
A Bridge over Troubled Water: Managing Parties' Mental Illness in Mediation

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One in five individuals in society has or will have a mental illness at some point in his or her lifetime. Conflict resolution theory, however, largely assumes that all individuals operate within the range of behaviors considered mentally healthy. Evidence suggests that professionals who deal with conflict, however, may have to deal with individuals who have mental health problems more frequently than would be the statistical norm. Clearly then, new theories of practice and norms of mediator behavior are needed to respond to the distinctive challenges presented by engaging with those who face mental health difficulty.

This paper surveys the research on how people with mental health challenges approach and respond to conflict and provides practical advice to conflict resolution professionals on how to recognize and tailor their approach to meet the needs of these individuals.

Key words: mediation, conflict resolution, mediation practice, mental health, mental illness.

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Introduction

Mental illness is prevalent but largely invisible in Western society. The United States National Institute of Mental Health has estimated that 25 percent of the population of the United States has a mental illness and that nearly 50 percent of the population will have a mental illness at some point in their lifetimes (National Institute of Mental Health 2011).

It is unrealistic to expect that all individuals with something as widespread as mental illness simply drop out of society altogether. Because of the pervasiveness and social invisibility of mental health disorders, it is nearly inevitable that those whose job it is to deal with conflict will end up engaged with individuals who are experiencing these conditions. The challenge to conflict resolution represented by mental disorders could be mitigated substantially if the affected individual is represented by his or her own counsel. Because more litigants now represent themselves—at least in North America—a professional trying to resolve a conflict that involves someone who has a mental illness cannot assume that he or she will be able to deal with a lawyer representing such an individual, however.

David Hoffman and Richard Wolman wrote that it stands to reason that, if anything, people with mental illness are over-represented among those of us who find ourselves in serious conflicts (Hoffman and Wolman 2013). At the same time, simply because someone has a mental illness does not mean he or she lacks the legal or practical capacity to resolve those conflicts. The conflict itself may bring on situational anxiety, depression, or other mental health disorders even if temporarily. Some research supports the proposition that the very act of thinking about how to resolve a problem will itself induce depression-like symptoms (Taylor and Gollwitzer 1995).

For all these reasons, professionals dealing with conflict “need to be cautious about assuming that the people in any given mediation are operating at full capacity and in a rational manner” (Hoffman and Wolman 2013: 805). Relying on misleading stereotypes of mental illness is not only harmful to parties afflicted by it, but also detracts from the effectiveness of the mediator. Now more than ever, the skilled mediator must include in her or his toolbox:

- an accurate and nuanced understanding of the effect of mental health disorders on parties to a conflict; and
- realistic methods to manage that effect and bring conflicts to a successful resolution.

What Is a Mental Health Disorder?

Mental health disorders may take many forms.¹ Mood disorders, which include depression, anxiety, bipolar disorder, and dysthymia, are characterized by significant distress or impairment in social, occupational, educational, or other important areas of functioning due to the emotional

state of the individual.² Schizophrenia, by contrast, is characterized by blunted or socially inappropriate emotions, disordered language and communications, and is often accompanied by delusions. Personality disorders manifest themselves in anti-social, often crassly manipulative behavior.

The common element in mental health disorders is that all relate to the inappropriate function of a human mind. The United States Surgeon General defines mental disorders as “conditions that are characterized by alterations in thinking, mood, or behavior . . . associated with distress and/or impaired functioning” (Surgeon General of the United States 1999: 5). It is important to understand that it is this *impairment* that separates mere eccentricity or individual personality differences from disorders. For example, many people place a high value on keeping their homes organized but someone suffering from obsessive-compulsive disorder may manifest that illness by organizing his or her home to the extent that this behavior impairs the individual’s physical health, work, and/or relationships.

This dysfunctionality aside, mental health disorders are not monolithic in their impacts. Their symptoms can vary widely. Individuals in the midst of a psychotic disorder will experience a break from reality.³ Paradoxically, evidence suggests that a disputant with mild depression may have a *more* realistic understanding of the particular challenges that need to be met when implementing a deal than would the average non-depressed person (Taylor and Gollwitzer 1995) and may to that extent be a *more* effective than average negotiator.

