

How Mental Health Issues Affect Mediation

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Introduction:

The purpose of this paper is give some insight to both mediators and lawyers about how a litigants' mental illness can affect a mediation. I should explain that my background as a mediator stems exclusively from a labour and employment law perspective, and therefore the examples I use in this paper relate to that type of dispute. However the observations and comments should apply across most practice areas.

It is important to distinguish between litigants with diagnosed mental illnesses and those without. A litigant with a diagnosed mental illness is one who has seen a qualified mental health professional who has rendered a diagnosis in a report which is available to the lawyer or mediator to review. A litigant without a diagnosed mental illness may be either a person without any mental illness or a person with a mental illness which has not yet been diagnosed.

The reason this distinction is vitally important is because lawyers and mediators, unless they also are also trained mental health professionals, are not capable of determining whether or not someone has a mental illness and if so what the actual diagnosis is. This ability to diagnose mental illnesses is obviously not something that can be done by untrained persons. Furthermore the reason why a diagnoses of mental illness can be useful information in a mediation setting is not so that the label of mental illness automatically changes the dynamics of the mediation process, but rather so that the lawyer and the mediator can be attuned to the fact that the existence of a mental illness may affect the actions, reactions and thought processes of the litigant with the mental illness.

In other words, the existence of a diagnosed mental illness in a litigant is information that a lawyer and mediator may find useful in understanding how to effectively communicate with that litigant. We all need certain information in order to deal with litigants in a mediation. We routinely find out what language they speak, their

age, their educational background, where they grew up, and their work history. We collect this information so that we can communicate with the litigant better and learn what motivates that person in either a negative or positive fashion. If in the course of a mediation we are discussing a difficult legal concept and how it may affect the outcome of this case, the words used and the examples given to explain this to the litigant may be different depending on the personal aspects of the litigant. In the same way the existence of a diagnosed mental illness may affect the way in which the litigant receives and processes the information, how he or she reacts to this information and most importantly, how he or she makes the difficult decisions that are required in a mediation.

Understanding the Mental Illness:

The first step therefore for the lawyer or the mediator is to be able to read and understand the medical report concerning the mental illness of the litigant. This is not an easy task because these reports are not generally written for the layman; rather they are written for other medical professionals.

Generally speaking most medical reports on mental illness refer to the DSM-IV Multiaxial Classification. This refers to the book published by the American Psychiatric Association entitled *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. In essence this is a catalogue of all generally recognized mental illnesses. The term Multiaxial Classification refers to the Five Axis Diagnosis. The Five Axis are the shorthand or summary of the diagnosis and is set out in a standard format. It is in essence a snapshot of the diagnosis.

The Five Axis Diagnosis can be briefly explained as follows:

Axis I: Mental Illness

This is where the doctor lists every mental diagnosis, except personality disorders and Mental Retardation. There are often more than one Axis 1 diagnosis and they are generally listed with the diagnosis that is most responsible for the current evaluation first and then in decreasing importance. There is often a number attached to the diagnosis, this simply allows you to cross reference the diagnosis to the DSM-IV more easily. An example of this from a very helpful book by James Morrison M.D. entitled *DSM-IV Made Easy: The Clinicians Guide to Diagnosis* 1995 The Guildford Press (see <http://mysite.verizon.net/res7oqx1/index.html> for an description of the book) is as follows:

Suppose that the patient was a man who had been admitted after a heavy episode of drinking. He had been taking lithium and had no symptoms of mood disorder for two years. Then his diagnosis should read:

<i>Axis I</i>	<i>291.8</i>	<i>Alcohol Withdrawal</i>
	<i>303.90</i>	<i>Alcohol Dependency</i>
	<i>296.46</i>	<i>Bipolar 1 Disorder, Most Recent Episode Manic, In Full Remission</i>

With this information the reader can then read the description of the disorder, and the criteria that is used by the clinician to determine if the symptoms meet the criteria. From the viewpoint of the mediator and the lawyer, this information can be helpful in understanding how the mediation may be affected by the mental illness.

Often the Axis 1 diagnosis, and for that matter any of the other Axis as well, also specify a degree of severity of the disorder. These terms include *Mild, Moderate, Severe, In Partial Remission, In Full Submission and Prior History*. This is an important aspect of

the diagnosis for mediators and lawyers because it can provide us with valuable information as to the degree in which the mental illness may affect the mediation itself. Probably a litigant who is diagnosed with a mental illness that is in Full Remission is one who is going to act differently than one who currently is experiencing Severe symptoms.

Axis II : Personality Disorders and Mental Retardation :

Dr. James Morrison describes a “personality disorder” at page 460 as follows:

Personality disorders are collections of traits that have become rigid and work to individual's disadvantage, to the point that they impair functioning or cause distress. DSM-IV personality disorders are all patterns of behaviour and thinking that have been present since early adult life and have been recognizable in the patient for a long time.

This part of the diagnosis can be most helpful to understanding a litigant's behaviour in mediation. Read this description of a Paranoid Personality Disorder from pages 463 and 464.

