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Matching Disputes and Responses. How to Diagnose Causes of Conflict, and to Respond with Appropriate Interventions and/or Referrals.

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Outline

This short paper will address three broad topics from an Australian perspective. Parts of this paper will be relevant to Canada and to other countries. **First**, where is the pressure coming from for dispute resolution professional **to improve** the diagnosis of causes of conflict; and to improve the choice of intervention and/or referral to other skilled helpers?

Secondly, what **diagnostic** dispute resolution services (**problem defining**) are currently “available”? What methods are used to make an initial diagnosis of causes of a conflict, and appropriate possible “interventions”?

Thirdly, what dispute resolution assistance (**problem solving**) is “available” in each area of conflict? (workplace, banking, personal injury, family, school, political, construction, insurance etc) What factors affect “availability”?

No doubt all of you have many individual and systemic examples of the “failure” of both diagnosis and of intervention/referral. Clients or yourself, who went to behavioural modification therapy, when they needed an interlocutory injunction; to lawyers’ letters, when they needed coffee with a patient accountant; to duelling expert doctors, engineers or lawyers, when they needed a joint early “neutral” evaluation; to early settlement mediation, when they needed the pain of litigious publicity; to blame-laden court documents

when they needed diagrams, life coaches, business risk analysis, or wise grandmothers. The latter are in short supply.

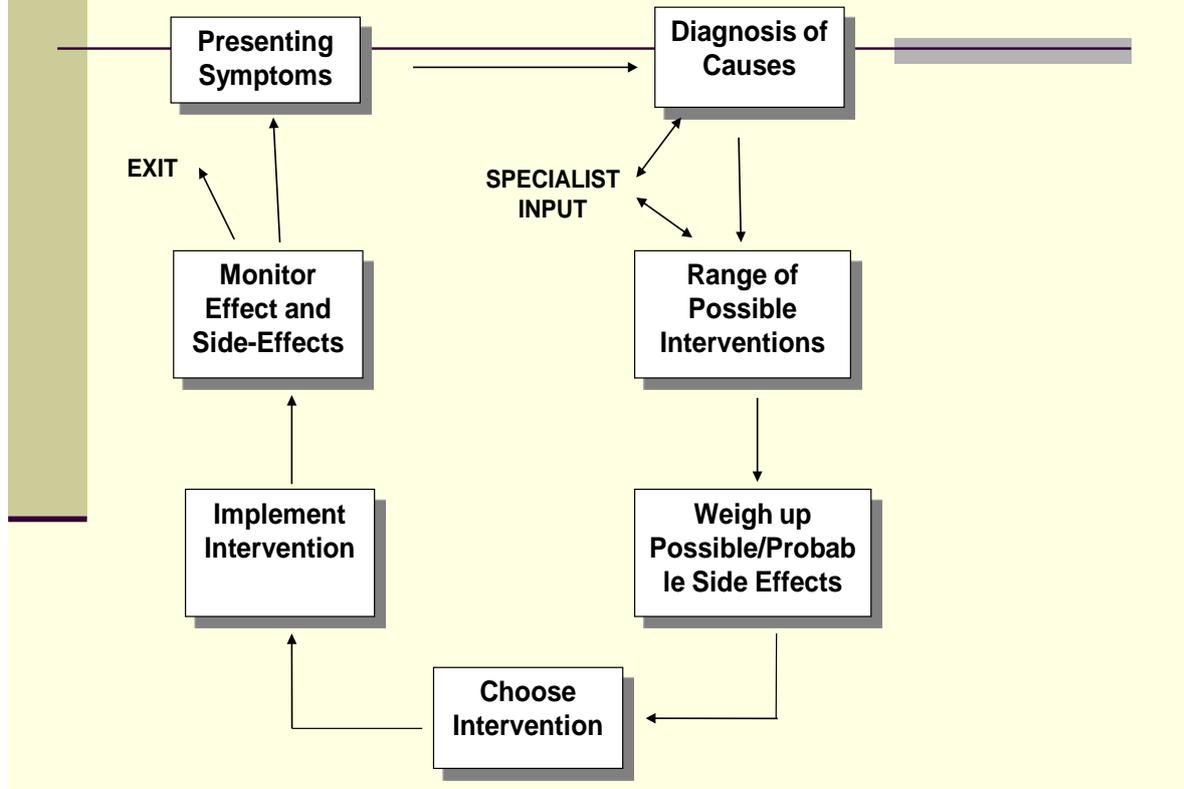
However, it is also challenging to categorise initial diagnosis and interventions as “failures”. Hindsight is marvellously wise. As with medicine, it is often necessary to have several misdiagnoses and missed operations before narrowing down to correct diagnosis and intervention.