The interaction between having a mental illness and a person’s capacity to negotiate is thus not a simple one. The varied symptoms and effects of mental health disorders may—or may not—have a profound impact on the mediator’s job when approaching dispute resolution that involves a party with such a condition.

Popular conceptions of mental health disorders would have one believe that mental health is a binary proposition. That is to say that we believe that people are either mentally ill or not. The truth is much more complex than that.

Individuals with mental health disorders often continue to function much as “normal” individuals do although to do so they may require interventions such as medications and talk therapy. Because of both the significant social stigma surrounding mental illness as well as the impact of effective treatment, a disputant’s compromised mental health may be either denied or at least not disclosed leading up to a negotiation. The disputant experiencing a mental health challenge may not even know it. For example, he may not realize that the anxiety he feels about how the resolution of a problem may cause change in his environment is based as much or more on his phobias or latent obsessive–compulsive disorder as on the change itself. Thus the answer as to whether or not a person with a mental illness is fit for dispute resolution is unlikely to be a simple yes or no.

The Impact of Mental Health Disorders on Dispute Resolution Behavior

To understand the effect of a mental health disorder on a disputant's approach to conflict one must first recognise that irrationality is not the exclusive province of the mentally ill.⁴ Following the development of interest-based negotiation as described by Roger Fisher, William Ury, and Bruce Patton (1991), some negotiation theorists cautioned that a purely rational approach to negotiation is limited because it fails to take into account the effect of parties' emotional responses to conflict. It is useful, then, to first consider how the nonrational element of even entirely ordinary human behavior affects conflict.

Any party approaching the negotiating table arrives bearing cognitive baggage that will affect his or her perception of not only the conduct of the other party or parties, but also his or her definition of success. As a means of making efficient decisions in our daily lives, the human mind has developed a number of what might be considered shortcuts to decision making, also known as heuristics or cognitive biases.

Confirmation bias is the phenomenon whereby humans unconsciously create a hypothesis based on incomplete information and then attribute significance and/or meaning to new facts based on the degree to which those new facts "fit" the existing hypothesis. Confirmation bias can have a significant effect on mediation. If parties have come into the forum as antagonists, they tend to perceive each piece of information they obtain from the other party or parties in a way that confirms their existing negative perceptions of the other (Hoffman and Wolman 2013). A party who comes into the conflict believing that the other party is quite wealthy, for example, will likely have difficulty accepting as true statements from the supposedly wealthy individual that she is short of money.

The effect of a mental health disorder can magnify the effect of confirmation bias. If the effect of the disorder is to distort perspective, the party affected may see mendacity in place of honesty. An individual experiencing mania, for example, is more likely to have unwarranted confidence in the correctness of his or her early conclusions. If an individual with an anxiety disorder fears that the negotiation process or the larger conflict will give rise to duplicity on the part of other disputants, he is more likely to believe that new information disclosed in the course of negotiation that contradicts his first impression of the other side's position is an example of such duplicity. In either case, the disorder could buttress an individual's existing bias toward the reliability of first impressions.

Readers may be familiar with other common heuristics such as anchoring, the hindsight bias, the representativeness heuristic, loss aversion, and the availability bias. As with confirmation bias, these other heuristics serve to distort the way in which both the mentally healthy and unhealthy

perceive our environments and in particular, distort the ways in which we make decisions (Archibald and O'Connor 2012). Like confirmation bias, these other cognitive "shortcuts" are likely to interact with mental illness, but they affect disputants whether they suffer from a mental illness or not.

The interplay between mental health disorders and common heuristics is complex. Depressed individuals, for instance, are more likely than the non-depressed population to see themselves as the cause of bad events (Kinderman and Bentall 1997). One might suppose that this would tend to amplify a tendency to loss aversion. For the depressed individual, a bad outcome is his own fault. He is less likely than a non-depressed person to comfort himself by blaming a loss on factors external to himself.

Depressed people, however, are also more likely than the rest of the population to predict poor outcomes for others as well as for themselves (Butler and Matthews 1983). If a party to mediation believes that the result is likely to be a bad one anyway, a big gamble and small gamble are equally risky and she may have less fear of taking larger risks. She may perceive that she has, after all, nothing to lose.