The central characteristic of patients with Paranoid Personality Disorder is their unjustified distrust and suspicion of others. They read unintended meanings into benign comments and actions. They will interpret untoward occurrences as a result of deliberate intent and will harbour resentment for a long time, perhaps forever. These people are rigid, often litigious, and have an especially urgent need to be self-sufficient.

Anyone who has practised law or mediation for more than a week has encountered many litigants who seem to fit this diagnosis. We become very frustrated dealing with these types of people because they do not follow our advice, give bizarre instructions and question everything we do for them as if we were the enemy. Obviously a settlement at a mediation with a person with this disorder would be difficult where the resolution involved relying on the good faith of others to carry out a settlement. This person will probably need a resolution that is iron clad and simple, with little or no possibility of ever falling apart. In other words a person with this disorder would probably accept a \$10,000 single payment settlement rather than \$12,000 settlement paid in 6 monthly instalments of \$2,000 each simply because he will be less capable of believing that the other side will actually make the future payments. Even if one could create a settlement that would insure, through escrow agreements, providing security etc. that was no real risk of failure, the litigant with this disorder will less likely be able to appreciate the situation than someone who thinks “normally”.

Similarly a person with Obsessive Compulsive Personality Disorder (DSM-IV 301.4) is said by Dr. Morrison at page 493 to have the following characteristic:

The rigid perfectionism of these patients often results in indecisiveness, preoccupation with detail, scrupulosity, and insistence that others do things their way.

This personality disorder can manifest itself in a mediation setting in a number of non-productive ways, including incessant focus on legally irrelevant information, inability to deal with more than one concept at a time and inability to make a decision on the basis that they more information first.

Axis III: Physical Conditions and Disorders

This lists physical illnesses that have a direct bearing on the patients Axis I disorder.

Axis IV: Psychosocial and Environmental Problems:

This is where the doctor lists any environmental or psychological event that might affect the diagnosis or management of the patient. Examples are numerous and include examples such as poverty, dispute with landlord, death of a close relative, termination of employment, poor school grades, race discrimination , being in jail, unable to access proper health care.

One item in this category that is especially helpful at mediation is that fact that doctors will often list as an Axis IV issue the existence of the lawsuit itself. In other words, this means that the litigant's doctor is telling the litigant/patient that the continued existence of the law suit that you are mediating is adversely affecting his or her mental health. This can be a powerful piece of information to use when the parties are close to a settlement and the litigant needs a non-monetary reason to reason to settle the case.

Axis V: Global Assessment of Functioning (GAF).

The GAF score (represented as a number between 1 and 100) reflects the patient's current overall occupational, psychological and social functioning. The lower the score the worse off is the patient. Anything above 80 is great. Between 60 and 80 you have problems but you or more or less coping. Below 60 is where the illness seriously is affecting your ability to function day to day.

How the mental illness affects the mediation:

Let us examine how the presence of someone with a mental illness can affect a specific mediation.

First of all, there is the rather obvious fact that if the mental disorder affects the outward emotional well being of the person, the mental illness may manifest itself at the mediation by way of emotional outbursts, crying, excess anger, withdrawal and the like. I am not talking of course of the usual level of emotion that affects many litigants in a mediation , rather the more extreme degree by which these emotional responses may come forth in a mediation setting. In a mediation the mediator may deal with these issues by asking him or herself the following questions:

- If this issue comes up in a joint session, do you try to stop it or let it go on?
- How long do you let it go on?
- How do you stop it?
- What if the apparent therapeutic value to the emotionally expressive litigant is being offset by the ever increasing discomfort and pain of the other litigant?
- If this emotion is expressed in the separate caucus , what do you communicate to the other side?
- Is terminating the mediation appropriate? What criteria do you use to determine this?
- What is the lawyer's role in this situation?

Secondly, there is a much more subtle and ultimately important way in which mental illness can affect a mediation, which is how it affects the decision making processes of the participant. Whether one practices a strictly interest based model of mediation or a more evaluative model, the underlying presumption is that a client will be able and willing to:

- Determine what his interests are, that is the matters that are most important to him or her.
- Appreciate that there are risks in all litigation and that assessing risk is a key component of decision making.
- Being able to understand the consequences of not settling.
- Appreciate the opinion of professional advisors in matters where the client has no such specialized knowledge.

However the existence of a psychiatric condition can severely affect the ability of the party to effectively participate in the mediation. I am not talking about legal capacity to enter into a legally binding settlement as a precondition to an enforceable settlement. Rather, I am referring to the client who, because of his or her mental condition exhibits characteristics or behaviours as follows:

- Being unable to focus on the issue of resolving the dispute and focussing only on the dispute itself or the reason for the dispute.
- Being unable to make decisions because of an apparent insatiable and unreasonable need for further information.
- Being unable to choose between alternatives.
- Putting forth settlement objectives that are impossible to achieve.
- Providing contradictory instructions.
- Belief that having the matter determined in Court will solve all the client's problems.
- Belief that only if the matter is determined in Court will the client's problems be resolved.

