

# Collective Disturbance

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Sandra L. Bloom, M.D.



A “collective disturbance” is a common group phenomenon representing a profound disturbance in the communication network, unfolding when conflict higher in a hierarchy is being actually played out lower in the hierarchy, without anyone recognizing that there is a destructive parallel process going on. The level of immediate stress, collective emotional intelligence and health of the communication system in an organization is likely to determine how rapidly and effectively a group manages this

common but largely unconscious phenomenon. The level of emotional intelligence in an organization is likely to determine how rapidly and effectively a group manages a collective disturbance, a specific form of parallel process.

Stanton and Schwartz wrote the first sociological study of the mental hospital in 1954. One of their most valuable observations centered on the role of covert conflict. They demonstrated that a covert conflict on the part of one subgroup, i.e. the staff, influenced another subgroup or the entire group in ways that were not ascribable to the individual interactions and that could lead to severe and pathological dysfunctions unless the conflict were surfaced (Stanton and Schwartz, 1954). It became clear to researchers that individual patients who became the focus of attention on a psychiatric unit were those who were the subject of unexpressed staff conflict and that as soon as the staff conflict was surfaced, the individual patients’ behavior improved [1].

Similarly, collective disturbances involving several patients or an entire unit could be traced to conflicts originating near the top of the institutional hierarchy and the intensity of emotional interpersonal conflict could be followed down through the staff and into the patient community. These originating conflicts usually seemed to revolve around disagreements between the priorities of institutional purposes or incompatibility between a given purpose and some institutional need. The signs of an impending collective crisis were abundant: errors in technique, doors left unlocked, messages forgotten, increased absenteeism frequently due to functional illness, staff preoccupation with problems of or with other staff, increased withdrawal by key staff members, increased sense of helplessness, breakdown in communication, missing or canceling meetings, inability to make decisions and finally, a sense that “something bad is going to happen”.

If the evolving crisis was not attended to and resolved, violence on the part of several, although not all, patients would be the result. If the managers and staff members were able to confront their own

unspoken conflicts they could prevent or at least terminate a collective disturbance and in doing so, reduce the level of violence within the therapeutic community.

In the therapeutic community literature, this phenomenon has been remarked upon repeatedly. Caudill observed that there seemed to be a “covert emotional structure” in the psychiatric hospital that could not be explained by the underlying emotional reactions of separate individuals, nor by the emotional contagion effect that takes over a mob. He noted that these “fields” were primarily emotional and led to the collective disturbances that Stanton and Schwartz had noted. He observed that these collective disturbances proceeded in a four-step fashion. First there would be a period of mutual withdrawal which would be followed by open collective disturbances, dividing the patients and the staff. In the next part of the sequence, the group would form a “paired role group response” in which different parts of the community created paired alliances with another subgroup. Finally, this unstable balance of forces would give way to restitution in which conflict was surfaced, aired, and adequately resolved. What is of great interest is that throughout this sequence emotional communication between the various role groups, of which there were four - senior staff, residents, nurses, and patients - was maintained while cognitive communication broke down, than re-formed and finally re-established. This description is reminiscent of the individual nonverbal-verbal split that occurs as a result of an overwhelming and highly conflictual experience [2].

### **Excerpt from William Caudill, “Occurrence of Collective Disturbances” in *The Psychiatric Hospital as a Small Society*, 1958,**

In a general way, a collective disturbance usually refers to a situation in which the majority of patients on a ward become upset at one time, although as will be seen later the disturbance is probably much wider and includes the staff.

In the months preceding the outbreak of the collective disturbance, the senior staff members were engaged in trying to define their own roles, in determining therapeutic policy, and in finding ways to formalize the routines of the hospital so that these would serve to implement therapeutic goals. The residents tended to see therapeutic problems in terms of their individual patients and were opposed to formalized routine. Such disagreement placed the nurses in confusion about their responsibilities and what were the rules to be followed. In line with the effort at transition, a new activities program headed by a professional group worker, was started on the wards.

This new program was felt as a threat by the occupational therapist and as another area of confusion in routine by the nurses. This unsettled state among the staff was reflected in the patients in a lack of certainty about what were correct and permitted actions. These questions of disagreement among role groups tend to remain covert and were not openly discussed at such expected points as the daily administrative conference. Such disagreements were, however, very often implicit in the discussion of plans for individual patients, who then became the vehicle through which differences of opinion were expressed.

Some two months before the collective disturbance, the observations clearly indicate that the various role groups had attempted to ease the difficulty of the situation by a process of mutual withdrawal in which each role group concentrated on the tasks which it felt were most sharply defined for its members and limited its interaction with other role groups to 'neutral' activities.

