

Reaching Across the Table: Conflict Resolution Skills for the Child Psychiatrist

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Few child and adolescent psychiatry fellowship programs offer substantive leadership development training, despite the fact that child psychiatrists frequently step into leadership roles soon after training.^{1,2} Becoming an effective and collaborative leader is a multidimensional process and the fine-tuning of leadership skills such as conflict resolution is one important step. Conflict resolution skills are essential for a child psychiatrist working with parents, teachers, and community leaders as they navigate interdisciplinary settings, balance competing interests, and advocate for their patients. This article will provide readers with a basic understanding of different conflict resolution approaches and how to flexibly apply them to different situations.

Background

While conflict tends to be seen as antagonistic and destructive, the presence of differing viewpoints can be beneficial in collaborative settings.³ Differences in perspective and judgment, when approached with a flexible mindset, can introduce new ideas, produce novel solutions, and enhance relationships. Leaders can more effectively engage in conflict resolution when they first understand their own personality and leadership style, and how their style may be appropriate or potentially inflammatory for the situation. Biases, triggers, and personality all come into play when facing conflict.

There is no single technique for resolving conflict because every situation is unique. Choosing how best to resolve a particular conflict is aided by a basic understanding of the different conflict resolution modalities. The idea of breaking up conflict resolution into different modes was first proposed by management theorists Robert Blake and Jane Mouton in the 1960s. They proposed that leadership styles and skills could

be described through dimensional models.⁴ Blake and Mouton broke down the approach to conflict resolution into 2 dimensions: *cooperation* to satisfy another's needs and *assertiveness* to satisfy one's own needs. Conflict "modes" were described based on their level of each dimension.

The "competing mode" is one of high assertiveness and low cooperation, in which one seeks to use authority to satisfy one's own needs without regard for the needs of the other party. While this approach may seem callous at first, it has its uses. For example, a psychiatrist may need to use the competing mode when hospitalizing a suicidal patient against his will. The "accommodating mode" is characterized by high cooperation and low assertiveness. In the accommodating mode, one prioritizes the other party's needs over one's own needs. This approach is most appropriate when the stakes are low and relationship building is important, such as when agreeing to work during a holiday so that a colleague can spend time with her family. The combination of low assertiveness and low cooperation was described as the "avoiding mode" in which one ignores the conflict and does nothing to resolve it. This is a common approach to conflict when stakes are low and the outcome is less important. However, the avoiding mode can lead to resentment and dissatisfaction when used too frequently. This can happen, for example, when a staff psychiatrist fails to tell his director that he is feeling overworked, thereby avoiding conflict but increasing burnout.

The "compromising mode" falls in the middle on both dimensions. When the compromising mode is employed, the goal is to reach a solution that is at least partially satisfactory to all parties, but completely satisfactory to none. An example of this would be the situation in which a parent agrees to allow screen time but only after

homework is completed. In contrast, the “collaborating mode,” with high assertiveness and high cooperation, seeks to find an integrative solution which is satisfying to all. This approach requires a balance between nonthreatening confrontation (eg, “I hear what you’re saying, but I disagree and here’s why...”) and active listening, ie, listening while providing feedback and validation. It depends on the willingness and ability of all parties to engage in the collaborative process. While collaboration is the ideal, it is not always feasible, as when safety is a concern, and can be time consuming.

Selecting the Conflict Resolution Approach

Conflict can be resolved by first evaluating the situation then selecting a systematic approach.⁵ This can be carried out via the following steps:

1. Self-monitor. Assess your own immediate reaction. Reflect on your own values, biases, and past experiences and how these factors may impact the conflict resolution process. Furthermore, consider your own leadership style and which approach best integrates your strengths.
2. Establish goals. Clearly identify what you hope to achieve and what compromises you are willing to make.
3. Determine which approach is most appropriate given your goals and the circumstances.
4. Consider the ideal setting for the discussion, particularly in regard to privacy, neutrality, timing, and layout. For example, addressing conflict with a family in a waiting room may not be ideal and taking the time to move to a private space can be valuable.
5. Employ active listening skills. Active listening includes inviting the other person to express his or her concerns, clarifying and restating the other’s perspective, seeking confirmation that the information has been heard correctly, reflecting feelings, and validating concerns. Demonstrating an intention to listen lowers the defenses of someone who is expecting to have his or her needs dismissed.
6. Assert your own needs clearly and with flexibility. The other party cannot accommodate unless they understand both perspectives.
7. Build an agreement that is applicable to the specific situation. The solutions may not be perfect or satisfy all parties, but should be reasonable, feasible, and future-oriented.

Hypothetical Case 1

Dr. Smith evaluates a 12-year-old boy with autism and aggression in the emergency department and determines that the child would benefit from an inpatient hospitalization because his mother is overwhelmed and is unable to keep the child safe. The mother agrees with this plan, but tells Dr. Smith the boy’s father, who shares legal custody and therefore all treatment decisions, is against admission and is on his way to the emergency department. The father arrives angry and shouting. He disagrees with admitting his son to an “institution” and demands immediate discharge. He is unable to take his son home due to his work schedule.