Of course, many individual and tribal conflicts are diagnostically caused by alcoholism, drug addiction, mental illness, or finding meaning by hating others (“negative intimacy”). After a number of misdiagnoses, these conflicts may only be resolved temporarily by the intervention of flight, prison or death.

Conversely, I presume that many of you have illustrations of individual and systemic successes, both of diagnosis and of intervention/referral. These successes may have occurred by skill or serendipity. The disputants ended up with the right person and process, at the right time, place and price.

Christopher Moore’s diagram helpfully illustrates an ideal problem defining and problem solving process:

Client – Skilled Helper Interaction



(C. Moore, *The Mediation Process* 1996)

Terminology

In this short paper, a number of words and phrases are used with medical overtones. These may or may not be familiar. Here are some working descriptions of these concepts in the field of dispute resolution. Such working descriptions are essential in a field where confusion and conflict recur about the meaning of words.

“Conflict” or **“a dispute”** is the actual or perceived competition of interests and subjective needs. For example: logging versus environmental protection; top down management versus democracy/consultation; direct versus indirect communication; preserve profits versus share profits etc

“Presenting problem” is the initial express or implied analysis of the causes and degree of escalation of a dispute, and by implication, of the most probably suitable responses to that conflict. This “presenting problem” or “initial

analysis” may be completely or partially correct, or totally wrong. For example, the presenting problem may be the wilful “breach” of a partnership contract and by implication the remedy is to clarify facts, evidence and the rules of contract law. The correct analysis may be that one partner is suffering from undisclosed depression, and needs a rest.

Diagnosis is a single or series of attempts to analyse or guess at the causes of a dispute. For example, a dispute over a division of property may be caused by different valuations; or the inability to listen; or high emotions; or cheersquads; or payback for past hurts etc.

Incorrect diagnosis almost always results in unhelpful or damaging responses.

Intervention is the conscious or subconscious response to a conflict or dispute which response is intended to cause a helpful change to the dynamics of that conflict. For example, by screaming or being quiet; by including/excluding a relative in a discussion; by encouraging /discouraging venting; by obtaining/avoiding expert opinions; by using /not using simplified diagrams; by speaking directly/indirectly; by issuing/not issuing court proceedings etc.

Once again, an intervention which is incorrect for that particular dispute, can be harmless, or cause serious damage—for example, continuing negotiations with a person who is habitually violent.

Big and Little Interventions are distinguished by matters of degree. A “big” intervention is a stereotypical process response such as evaluative mediation; or full-blown litigation; or cognitive therapy; or personal coaching; or early neutral evaluation. Whereas a “little” intervention is a conscious or subconscious nuance within each of those larger processes such as wearing formal clothing; summarising regularly; telling simple stories using client language; serving tea and coffee; including or excluding tribal members; showing empathy or not etc.

Referral is the process whereby one “skilled helper” encourages a disputant to consult another particular or generalised skilled helper because that other helper may be able to provide more useful and accurate diagnosis and/or interventions. For example---“You must consult”--- a lawyer; a tax accountant; a grief counsellor; an expert in French culture; a negotiation coach etc; and

“here is a person whom I trust”. (See generally the classic, G. Egan *The Skilled Helper* 6th ed)

It appears that the majority of referrals recommended, are not acted upon by clients.

Resolution of a dispute is a transition of the dynamics of a dispute from higher to lower in intensity of emotions, engagement, aggressive behaviour and language, demonising beliefs etc.

The majority of conflict resolution methods, if successful, effect a transition of conflict dynamics to mutually tolerable levels for a useful period of time. Some disputes reach only momentary de-escalation as “resolution”. Residual toothpaste remains out of the tube in relation to behaviours, beliefs and emotions (see particularly Pruitt and Kim, *Social Conflict* 2006).