- An irrational belief that something will happen in the future that will radically change the chances of the client's success.
- A desire to not end the conflict because it would end the only relationship that the client has with the other party.
- A desire to not end the conflict because it would end the attention that many important people have to pay to the client for as long as the conflict continues

Third, the presence of the psychiatrically ill client can also put a severe strain on the client / lawyer relationship. These types of client are often the type that lawyers like the least. They often make excessive demands on the lawyer's time, often are slow or non-payers, do not follow their lawyers' advice and are the first to file complaints with the Law Society. By the time you get to mediation there is often open conflict between the lawyer and his client. This becomes, for the mediator, another conflicted relationship for the mediator to manage.

Fourth, clients who have psychiatric problems often bring family members along to the mediation. This can be a blessing or a curse. If the family member is a supportive person who truly wants to help the client get better, they can be very helpful by acting both as a support person and a second mediator managing the communication between the ill client and their own lawyer and the mediator. However if the family member is encouraging the continuation of the conflict, then their involvement (which undoubtedly manifests itself as an attempt to speak for the client, often to the exclusion of the client) is typically disastrous. An attempt by the mediator or the lawyer to deal directly with the client, thereby excluding the family member, often leads to more problems and no settlement. In my experience, this type of family member often has more psychiatric problems than the client, however the only difference is the client is at least getting treatment for his or her disorder.

How to deal with mental illness in the mediation:

So far I have helped you identify how you can gain an understanding of the client's diagnosed mental illness and how the mental illness can manifest itself at the mediation . Now I hope that I can provide you with some guidance on how to use that information so that the mediation can result in a settlement. These are some of my ideas:

- Do not be reluctant or embarrassed to discuss the mental illness with the affected client. Remember, the premise of this paper is that you have had the opportunity to read a proper diagnosis from a qualified mental health professional. You are not self diagnosing the client. Therefore the client is probably quite aware of his or her own mental condition and how it is affecting his or her decision making process. By discussing the issue openly you are telling the client that he or she need not hide or be embarrassed about their condition. You show the client that you can separate the client from the condition. I once had a mediation client with Obsessive Disorder Condition (OCD). We were trying to understand why

he was failing at one part of his job and succeeding at another. Only by discussing openly his medical condition could we then appreciate that the part of the job he was failing at (participation in group discussion on many topics at the same time) was directly related to his OCD, which at the same time made him excel at the solitary problem solving part of his job. With this information we were able to open a discussion with the employer about redefining his job to limit the meetings and expand the solitary work aspect.

- Recognize that the reason the client is not “getting it” is not because he or she is necessarily stupid, stubborn or evil, but rather it is probably a manifestation of the illness. Therefore talking louder, repeating your statements more forcefully or threatening to terminate the mediation will likely not succeed in changing the client’s position. Try to work around the problem, try to focus on other issues and come back to the problematic ones when you have made some progress in other areas. Not all needs have to be satisfied at the same time. I once had a plaintiff who insisted that she wanted to tell her ex-employer how horrible they had treated her. Her lawyer and I were reluctant to let her “vent” at that time as we were both convinced that the employer would dig in its heels and become even less willing to settle if they were forced to hear the ex-employee “rant”. I assumed that the client would insist that the her venting be a precondition or part of the settlement, because if it wasn’t then there would be no assurance that it would ever even occur. However, that is the way I would have acted if I was her, but I was not her. She was perfectly content to do the deal, sign the Minutes of Settlement and then tell the employer what she really thought of them. The employer did not care because after the deal was signed the President left the mediation, leaving the Human Resource Manager behind to listen to the ex-employee tell her how evil the President was. As Human Resource Managers are trained to listen (or at least pretend to listen) to angry and disgruntled employees, the ex-employee was satisfied telling her story to the seemingly interested Human Resources Manager.
- Do not be reluctant to discuss the ongoing health of the client and the effect on his or her mental health of not settling. Assume that the mediation has progressed to the point where the other side has made an offer, which objectively is as good as or perhaps even better than the expected outcome in Court. The client’s lawyer supports the settlement, you as the mediator believe that it is a good offer and that the no better offer will come forward at the mediation. This is often when it is useful to discuss with the client whether he feels that he will become better or worse if he settles. If the client acknowledges that the continuation of the lawsuit will delay or hinder his recovery, then it usually not to difficult to get the client to agree to a settlement. The supportive family member can be crucial at this point. The family member who “gives permission to

settle” to the client allows the client to make the difficult decision “for the sake of my family”, thereby allowing the client to continue to believe in the rightness of their case but still settling solely for the benefit of others that love him.

Conclusion:

In conclusion, mediating with people with psychiatric disorders presents many challenges to the mediator and the lawyer. However if the mediator and the lawyer have some basic understanding of the disorder and is prepared to work on the presumption that not every one determines their own self interest in the same way, there is no reason that mediation cannot be an effective dispute resolution technique for most people with psychiatric disorders.