R (2005) Overcoming the barriers to patient-centred care: time, tools and training. *J Clin Nurs* 14: 435-443.
18. Jenkinson C, Coulter A, Bruster S, Richards N, Chandola T (2002) Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Qual Saf Health Care* 11: 335-339.
19. Meitar D, Karnieli-Miller O, Eidelman S (2009). The impact of senior medical students' personal difficulties on their communication patterns in breaking bad news. *Acad Med* 84: 1582-1594.
20. Vail L, Sandhu H, Fisher J, Cooke H, Dale J, et al. (2011) Hospital consultants breaking bad news with simulated patients: An analysis of communication using the Roter Interaction Analysis System. *Patient Education and Counseling* 83: 185-194.
21. Mudge S, Stretton C, Kayes N (2014) Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disabil Rehabil* 36: 457-463.
22. Taylor E, Mckevitt, Jones F (2015) Factors shaping the delivery of acute inpatient stroke therapy: a narrative synthesis. *J Rehabil Med* 47: 107-119.
23. Daniëls R, Winding K, Borell L (2002) Experiences of occupational therapists in stroke rehabilitation: dilemmas of some occupational therapists in inpatient stroke rehabilitation. *Scandinavian Journal of Occupational Therapy* 9: 167-175.
24. Whitney S N, Mccullough L B, Frugé E, Mcguire A L, Volk RJ (2008) Beyond breaking bad news: The roles of hope and hopefulness. *Cancer* 113: 442-445.
25. Phillips J (2013) Breaking bad news in stroke rehabilitation: a consultation with a community stroke team. *Disability and rehabilitation* 35: 694-701.
26. Zapf D (2002) Emotion work and psychological well-being: A review of the literature and some conceptual considerations. *Human resource management review* 12: 237-268.
27. Hochschild A R (1979) Emotion Work, Feeling Rules, and Social Structure. *American Journal of Sociology* 85: 551-575.
28. Wittenberg-Lyles E (2014) Assessment of an inter professional online curriculum for palliative care communication training. *Journal of palliative medicine* 17: 400-406.
29. Ventres W (2015) ABCDE in Clinical Encounters: Presentations of Self in Doctor-Patient Communication. *Ann Fam Med* 13: 276-278.
30. 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. *Oncologist* 5: 302-311.
31. Villagran M, Goldsmith J, Wittenberg-Lyles E, Baldwin (2010) Creating COMFORT: A communication-based model for breaking bad news. *Communication Education* 59: 220-234.
32. Cooley L A (2012) Patient-centered care and mindfulness in hospice volunteer communication experiences. (Doctoral dissertation, Bowling Green State University).
33. MAST M S (2005) Recipients' perspective on breaking bad news: how you put it really makes a difference. *Patient education and counseling* 58: 244-251.
34. Pallesen H (2014a) Body, coping and self-identity. A qualitative 5-year follow-up study of stroke. *Disability and rehabilitation* 36: 232-241.
35. Narayanan V, Bista B, Koshy C (2010) 'BREAKS' Protocol for Breaking Bad News. *Indian J Palliat Care* 16: 61-65.
36. Bandura A (1977) Analysis of self-efficacy theory of behavioral change. *Cognitive therapy and Research* 1: 287-310.
37. Steckler R (2012) Improving communication skills among nursing students: Assessing the comfort curriculum as an intervention.
38. Maddux J E (1995) Self-efficacy theory. In *Self-efficacy, adaptation, and adjustment* Springer US. (pp. 3-33).
39. Schunk D H (2009) Self-efficacy theory. *Handbook of motivation at school* 35-53.
40. Kirshblum S C (2016) Breaking the news: A pilot study on patient perspectives of discussing prognosis after traumatic spinal cord injury. *The journal of spinal cord medicine* 39: 155-161.