Individual Identity and Self Stories

The irrational response that individuals often have to conflict does not arise out of a vacuum, but rather from the individual's perception of the meaning and structure of the conflict in which she is involved. The way in which a person organizes her perceptions of an event such as a conflict is referred to in the psychology literature as the "self-story" or sometimes the "extended consciousness." Neurologist Antonio Damasio (1999: 189) described the human tendency to structure subjective experiences into "stories" about the world:

Telling stories, in the sense of registering what happens in the form of brain maps, is probably a brain obsession and probably begins relatively early both in terms of evolution and in terms of the complexity of neural structures required to create narratives. Telling stories precedes language, since it is, in fact, a condition for language, and it is based not just in the cerebral cortex but elsewhere in the brain and in the right hemisphere as well as the left. Philosophers often puzzle about the problem of so-called "intentionality," the intriguing fact that mental contents are "about" things outside the mind. I believe that the mind's pervasive "aboutness" is rooted in the brain's storytelling attitude. The brain inherently represents the structures and states of the organism, and in the course of regulating the organism as it is mandated to do, the brain naturally weaves wordless stories about what happens to an organism immersed in an environment.

Thus, we would expect that the circumstances in which the person functions express themselves in the story of his environment. A brain in someone who is hungry, for example, would be expected, according to this theory, to

structure its perception of other people's behavior as being about access to food regardless of whether food is objectively a motivator of that behavior.

This characteristic of "aboutness" affects more than just how the individual perceives the course of conflict. It may even determine the identity or role that the individual disputant may take on in the negotiation. In a study of large negotiations in which the principles were represented by agents, such as labor-management disputes, researchers identified three different cohorts of participants (Corry and Mercier 2010). The first group, whom the researchers referred to as "stabilizers," brings to the bargaining table a desire to settle the conflict and is prepared to sacrifice self-interest or the interest of the group for the purpose of achieving resolution. A second group, the "non-stabilizers," prefers adversarial roles and outcomes and seeks to disrupt accommodation by stabilizers, even to the point of being reckless about their own interests. A third group, referred to as "quasi-mediators," seeks to bridge the divide on the negotiation team by bringing together the interests and desires of those who would seek resolution and those who promote impasse. According to these researchers, individuals and groups are frequently willing to sacrifice self-interest in favor of maintaining collective or individual identities.

The sense of identity of even the most emotionally stable and consistent individuals can affect their approaches to conflict. The identity of an individual in conflict will also reflect the milieu of the relationships involved in the conflict (Sargent, Picard, and Jull 2011). The story the participant has told herself *about* how she became involved in current and previous conflicts is key to conflict identity. If she assumed the role, for example, of disruptor or accommodator in a previous conflict and she believes her contribution to that previous conflict was beneficial, then she is more likely to don that same identity again the next time she finds herself in a conflict.

Mental health disorders operate within that identity-story construct. Damasio described the impact of mental illness on individuals' self-story, which he referred to as "extended consciousness" (Damasio 1999: 215–216):

[I]n their acute and severe stages, mania and depression exhibit alterations of extended consciousness. One might venture that the autobiographical self of severe depression shrivels. Some manifestations of schizophrenia, for instance, thought insertions and auditory hallucinations may be interpreted in part as disorders of extended consciousness. In all likelihood, the patients so affected have anomalous autobiographical memories and deploy anomalous autobiographical selves. It should be noted, however, that during the appearance of such manifestations, the "objects" of their perceptions may be in and of themselves anomalous.

Why does someone's self-narrative matter, particularly if it is a distorted narrative? It matters simply because it is that same narrative that leads a

person into and through a conflict. As mediator Bernard Mayer wrote, “[h]ow people approach conflict determines and is determined by the narratives they use to describe and conduct conflict. Polarized narratives promote polarizing interactions. Rigid narratives encourage rigid approaches to conflict” (Mayer 2009: 87). Scholarly attention has largely focused on how personal history, culture, and values inform a disputant’s narrative. The disputant’s mental health and even the effect of whatever medications he may be taking to address whatever disorder he may have, however, are also likely to be formative to the conflict story.