The word “**settlement**” is sometimes used interchangeably with “resolution”, and sometimes to signify a lesser degree of modification of the dynamics of conflict (“shallow peace”).

Pressure for Better Diagnosis and Better Intervention/Referral of Disputes

Where does the pressure come from for better diagnosis and better intervention/referral of disputes? From disputants? From judges? From court administrators? From counsellors? From government funders? Repeat clients? Particularly from media horror stories?

Many helpful analogies can be drawn from medical diagnosis and treatment of illness. These pressures for change have been documented many times in the past.

What follows repeats four of the particularly recurrent pressures for improving diagnosis in Australia and elsewhere:

1. Limited Public Funds

There are no votes in the topic of “dispute resolution” in most democratic countries. Politicians are under pressure to cut funding of any public dispute resolution services, from courts to neighbourhood

mediation services, in order to pay large government debts following the global financial crisis.

Governments want disputes to be resolved quickly by resilient citizens engaging in DIY services; or by privately funded counselling, mediation, and arbitration (in all their varieties); or by cheap, fast and publically-funded telephone, on-line, education and decision-making services. Federal and State governments in Australia conduct constant number evaluation of dispute resolution services,(“how much does it cost to resolve a unit of conflict in your service?”) and want much more for less--especially from courts. (See ALRC; AAGD)

2. “Access to Justice” Ideology

In direct tension with the previous point, governments in democratic countries, especially in Australia, New Zealand and Canada, want more citizens to have access to cheap, fast and informal partly or fully government funded dispute resolution services. This tension involves raising the expectations of citizens that competent dispute resolution services are available somewhere. However, these same citizens are then disappointed if the available DR services are “cheap” (unskilled and stressed); “informal” (lacking procedural justice); and “fast” (hurried bandaids). There is little satisfaction when medical services reflect similar patterns.

These governments remain irrevocably committed to diagnosing conflict as cheaply and accurately as possible; and then referring clients onto the cheapest and most suitable dispute resolution pathways possible.

3. Stressed Dispute Resolution Services

The third and overlapping pressure for better diagnosis and intervention/referral, is the current sense of stress and crisis being experienced by a number of dispute resolution services---especially by the majority of courts. Many judges and court officials report their feelings of being overwhelmed by the labour intensive “docket” system;

by DIY, SRL, or pro se disputants; by “dysfunctional” litigants; by increasing national population and decreasing court staff; by expanding administrative duties; by clients from multiple cultures; by the glare of critical publicity; by funding cuts; and by their own high personal expectations of serving the public.

All of this is occurring despite the steady and well-documented decline of “full-blown” trials since the mid 1980s!

Predictably, judges, court officials, and Attorneys-General want to “refer”, “dump”, “shunt” or “divert” the majority of this demanding traffic elsewhere. But which disputes, when and where?

This “desire to divert” is also understandable as between 85%-98% of cases filed in court settle via negotiation, mediation or abandonment; and the majority of disputes filed in court are neither caused or settled around debates of fact, evidence or rules of law. “The pleadings never/rarely reflect what the dispute is about.”

So why not divert early if the cases will settle later anyway, and diversion will cause at least 40% of disputes to “settle” or be abandoned?

The above settlement and abandonment patterns lead inevitably to the question--diagnostically, why do the majority of “court” cases even enter “court” queues. There are complex answers to that question. (See Wade)

4. Time-Rich and Time-Consuming Clients

Three classes of time-rich clients have emerged in courts and other dispute resolution services over the last twenty years in western democracies, including Australia. These three classes of clients eat up limited resources, patience and skills of these dispute resolution services. No-one has found particularly effective responses to these high maintenance groups. The three groups are---first, the DIY, LIPs, (“litigants in person”), SRLs (“self represented litigants”), or “pro se” clients; secondly, alcoholic, drug addicted and mentally ill clients; and thirdly, mega-corporations engaging in years of tactical litigation to secure or break market monopolies.

All dispute resolution services desperately attempt to refer or “dump” these three classes of clients onto someone else---anyone else, and back again. Everyone agrees that skilful diagnosis; and interventions/referrals are necessary.

What Diagnostic Dispute Resolution Services are Available?

