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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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Practice steps in ADR

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 article addresses three broad topics from an Australian perspective. First, where is the pressure coming from for dispute resolution professionals *to improve* the diagnosis of causes of conflict and to improve the choice of intervention and/or referral to other skilled helpers?

Second, 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?

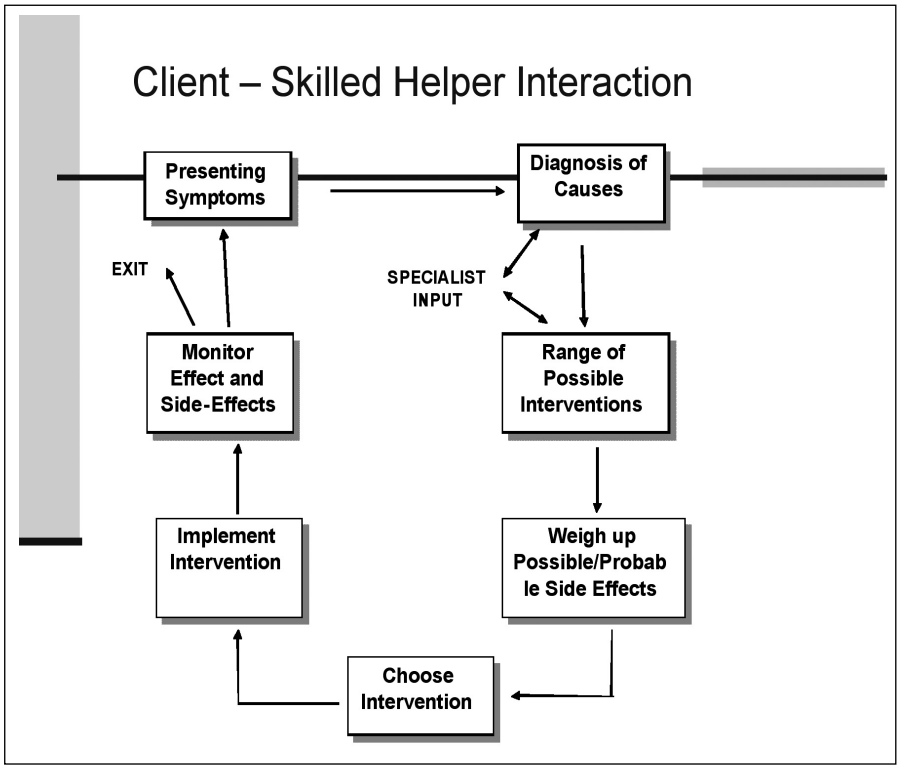
Third, what dispute resolution assistance (problem solving) is available in each area of conflict (workplace, banking, personal injury, family, school, political, construction, insurance, etc)? What factors affect this availability?

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 need 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:



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

Terminology

In this short article 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 recurs about the meaning of words: see Table 1.

Pressure for better diagnosis and better intervention and 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 the

Table 1: Terminology

Conflict/dispute	*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, and so forth.
Presenting problem	*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	*Diagnosis* is a single attempt, 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 cheer-squads, or payback for past hurts, and so on. Incorrect diagnosis almost always results in unhelpful or damaging responses.
Intervention	*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 or by issuing/not issuing court proceedings. 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	*Big and little interventions* are distinguished by matters of degree. A 'big' intervention is a stereotypical process response such as evaluative mediation, full-blown litigation, cognitive therapy, personal coaching or early neutral evaluation. 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 or showing empathy, or not.

Table 1: Terminology (con't)

Referral	*Referral* is the process whereby one 'skilled helper' encourages a disputant to consult another particular or generalised skilled helper because they may be able to provide more useful and accurate diagnosis and/or interventions. For example, a skilled helper may suggest that a disputant consult a lawyer; a tax accountant; a grief counsellor; an expert in French culture; a negotiation coach ; and 'here is a person whom I trust'. (See generally the classic text, G. Egan *The Skilled Helper* 6th ed). It appears that the majority of referrals recommended are not acted upon by clients.
Resolution	*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 and so forth. 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).
Settlement	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').