Although a mental health disorder may help shape a disputant’s conflict narrative, the narrative need not be *about* the disorder. The disputant’s perceptions of her environment are critical to the way in which she shapes her conflict narrative. The narrator of such a story identifies a beginning and a clear progression of events leading to a climax, and edits out of the narrative those events that do not fit the structure. The arc of the narrative typically suggests the appropriate resolution of the story and by extension the resolution of the conflict. Individuals use their personal histories and refer to cultural phenomena in telling their self-stories. A disputant might believe “I’ve always been the one who knocks heads together” or “I’m kind of like the sheriff in those old westerns who comes into town and cleans things up.” Mental health disorders inform individuals’ conflict narratives without making the narrative about the disorder itself. An individual with depression or anxiety could well add to his self-story: “Things usually don’t work out well for me when there’s a fight.”

Emotions, whether “healthy” or not, can also cause or catalyze conflict as well as responses to it. Emotions may drive what appear to be entirely rational responses to conflict. Someone who favors competitive bargaining over an integrative, “win-win” approach may act rationally to achieve the entirely irrational principle that winning at the expense of the other side is the only realistic approach, because “winning” the negotiation bolsters her own fragile and non-rational sense of self-worth. The human tendency to embody non-rational perceptions in rationally understandable narrative structures—our resolute “aboutness” as Damasio put it—makes those foundational non-rational perceptions critical in conflict resolution.

Emotions and Conflict

Among the many emotions that both generate and result from conflict, anger is particularly noticeable and can therefore exemplify the role of emotions in conflict. Anger has consequently been a popular topic of conflict research. One series of experiments explored the link between negotiators’ willingness to make concessions and their counterpart’s emotions (Van Kleef, De Dreu, and Manstead 2004). The researchers conducted three experiments on the effect of expressed anger. In two of the three, research subjects engaged in a simulated negotiation with a computer program, although they were told

they were negotiating with other humans stationed at computers in the same room.

At the outset students were given tests to ascertain their need for cognitive closure; that is, a desire for fixed rules and conclusions as opposed to more open-ended views of what is correct. (For example, someone with a higher need for closure might tend to decide quickly and relatively finally where he stands on a moral issue such as physician-assisted death. Someone with a lower need for cognitive closure might be more inclined to wait for more information and would be more likely to change that determination given new information.)

The subjects were given cues to indicate their counterparts' private emotional responses to their proposals. Students whose computers told them their negotiating partner was angered by their proposals were more willing to make concessions to that "angry" partner.

The effect of anger, however, was not uniform across all students. Participants with less need for cognitive closure were strongly influenced by the other partner's apparent emotional response and were more willing to make concessions. Participants with greater need for cognitive closure were more impervious to their negotiating partner's apparent emotional state. A non-rational cue, apparent anger, interacted with a non-rational attribute, the negotiators' relative willingness to suspend judgment, and altered negotiators' bargaining behavior.

Another study used a survey to examine the effect of expressed anger on the resolution of workplace conflicts by measuring perceptions of positive change that occurred in workplaces following incidents in which a co-worker expressed anger about some aspect of the job or the performance of colleagues (Gibson et al. 2009). The study tested hypotheses such as:

- expressions of anger that were restricted to verbal expressions would be more likely to trigger positive change;
- expressions of intense anger would be less likely to precipitate positive change than expressions of less intense anger; and
- individuals with higher status would more openly express anger at those whose status in the organization was lower, with such expressions of anger being more likely to be perceived as resulting in a positive outcome than incidents when low-status individuals expressed anger toward high-status individuals.

The researchers found that the lower intensity anger led to more positive reported outcomes but the expression of higher intensity anger correlated to less positively perceived change. They also found that purely vocal expressions of lower intensity anger led to more positive organizational change than did expressions of intense or violent anger accompanied by physical signs of anger such as throwing a chair. Thus the intensity of anger

and the method in which it was expressed were predictive of its effectiveness in generating change. The individual's status in the organization did not affect whether his expression of anger would catalyze change (Gibson et al. 2009).

What do anger studies tell us about the effect of mental illness on conflict resolution? As Damasio noted, emotive elements to a conflict can be affected by the psychological health of one or more of the parties. A person's anger response, for example, may be out of proportion to the dimensions of the specific dispute if his self-narrative is that he is typically persecuted.⁵ A disputant may suddenly find that a comment, gesture, or even a facial expression provokes a reaction that she finds baffling because she does not share the other party's feelings of persecution. Because of the impact that anger can have on concessions, disproportional emotive responses may well distort the parties' bargaining behavior.