41. Schoeff R (2008) Breaking bad news. *Dig Dis* 26: 56-58.
42. Fujimori M, Shirai Y, Asai M, Kubota K, Katsumata N, et al. (2014) Effect of communication skills training program for oncologists based on patient preferences for communication when receiving bad news: a randomized controlled trial. *J Clin Oncol* 32: 2166-2172.
43. Goldsmith J (2013) Comfort: Evaluating a new communication curriculum with nurse leaders. *Journal of Professional Nursing* 29: 388-394.
44. Cloyes K G (2012) Exploring communication patterns among hospice nurses and family caregivers: A content analysis of in-home speech interactions. *Journal of Hospice & Palliative Nursing* 14: 426-437.
45. Ferguson A, Armstrong E (2004) Reflections on speech-language therapists' talk: implications for clinical practice and education. *Int J Lang Commun Disord* 39: 469-477.
46. Jette D U, Grover L, Keck C P (2003) A qualitative study of clinical decision making in recommending discharge placement from the acute care setting. *Phys Ther* 83: 224-236.
47. Masley P M, Havrilko C L, Mahnensmith M R, Aubert M, Jette, D U (2011) Physical therapist practice in the acute care setting: a qualitative study. *Phys Ther* 91: 906-919.
48. Sayer A (2000) *Realism and social science*. SAGE.
49. Pawson R, Greenhalgh T, Harvey G, Walshe K (2005) Realist review-a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy* 1: 21-34.
50. Bhaskar R (2013) *A realist theory of science*. Routledge.
51. Sayer A (2010) *Method in Social Science: Revised 2nd Edition*, Routledge.



- 
52. Pawson R, Greenhalgh T, Harvey G, Walshe K (2004) Realist synthesis: an introduction. Manchester: ESRC Research Methods Programme, University of Manchester.
  53. Speziale H S, Streubert H J, Carpenter D R (2011) Qualitative research in nursing: Advancing the humanistic imperative. Lippincott Williams & Wilkins.
  54. O'campo P, Molnar A, NG E, Renahy E, Mitchell C, et al. (2015) Social welfare matters: a realist review of when, how, and why unemployment insurance impacts poverty and health. Soc Sci Med 132: 88-94.
  55. Flick U (2009) an introduction to qualitative research, SAGE.
  56. Tomasek T (2009) Critical Reading: Using Reading Prompts to Promote Active Engagement with Text. International Journal of Teaching and Learning in Higher Education 21: 127-132.
  57. Paul R, Elder L (2008) Critical thinking. The Foundation for Critical Thinking.
  58. Lobiondo-Wood G, Haber J (2014) Nursing research: Methods and critical appraisal for evidence-based practice. Elsevier Health Sciences.
  59. Ulu H, Akyol H (2016) The Effects of Repetitive Reading and PQRS Strategy in the Development of Reading Skill. Eurasian Journal of Educational Research (EJER).
  60. Phillips J, Kneebone, Taverner B (2013) Breaking bad news in stroke rehabilitation: a consultation with a community stroke team. Disabil Rehabil, 35: 694-701.
  61. Goldsmith J (2015) the Entry-Level Physical Therapist: A Case for COMFORT Communication Training. Health communication 30: 737-745.
  62. Pallesen H (2014) Body, coping and self-identity. A qualitative 5-year follow-up study of stroke. Disability and rehabilitation 36: 232-241.
  63. Sparks L, Villagran M M, Parker-Raley J, Cunningham CB (2007) A patient-centered approach to breaking bad news: Communication guidelines for health care providers. Journal of Applied Communication Research 35: 177-196.
  64. Van Dulmen S A, Lukersmith S, Muxlow J, Santa Mina E, Nijhuis-VanDer Sanden MW, et al. (2015) Supporting a person-centred approach in clinical guidelines. A position paper of the Allied Health Community - Guidelines International Network (G-I-N). Health Expect. 18: 1543-1558.

**Copyright:** ©2017 Selma Pelaez. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.