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:

- limited public funds;
- 'access-to-justice' ideology;
- stressed dispute resolution services; and
- time-rich and time-consuming clients

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 systems, 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 and online, education and decision-making services. Federal and State governments in Australia conduct constant quantitative evaluations 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.

'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.

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 courts settle via negotiation, mediation or abandonment; and the minority of filed disputes 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, of why do the majority of 'court' cases even enter 'court' queues. There are complex answers to that question.

Time-rich and time-consuming clients

Three classes of time-rich clients have emerged in courts and other dispute resolution services over the last 20 years in western democracies, including Australia. These three classes of clients eat up limited resources, patience and skills of the 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 appear 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 help lines
- 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 evaluation, for example 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 and so on), especially early in our careers:

- usually have not been trained or mentored about complex possible causes, escalations 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

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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'.

One irony repetitively experienced by Australian diagnostic or intake services is worth noting. If clients encounter initial diagnostic service providers — for example the intake people who answer the telephone at a particular DR agency who are (a) caring; or (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 telephone 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 more formal expectant DR services.

Another model which is apparent in Australian government DR services (for example 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, it is followed by short-term decisions about matters such as interim payments, or procedural requirements before any further access to courts or government funding can occur.

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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 disputes, prior to filing (with a list of emergency exceptions).

All disputes, prior to hearing (with a list of emergency exceptions).

All disputes, unless at an (expensive) interim procedural hearing, one party establishes acceptable reasons for non-attendance.

All disputes, where the monetary remedy claimed is ABOVE say $100,000.

All disputes, where the monetary

remedy claimed is BELOW say $100,000.

All disputes, where ongoing relationships are probable (for example business, family, succession, employment, organisational, sporting disputes).

All disputes, whenever a DR provider (such as a court) has overcrowded lists.

All disputes, at certain times of the year (such as pre-Christmas mediation weeks).

Some disputes, based on a list of criteria applied by a court official or intake officer.

Some disputes, based on a preliminary discussion/hearing between a decision-maker and the disputants.

Some disputes, based on random chance (such as odd numbers, even numbers).

Some disputes, 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% and 70% of the referred 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 — about 70%.

What dispute resolution interventions are available in each area of conflict? 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 and the like.

Each of these big interventions is then qualified by the variables of different skilled helpers' experience, empathy, perceived care for clients, core skills, cross-cultural awareness, speed, specialised knowledge, flexibility, ability to customise and cost.

However, this impressive list of variables on the intervention menus is subject to predictable and important qualifications. Few can dine at the Ritz.

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, valuators, children's lawyers, and child psychologists. 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 or 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

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teleconferencing, and 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 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.
- 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 are lumped in as one of many disputants.

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

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ADR RECENT DEVELOPMENTS

Police training as mediators in India

Police officers in Punjab and Haryana in India are being trained by the High Court to act as mediators and conciliators. The court proposes to encourage police to use their new skills to provide a final solution for issues rather than have cases progressing to court. They also anticipate that the new found skills will 'transform the personalities' of the officers.

Mediation in Europe

Mediation has become an even more wide-spread form of dispute resolution in Europe. In 2008 the EU Commission agreed to a Directive to encourage the use of mediation as a quicker and more cost effective way of settling disputes. Member states were required to implement this directive by the end of May 2010. European courts have been struggling to handle the high volume of litigation cases that have emerged during the GFC. It is anticipated that the fast resolution of cases will renew cross-border business relationships that have suffered because of the instability of many EU member states during the GFC.

In-vitro mediation

In the US, mediation is being used to settle a dispute for two families battling for control of two frozen embryos. The Lamberts entered into a contractual agreement in February 2009 granting custody of four frozen embryos to the McLaughlin family for the purposes of in-vitro fertilisation. The agreement contained a clause stating that if the embryos were not used within a year the Lamberts could revoke the agreement. Mrs McLaughlin gave birth to twins as a result of the donations and now wants to give birth to the last two. The Lamberts are seeking the return of the remaining embryos. The embryos are being stored at a fertility clinic until agreement can be reached.