Someone with a mental illness is also more likely than the typical disputant to respond atypically to emotional cues exhibited by others during conflict. In a study comparing how depressed patients, anxious patients, and a control group would predict future events when making decisions, British researchers discovered that participants with anxiety disorders predicted poor outcomes for themselves and depressed participants predicted poor outcomes for everyone involved (Butler and Matthews 1983).

Even a mild mental health disorder may complicate a disputant's emotional response. For example, the effect of depression—which is by far the most widely diagnosed mental illness—is highly nuanced. For example, people suffering from depression may have difficulty modulating their anger. A depressed person may have outbreaks of rage, but irritability is more common. Depressed individuals are commonly concerned that expressions of anger will jeopardize their relationships and thus they often feel guilt and express self-recrimination after having expressed anger (Busch 2009). This can enhance and distort the existing tendency of others to accommodate those who seem to be angry as described above.

This dynamic can have a significant impact on conflict. The depressed disputant may express resentment of the other parties to the negotiation, of real or perceived power imbalances, and even of the role of a mediator. Following such an anger episode, the depressed party may well “cave” or give in on significant issues in the dispute out of a desire to preserve the relationship or she may behave in a passive-aggressive fashion that sabotages either the deal itself or its implementation (Busch 2009).

Some Practical Effects of Mental Illness on Mediation

Bernard Mayer (2009) has postulated that conflict resolution should seek to do more than merely end the immediate conflict. In his view, conflict (and conflict's resolution) is less an event than it is a habit. The conflict, he has argued, is the result of incompatible narratives on the part of the parties to the

dispute. The mediator's role is to help the parties develop adaptable understandings of each other's narratives. This approach is particularly useful if the parties to the conflict have relationships and are likely to re-engage with each other.

Such a concept has implications for how mediators deal with the effect of mental health disorders on a dispute. Helping the parties come to a common understanding of each other's narratives may be particularly challenging if a mental health disorder (or a medication taken to ameliorate a disorder) is distorting the disputant's conflict narrative. Assuming the parties will have ongoing interactions, the difficult task of learning to understand each other's narratives—and when necessary revise that understanding—is made even more difficult by the influence of a mental illness.

Mental illness's impact on mediation is not necessarily entirely negative, however. In her research Shelley Taylor of the University of California at Los Angeles has found that resilient and mentally healthy individuals are more likely to over-estimate their own abilities and contributions and underestimate challenges facing them. As exemplified by the oft-noted paradox that eight out of ten drivers rate themselves as above-average drivers, much of what are considered to be normal attitudes seem antithetical to accurate appraisals of reality. By contrast, mildly depressed people have been found to actually have a more acute grasp of reality than do people who are not depressed. Even a temporary low mood had a salutary effect on Taylor's test subjects' capacity to engage in deliberative problem solving (Taylor and Gollwitzer 1995). Particularly mild forms of mental illness, then, may enhance rather than reduce a party's capacity to negotiate (Taylor 1989).

Severe mental illness correlates strongly to poverty because it can pose significant barriers to employment. Among all sources of disability, mental health conditions are associated with the highest rates of unemployment; globally 70-90 percent of people diagnosed with a mental illness are unemployed (Funk et al. 2010: 21). The high cost of litigation may well prevent many such individuals from even raising an issue. Additionally, mental health disorders are also associated with social isolation (Health Canada 2002). Taken in combination, mental illness's tendency to induce both poverty and social isolation will make it even more probable that an individual with a mental health disorder will prepare for and attend mediation with little in the way of outside support (i.e., without counsel).

The Mediator's Response

Prepare Prepare Prepare

For the mediator who is about to deal with a mentally ill individual, deliberate advance preparation is critical. Roger Fisher and Daniel Shapiro (2005: 149) wrote:

The worst time to craft a strategy to deal with strong negative emotions is while experiencing them. Imagine what would happen if hospital staff waited until each new patient arrived in the emergency room before considering from scratch what they should do. . . . Negotiators need their own standard operating procedure to avoid facing strong negative emotion unprepared.