There appears to be few professionals who offer specialised diagnostic dispute resolution services. “Come to me and I will diagnose the conflict, define the problem and refer you to the most suitable option to match your needs.”-- “ I have no conflict of interest, as I do not provide, or receive commissions from, the mainstream dispute resolution service.” Nevertheless, such diagnostic services are provided incidentally by:

- *gossip
- *books
- *online websites
- *telephone helplines
- *wise elders in organisations and families
- *life coaches
- *intake officers at courts, counselling agencies, and mediation services
- * human relations departments
- *all mainstream DR providers, working both at initial interviews and at ongoing evaluations—eg lawyers, counsellors, mediators and arbitrators.

There are well-documented tensions or potential conflicts of interest where mainstream DR providers also purport to act as diagnostic services. (Compare again the equivalent tensions in medical services). For example—mainstream providers (counsellors, mediators, lawyers, arbitrators etc), especially early in our careers:

- usually have not been trained or mentored about complex possible causes, escalation and interventions (“when all I have is a hammer, then every problem is a nail”);

- are comfortable with our own expertise, and tend to repeat that which is comfortable;
- are likely to refer to friendly associates who are expected to cross-refer;
- are tempted to hang onto our “own” paying clients;
- do not necessarily have a wide range of alternative skills and processes in our own repertoire to which to make a “self-referral”, or to enable “hat-switching”;
- do not necessarily have a wide range of known and skilled alternative DR providers to whom we can confidently make referrals;
- often have had negative feedback from clients after referrals are made;
- are reluctant to make referrals as so many clients “disappear” during the referral process.

Despite the above daunting list of challenges associated with referrals of clients, all mainstream DR providers act also as diagnostic agents. At initial interviews or later, the comments are heard constantly—“ I just want to ask you some questions to see if you are at the right place”; “What are you hoping that I can do for you?” “ Why are you phoning a mediator and not a counsellor?” “ Once I send a lawyer’s letter, the dynamics will change suddenly—what else can we try first?” “From what you’ve said so far, the company losses could be caused by the GFC, or your partner’s expenditures, or a bit of both?”

“You seem to be carrying some deep scars from the way you were treated in the past?” “Joan, I can get you a court order, but it will not make your employer/son/insurer/neighbour treat you with respect”; “I can help you in one particular way, but first you must consult a tax accountant/lawyer/counsellor/ doctor/mediator etc”.

One irony repetitively experienced by Australian “diagnostic” or “intake” services is worth noting. If clients encounter initial diagnostic service providers --eg the “intake” people-- who answer the telephone at a particular DR agency—who are (a) caring; (b) competent at the “core

skills” of listening, empathy, reframing, summarising and questioning, then most clients will be reluctant to be “referred away” to a specialist.

Clients seem to prefer the initial skilled person to multi-skill and provide both diagnosis and “problem-solving”. This partly explains the remarkably high settlement rate of skilled intake officers who provide advice during ‘phone conversations, or attempt fast shuttle telephonic mediation, instead of referring clients onto the formal mediation or adjudication service. Funders rejoice in this pattern, and quickly divert money to the training of the telephonic intake officers, sometimes to the disappointment of the waiting, more formal DR referral services.

Another model which is apparent in Australian government DR services (eg legal aid, workers’ compensation, child support, parenting disputes), is the “ed-med-decision” process. A single person takes the disputants through an educational process (including video, online and face-to-face information); followed by a time limited form of mediation; and if the dispute does not “settle”, then followed by short term decision on interim payments, or procedural requirements before any further access to courts, or government funding can occur.

Diagnosis of Disputes on the Court Track

On what criteria are disputes on the court or tribunal track being “referred out” to other processes, even if those other processes are conducted in-house by a judge or registrar? This question is particularly applicable to court referrals to some kind of mediation, due to this widespread practice.