What appeared to have happened was that an adjustive process of defense against the stresses of change and reorganization in the hospital policy was taking place within each group and looked at from the point of view of each separate group was reduced by the defenses used; but, looked at from the point of view of the hospital system as a whole, stress was increased, because all groups were still part of the hospital.

In such a state of mutual withdrawal, cognitive communication had been disrupted, while affective communication was still going on, although the members of various groups were not aware of precisely why they seemed to be sharing certain feelings.

The second type of balance of forces which occurred was initiated by the peak of acute difficulties and may be called the period of open collective disturbance. Just prior to the open collective disturbance two key members of the patient group were discharged, and this resulted in a fragmentation of the group structure on the ward. At the same time, two patients who were very upsetting to the patient group were admitted. The patients could not, at this point, reform adequate companionable groups, and, in various ways, appealed to the staff for greater control over their activities. Because of the state of mutual withdrawal, the patients' attempts at communication did not get through in a meaningful way to the staff, and the open collective disturbance ensued.

During the open collective disturbance, the patients were unable to maintain a state of relative equilibrium in the face of events on the ward, and the integration of the patient group was shattered.

Following the outbreak of open disturbance on the ward, the staff were at first bewildered and then were divided in their efforts to help the patients... a situation was created in which the residents identified themselves with the patients, and the nurses with the senior physicians. This forms the third type in the sequence of structural balances – and may be called a paired role group response which was taking place in a social field that was seriously split apart.

During this time, cognitive communication was somewhat better between the role groups which were paired with each other, but the two sets of pairs were not in communication on a cognitive basis – indeed, there was active resistance to this type of communication, as when the residents withheld information from the administrative conferences. Affective communication, however, in the sense of emotional discharge, continued to spread throughout all role groups in the hospital system as it had done during the preceding periods of mutual withdrawal and open collective disturbance.

Two other matters of importance can be seen: (1) the expression of disagreement indirectly through the medium of the individual patient; and (2) the concentration on the 'defiance and rebellion' within the patient group, without bringing out the possibility of similar feelings present among the residents and nurses.

Such an unstable balance of forces could not persist and, after several weeks, the discrepancies between the procedures followed by the residents in granting privileges to patients and the general policy of the hospital on this matter were 'discovered'. This led to several conferences in which the real disagreements between the various staff role groups were openly discussed, and the operation of the hospital returned to a more stable equilibrium. This process of restitution comprises the fourth type in the sequence of balance of forces.

In subsequent conferences a great many further topics were discussed. These included: (1) the difficulties the resident staff had in presenting their cases to the senior staff; (2) the senior staff's supervision of the therapy done by the residents; (3) the whole area of the administrative management of patients and its effect upon therapeutic progress; (4) the financial situation of the patient and the meaning of this both therapeutically and administratively; and (5) the practical and emotional needs of ward personnel and residents which had to be satisfied in order for them to function effectively in the hospital.

During all four phases of the collective disturbance outlined in this chapter, affective communication between the various role groups was maintained, but the lines of cognitive communication were at first broken, then re-formed rather strangely in the period of paired role group response, and only finally re-established during the period of restitution. Thus the covert emotional structure of the hospital was operative throughout the three-months' cycle that included the acute period of the open collective disturbance, but the spread of emotions in the system was not supported by the effective operation of the overt social structure, which was fractured and twisted in many ways before it returned to normalcy.

The process referred to here as a collective disturbance is not necessarily bad, and, in fact, much good can come of it. A hospital (or any other organization for work) which did not have some rhythm in its activities would not be a good hospital, it would be a dead one. The opposite is also obviously true – the ups and downs in everyday life can reach too great proportions for adequate functioning. In between a state of extreme oscillation and one of dead calm there is much to be learned from such processes and many ways in which they can be put to use for truly therapeutic ends.

Rapaport (1956)...indicates that "these tension states need not be seen as antitherapeutic and therefore categorically to be avoided. On the contrary, they may have therapeutic value". He proposes the term 'sociotherapy' for the activities associated with the didactic, beneficial resolution of these tension states. Concerning this he says: "The resolution of a hidden staff conflict might alleviate a patient's disturbance and thus be beneficial but it would only become sociotherapeutic if it were done to the accompaniment of an analysis of the patterned personal significance of the development and alleviation of discordant relationships for those concerned.

The conclusion would appear to be that rather than attempting to do away with the processes that make up a collective disturbance (at bottom an impossible task because of the nature of both staff and patients as human beings), what is needed is the development of methods for studying the covert

emotional structure in its relation to the overt social structure with the goal of first coming to some understanding and then perhaps bringing about changes in both.

## References

1. Stanton, A.H. and M.S. Schwartz, *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment*. 1954, New York: Basic Books.
2. Caudill, W., *The Psychiatric Hospital as a Small Society*. 1958, Cambridge, MA: Harvard University Press.