Fisher and Shapiro recommended that negotiators first list their goals for the interaction, including its purpose, a product (e.g., a settlement agreement), and a process. When the conflict takes a turn for the worse, they wrote, one can pause at difficult moments and review whether one's responses align with those written goals. A mediator facing a session involving a party whose mental health is compromised would similarly do well to plan out the session to ensure that responding to disordered thinking or other symptoms of that party's illness does not sidetrack her from a focus on resolving the substance of the dispute.

Mental health disorders often cause individuals to respond inappropriately to social situations, ranging from open disruption, as in a manic or psychotic episode, to more subtly inappropriate responses such as a depressed person's listless failure to advocate on his own behalf. Writing a plan can decrease the likelihood that such responses will derail mediation.

What to Include in the Plan

More mundane but critical considerations should not be left out of the plan. Mediation sessions may be lengthy. A party may find her or his mental health condition exacerbated by exhaustion or the effects of medication may wear off. The individual with a mental health disorder may need the support of counselors, family members, or friends to maintain equilibrium, and a lengthy mediation session may deprive her of that needed contact (Kichaven 2000), which could cause agitation, listlessness, or an inability to focus.

As an example of pre-session planning, a mediator who knows that one of the participants has bipolar disorder could reasonably foresee that such a participant might speak increasingly rapidly or have difficulty staying on an issue-by-issue agenda. Mediator Judy Cohen recommended the mediator address such behaviors by, for example, frequently summarizing the discussion of the issues to keep any participants who may have trouble sticking with the agenda on track. This response, she added, also signals to the party in distress that the mediator wants to hear what everyone has to say (Cohen 2000).

It is obviously impossible (and possibly unethical) for conflict professionals to diagnose parties "on the fly," and devoting extra attention to the psychological dimension of the negotiation risks obscuring the more substantive aspects of the dispute. If a disputant's mental health issues do have a noticeable impact on the progress of a mediation, however, the

mediator's awareness of how those issues affect bargaining table behavior can enhance her capacity to address the needs of all parties.

In a mediated dispute resolution process, a skilled mediator who notices such symptoms could respond by, among other things:

- recommending a break in the discussions,
- encouraging the affected party to contact support persons, and
- encouraging the affected party to rely on his legal counsel or obtain some form of counsel.

These suggestions should be framed so that they allow the client to “save face.” The need for a break could be ascribed to things other than a person's evident distress. For example, the mediator could recommend approaching support persons because they may have some information or input to the discussion that is missing. The mediator is best-positioned to raise disability-related communication problems in caucus and to focus on the problem rather than on blaming the individual's condition, and in the process demonstrate how to “separate the people from the problem” (Fisher, Ury, and Patton 1991: 17).

The mediator could also suggest taking a break by indicating that he or she needs time to assess different approaches to resolution. When an apparently depressed disputant seems to be capitulating too suddenly, for example, it is entirely reasonable to encourage the parties to take a short break to ensure they do not agree to something they may regret—and perhaps seek to undermine—later.

Such actions are consistent with what is good mediation practice anyway. Whether a party's struggle with the dialogue is rooted in a disorder or something else, it is the mediator's role to reduce roadblocks to engagement. If the negotiation is breaking down, a facilitator can detect and act on that without necessarily understanding the exact cause of the breakdown.

Inducing Rationality

As Max Bazerman has advised (Bazerman 2005), it is possible to help parties reduce their cognitive biases in several ways.⁶ Thinking that is skewed by a mental health disorder is, of course, distinct from thinking that is skewed by common cognitive biases. As noted previously, however, cognitive heuristics provide clues to irrational decision making and consequently shed light on how to manage more serious thinking disorders.

One method of countering distorted decision making is to communicate clearly that the parties need not rush into a decision. While there may be good reason to impose deadlines or reduce the amount of time an offer remains open, such pressure can also serve to enhance sub-rational decision making. Individuals forced to choose quickly may say “no” when a more considered

response would be more constructive to the process. Another strategy is to help parties communicate the relative priorities of their needs.

A logical way to respond to irrational behavior is to model rational behavior. Regardless of their cognitive irrationality, humans show a strong tendency to adjust their own behavior to accommodate the expectations of others (Bandura, Ross, and Ross 1961). By modelling a calm and logical response to what could be seen as provocative behavior the mediator can help establish norms for all parties at the table.