- **All**, prior to filing (with a list of emergency exceptions)
- **All**, prior to hearing (with a list of emergency exceptions)
- **All**, unless at an (expensive) interim procedural hearing, one party establishes acceptable reasons for non-attendance
- **All**, where the monetary remedy claimed is ABOVE say \$100,000
- **All**, where the monetary remedy claimed is BELOW say \$100,000

- **All**, where ongoing relationships are probable (eg business, family, succession, employment, organisational, sporting disputes)
- **All**, whenever a DR provider (eg a court) has overcrowded lists
- **All**, at certain times of the year (eg pre-Christmas mediation weeks)
- **Some**, based on a list of criteria applied by a court official or intake officer
- **Some**, based on a preliminary discussion/hearing between a decision-maker and the disputants
- **Some**, base on random chance (eg odd numbers, even numbers)
- **Some**, where the courts are exhausted by disputants who are pro se, alcoholic, drug-addicted and/or mentally ill; or are wealthy corporations wasting court resources.

The majority of these methods are mechanistic, and require limited costs, time or skills to effect a diagnosis. Mechanistic referral to competent or semi-competent mediation remains very attractive to courts. Why? Between 40%-70% of the referred away disputes do not come back and are abandoned or settled for a variety of reasons!

That is, cheap and mechanistic diagnostic methods result in relatively high settlement or abandonment rates. Would expensive and customised diagnostic methods result in higher settlement rates; or other measures of “success”? From anecdotes, the answer is a tentative affirmative, but this needs more confirmation from research, and then a cost-benefit analysis.

Legendary scholar and San Francisco magistrate Wayne Brazil refers cases in his court by random chance---odd numbers to mediation; even numbers to early neutral evaluation. What are the comparative settlement rates over the years? Almost identical, around 70%.

What Dispute Resolution “Interventions” are “available” in each area of conflict in your province? What factors affect “availability”?

This third question is often answered by a comprehensive list of big interventions such as mediation (subdivided into 20 different types); therapy (subdivided into over 400 different types); arbitration (subdivided into 12 different forms); collaborative lawyering (currently in 4 different schools and growing); early neutral evaluation (subdivided into 8 different types); litigation filing; litigation interim hearings; informal negotiations etc.

Each of these big interventions is then qualified by the variables of different skilled helper's experience, empathy, perceived care for clients, "core skills" (LARSQ—listening, acknowledging, reframing, summarising and questioning), cross-cultural awareness, speed, specialised knowledge, flexibility, ability to customise, cost etc.

However, this impressive list of variables on the "intervention" menu is subject to predictable, and important qualifications. Few can "dine at the Ritz". (Galanter).

For example, in Australia and elsewhere, most experienced "family dispute resolution practitioners", whether private or public, have impressive informal networks to assist with both diagnosis and interventions for clients. These include a stable of advocates, counsellors, specialist lawyers of various brands, mediators of different personality and process, mental health workers, tax advisors, domestic violence shelters, early neutral evaluators, court officials, a stock of arbitrators, children's lawyers, child psychologists and valuers. Some of these teams have been formalised in various versions of "collaborative law", but more commonly are informal.

Each stable of trusted specialists is expanded or diminished by gossip, repeat experience and conference attendance. Trust is nurtured and yet is precarious. Experts are gossiped about on their way into competence, at their peak, or on the way out. Sometimes, a specialist is "only as good as his/her last case."

Obviously, access to such extensive and competent networks is only available to a few privileged people. This is at least because of:

- The cost of hiring the initial gate-keeping expert;
- The relatively few gate-keeping experts who have up-to-date stables of trusted specialists;

- Geographical isolation of clients and skilled helpers (modified extensively in Australia by the use of teleconferencing—with pockets of other kinds of electronic meetings)
- The majority of younger dispute resolution practitioners are not familiar with, or comfortable with, available agencies or individuals. For example, in Australia, it took at least a decade of trial and error during the 1990s before the majority of lawyers became comfortable with certain limited models of mediation (See now in USA, Riskin and Welsh, 2009).
- The challenge of finding gatekeepers and specialists who are skilled at working with disputants from different cultures.

Once again, there are many helpful analogies in the provision of medical services. How to find the right diagnosis? How to locate basic services? How to find specialist services?

Conclusion

How to match the right diagnosis and intervention at the right time, price and place with the right disputants? The majority of citizens find this to be a strange question. They muddle through with self help and “lumping it”.

However, for DR professionals and governments, managers and friends, and for some disputants, this will remain as a key question driven by the frequently competing goals both cost reduction, and better quality service to clients.

JW

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