Approach to Case 1: First, Dr. Smith will need to self-monitor as verbal aggression can trigger strong emotional and physiological responses. Dr. Smith’s primary goal is to ensure a safe disposition for the child. While there is no “right” conflict mode for approaching a particular situation, there can be a wrong one. Here, the conflict cannot be avoided and accommodation of any one party is likely to worsen the problem. The ideal approach would be a collaborative one, given the shared custody, but this first requires de-escalation of the father’s agitation. A competing approach—exerting Dr. Smith’s authority as the evaluating psychiatrist—may be necessary, but could have detrimental effects on the father’s future interactions with mental health care clinicians and the likelihood of successful co-parenting. Given the father’s agitation, a safe location should be identified for the discussion. Dr. Smith should take a listening stance and be open to understanding the father’s concerns about “institutions.” Once the father’s concerns are validated, the needs of the child should be reiterated clearly. Collaboration requires flexibility:

for example, outpatient treatment may be reconsidered if the patient is not imminently at risk. The parents should both be approached with calm and respect, and both views should be validated. The goal is to build an agreement that considers the perspectives of everyone involved, but it must also be feasible.

In this case, Dr. Smith sits down with the patient's father in a private consultation room while the mother stays with the patient. He listens to and validates the father's concerns, calmly provides psychoeducation, and encourages the father to ask questions without judgment. After reviewing all disposition options, the father agrees that a brief inpatient hospitalization may be helpful and provides his consent.

Hypothetical Case 2

Dr. Patel has been working at her current faculty position at an academic institution for the past 5 years. She enjoys working in the outpatient clinic, but charting burden has increased over the past few years and funding for support staff has decreased. During her annual performance meeting, her division chief tells her that there is pressure on the psychiatry department to increase revenue. As result, clinic faculty will be expected to see 10% more patients, which means 5 additional patient appointments per week.

Approach to Case 2: Before engaging in any approach, Dr. Patel should reflect on the nature of the conflict. Affective conflict (conflict based on emotions and personal differences) tends to be destructive and unproductive. Cognitive conflict, on the other hand, is task-oriented and arises from differences in perspective or judgment and can be productive.³ In this case, is Dr. Patel's frustration due to the burden of extra appointments or to feeling undervalued? In selecting her conflict mode, Dr. Patel should weigh the relative importance of the issue versus her relationship with the division chief and consider the power imbalance. A number of conflict modes could be appropriate in this case: compromising, collaborating, or accommodating. The competing mode would be inappropriate due to the power differential which favors the division chief. The avoiding mode would be a short-term solution

and could lead to resentment. By assuming a listening stance, Dr. Patel can better understand why this change is necessary for the department. She should assert her own needs clearly so that her division chief is aware of the challenges. While she may not change the department's expectations, the discussion may shed light on opportunities to decrease other demands on Dr. Patel's time or to provide additional support and mentorship.

After brief reflection, Dr. Patel concludes that her frustration is driven not by the number of patients, but rather by feeling unheard and undervalued. She chooses to take an accommodating approach and agrees to the increased productivity expectations, but states her own needs for increased support staff and administrative time. The division chief agrees to continue working on these issues and offers to identify a senior faculty member who can serve as a formal mentor.

Conclusion

Conflict generally has a negative connotation, but it is a natural aspect of a team dynamic. Conflict can be beneficial when approached with a flexible mindset. Differing opinions and perspectives can be a starting point for growth and collaboration. Child psychiatrists are in a position to become leaders within institutions, communities, and organizations, and the development of leadership skills is essential. Conflict resolution is one skill that can promote an environment of teamwork and collaboration when used effectively.

Take Home Summary

Effective conflict resolution skills are essential for psychiatrists in their practice and when taking on leadership roles. While daunting at times, conflict can serve a role in problem solving and relationship building when approached in a systematic way.

References

1. Stubbe DE. Preparation for practice: child and adolescent psychiatry graduates' assessment of training experiences. *J Am Acad Child Adolesc Psychiatry*. 2002;41(2):131-139. <https://doi.org/10.1097/00004583-200202000-00006>

2. Zachik AA, Naylor WM, Klaehn RL. Child and adolescent psychiatry leadership in public mental health, child welfare, and developmental disability agencies. *Child Adol Psych Cl.* 2010;19:47-61. <https://doi.org/10.1016/j.chc.2009.08.007>
3. Madalina O. Conflict management, a new challenge. *Procedia Econ Fin.* 2016; 39:807-814. [https://doi.org/10.1016/S2212-5671\(16\)30255-6](https://doi.org/10.1016/S2212-5671(16)30255-6)
4. Blake RR, Mouton JS. *The New Managerial Grid. 4thed.* Houston, TX: Gulf Publishing Company, 1981.
5. University of Wisconsin-Madison: 8 Steps for Conflict Resolution; <https://www.talent.wisc.edu/home/HideATab/FullyPreparedtoManage/ConflictResolution/tabid/297/Default.aspx>. Accessed April 21, 2019.

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