For the mediator, understanding how a disputant's worldview intersects with the problem at the heart of the conflict being negotiated is critical. By accepting at face value an element of what is important to the person across the table and then discussing the rational means of attaining that outcome, the mediator may be able to uncover the rational element of that person's position to help construct a rational outcome.

An anxiety disorder may, for example, prompt a disputant to worry that implementation of an agreement affords the other party an opportunity to disadvantage him all over again. Goods that the parties have agreed to exchange may be defective or prices may have hidden costs buried in them. Faced with that anxious response, the mediator can seek to build greater buy-in to the agreement by helping the parties develop plans to deal with such contingencies. While the anxious disputant's concerns about implementation may reflect his irrational fears, such fears often do contain entirely rational elements and effective resolutions must address them.

Mediators rarely learn their clients' complete life stories, let alone their psychiatric histories, and it is unrealistic to expect a mediator to understand a mentally ill disputant's underlying disorder, its roots, or all of its symptoms. That deep, specific understanding is not necessary. By mindfully attending to the degree to which the disorder creates or amplifies basic needs—for respect, for support, even for rest in the form of breaks from the mediation—the mediator can make significant progress toward improving the disputant's mediation experience.

Adding Useful "Load"

Research on the impact of mood disorders on cognitive functions also has interesting implications for mediators. In an experiment undertaken to assess the capacity of individuals with mood disorders to make accurate social judgments, researchers found that depressed individuals were less accurate in reading non-verbal cues to determine whether pairs of people were in romantic relationships (Ambady and Gray 2002). After being given a backward-counting task, however, their ability to read social-relationship cues returned to the same level as non-depressed participants. The researchers theorized that the additional cognitive load created by the counting exercise generated enough distraction for the depressed participants that they were only able to spare the mental effort required to answer the researchers'

question (“Are these people in love?”), but not enough to engage in the self-doubt that might ordinarily paralyze or distort their judgment (i.e., “What do I know about these things?”).

Although it may seem counter-intuitive, added cognitive load may, in some circumstances (i.e., when it does not challenge the disputant’s sense of identity or legitimacy), ameliorate the impact of a disputant’s disorder. This could be particularly helpful if the disputant is prone to over-thinking or “paralysis by analysis.” In a negotiation that has bogged down because a disputant’s depression manifests as a fatalistic disengagement from the process, the skilled mediator could refocus the parties toward less conflictual administrative and process details such as, for example, the mediation agenda, rather than the substantive issues of the conflict. The added cognitive load could diminish the depressed disputant’s symptoms and help unblock the impasse. For example, a depressed party may refuse to work toward resolution because she fatalistically believes the other party “will just screw me over when the time comes to make good on this deal anyway.” When forced to divert her mental energy, however, she may have less cognitive capacity to devote to her worst fears.

Knowing What to Ignore

When their disputants display signs of mental illness, mediators should also consider what behaviors and statements to disregard. Mediation behaviors that one might ordinarily interpret as signs of disengagement, hostility, or disingenuousness may, in fact, be symptomatic of the disease itself or a side effect of medication. The symptoms of mild schizophrenia include a flat vocal and facial affect, which could ordinarily be mistaken for lack of conviction or insincerity (World Health Organization 2010). Individuals experiencing depression are likely to avoid making eye contact (Segrin and Abramson 1994). A bipolar person experiencing a manic episode may well speak quickly and loudly in a manner that could easily be mistaken for aggression (World Health Organization 2010). Medications such as phenothiazines and atypical antipsychotics, which are prescribed to treat schizophrenia, depressive psychoses, or extreme mania, may cause fidgeting and facial tics (Lilly, Harrington, and Snyder 2011); these could also be taken as indicia of agitation or impatience.

Even under ordinary circumstances, mediators typically attend to the parties’ non-verbal communications. In the case of a mentally ill disputant, the mediator should consider whether the behavior is truly a response to the substance of the discussion or nothing more than a symptom or side effect. The mediator who understands the underlying condition can choose not to be distracted by the behaviors that often accompany the condition, and in so doing can set an example for the other parties so that they avoid reacting in ways that are disruptive to the conflict resolution process.

Mindfulness and Reflection

Several mediation theorists have urged the benefits of incorporating mindfulness practices into mediation. Mindfulness practices typically include observing one's present emotions without judgement. Such approaches could help disputants affected by a mental health disorder: rather than being consumed by despondency or anxiety; for example, the practitioner of mindfulness is better able to question the connection between such emotions and objective reality to determine the validity of her emotional responses and what, if anything, she should do about them (Freshman, Hayes, and Feldman 2002).

Mediators cannot force disputants to be mindful, but they can mindfully control their own responses during mediation. When confronting a mentally ill disputant, taking a mindful approach can help the mediator pause and recognize without alarm that a party's inflammatory behavior may merely be a symptom of a disorder.

Communicating with people who behave in apparently irrational ways can be frustrating. Mindful self-reflection can help a mediator manage his own reactions (Moon 2006). In addition, making notes of her own responses can help the mediator continue to develop her skills so she will be better prepared the next time she encounters that disputant or one who faces similar mental health challenges. Obviously, having the support of a co-mediator (see discussion below) makes such reflective processes easier; for example, splitting up into mediation teams, which can help break an impasse, becomes possible when there is a second mediator.

Additional Considerations

Some authors have suggested that, when psychological issues seem to be derailing a mediation, mediators should consider consulting with or even engaging a mental health professional as co-mediator (Cohen 2000; Hoffman and Wolman 2013). Mediators typically lack the capacity to diagnose a mental illness, however, and it is *not* their role to "treat" their clients. Conflict resolution should not be used as therapy—doing so could threaten the integrity of the conflict resolution process and violate the mediation imperative to work to achieve the best outcome for *all* parties.

One should not assume that the presence of someone with a mental illness will always have a negative effect on either the process or on that individual's mental or emotional state. An individual who has learned to manage an illness well may contribute more, not less, to the conflict resolution process because she will have gained substantial practice in consciously monitoring her thought processes.

Conclusion

A mediator charged with resolving a conflict involving a party suffering from a mental illness should bear in mind that most mental health problems seem

less intimidating when considered in the context of many typical conflict behaviors. While mental illnesses present distinctive challenges to the conflict professional, managing their manifestations in mediation often requires using familiar tools from the mediator's tool kit.

A defining feature of a mental health disorder is that an affected individual is often unable to respond to social stimuli in socially appropriate ways. In conflict, disputants' views of what is and what should be usually diverge. By helping them reconcile those divergent views, the skilled mediator can help them resolve their conflict. Mental illness certainly introduces new layers of complexity, but the task of the mediator remains the same: to give all who come to the table the chance to speak, listen, and be fully heard.

NOTES

1. There is a wide variety of mental health disorders. Among the most commonly diagnosed disorders are depression, anxiety, bipolar disorder, and schizophrenia. There are too many particulars of such disorders, their symptoms, and the medications that are used to treat them to provide in a survey article of this nature. A good place to begin gaining an understanding of these details is the National Institutes of Mental Health website, which is at <https://www.nimh.nih.gov/health/topics/index.shtml>.

2. This is a form of chronic depression. The expression "dysthymia" was coined to replace the previous label "depressive personality."

3. This paper does not address conditions such as autism spectrum disorder, attention deficit disorder, and other conditions that are commonly considered to be "learning disorders" with wide-ranging cognitive and behavioral impacts. Although the mental and behavioral states associated with these conditions could have significant impacts on dispute resolution, their effect on behavior is distinct from what would normally be considered a mental illness.

4. There are, of course, significant restrictions on the capacity of an individual to negotiate on his or her own behalf when a mental health disorder renders him or her incompetent to make decisions. For the purposes of this article, we assume that the mediator will be able to discern whether the people across the table are entirely incapable of making rational decisions. The more difficult issue is to know how to proceed when a party to the conflict is affected by a mental health disorder but is still capable and willing to manage his/her own affairs. Issues of incapacity and unconscionability in contracts are covered ably by other authors.

5. A variety of disorders, including paranoid schizophrenia, bipolar disorder, and even depression feature delusions that the sufferer is being persecuted, often by complex conspiracies. Paranoia is also a common effect of long-term drug use; see Kinderman and Bentall (1997).

6. Bazerman's article (2005) is focused on bilateral negotiations, but these lessons are adaptable to a mediation setting as well.

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