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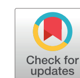
Original article

When patients and physicians get mixed up: An investigation and differential description of collusion by means of a case series of supervisions



Quand patients et cliniciens se confondent : une investigation et description différentielle de la collusion basée sur une série de cas de supervisions

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ABSTRACT

Introduction. – Collusion designates a specific type of transference-countertransference interaction between two or more persons, linked by an unconscious and shared unresolved issue, which they avoid on an intrapsychic level by externalizing it in the interpersonal space.
Objective. – To find a way to identify collusion and to delineate it from other transference-countertransference interactions. We conducted this study based on a case series approach.
Methods. – The study material consisted of audiotaped clinicians-centered supervisions with oncologists. The case series methodology involved the systematic examination of a purposive sample of supervisions, with the aim to understand how and why they differ from one another with respect to the relational dynamic between the physician and his/her patient.
Results. – Four cases/supervisions were selected as they allowed to situate collusion on the spectrum of transference-countertransference interactions. We report on it by describing a countertransference reaction, two transference-countertransference interactions, and a collusion.
Conclusions. – The study reveals the challenges and pitfalls of research on collusion. The results allow to confirm the criteria of our working definition of collusion and to delineate collusion from other transference-countertransference interactions, which represents a first step for the empirical investigation of collusion.
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RÉSUMÉ

Introduction. – La collusion désigne un type spécifique d'interaction transféro-contre-transférentielle entre deux ou plusieurs personnes, liées par un sujet inconscient partagé, qui est évité au niveau intrapsychique en l'externalisant dans l'espace interpersonnel.
Objectif. – Le but de notre étude était de trouver une méthode pour identifier la collusion de manière empirique et pour la distinguer d'autres interactions transféro-contre-transférentielles. L'étude prend la forme d'une « série de cas ».
Méthodes. – Le matériel de l'étude consistait dans des enregistrements audio de supervisions centrées sur le clinicien, conduites avec des oncologues. La méthodologie de la série de cas a impliqué d'analyser de manière systématique un échantillon choisi à dessein de supervisions, dans le but de comprendre comment et pourquoi celles-ci différaient les unes des autres au plan de la dynamique relationnelle entre le médecin et son patient.

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Résultats. – Quatre cas/supervisions permettent de situer la collusion sur un spectre d'interactions transféro-contre-transférentielles. Une réaction contre-transférentielle, deux interactions transféro-contre-transférentielles et une collusion sont ainsi rapportées dans cette série de cas.
Conclusions. – L'étude montre les défis et les écueils de la recherche sur la collusion. Les résultats confirment les critères de la définition de travail de la collusion et établissent une distinction entre la collusion et d'autres interactions transféro-contre-transférentielles; c'est un premier pas pour la recherche sur la collusion.
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1. Introduction

Collusion is a specific unconscious relational dynamic between two or more persons, which is part of the transference-countertransference phenomena [12,29]. The concept of collusion was introduced in the psychiatric and psychotherapeutic literature by Henry Dicks, a psychoanalyst from the Tavistok clinic in London. Dicks had an interest in couple therapy (Marital tension: Clinical studies towards a psychological theory of interaction [10]), and adopted a systemic perspective in his work (Licensed mass murders: A socio-psychological study of some SS killers [11]). Based on the investigation of a series of couples in treatment, Dicks wrote: "[I was able] [...] to see for the first time the interacting pair as the unit of perception and study [...]. To anyone making this discovery, psychopathology and stress reactions cease being attributes of a single 'figure against a background', but of reaction of figure with figure, even if both are but inner fantasies to each other. The 'background' are human beings with their needs and fantasies impinging on, and being impinged on [...] in a system of interacting personalities we have come to call collusion" (italics by the author [10], page 51). Later, Jürg Willi, a family therapist from Zürich, popularized the concept of collusion by spreading it to the public (Couples in collusion [36]). Moreover, scholars using psychodynamic system theory [21,22] introduced collusion in the analysis of institutions; in social psychology, group dynamics and organizational crime have been analyzed based on the concept of collusion [25,26]. Collusions have been described in different clinical settings, such as in psychoanalysis, psychotherapy and group therapy, psychiatry and medicine [2,6,9,17,32], but also in prisons, schools [33] and natural groups [13,23]. In the psychoanalytic setting, collusion may be understood as a way to enter in unconscious communication with the client and thus a mean to obtain relevant information [28]. However, in settings with less awareness of the unconscious, collusive relationships may lead to separation or symbiosis [5,18,34], intense negative emotions and enactments, and may thus hamper clinical judgment or decision-making [2,19,29].

1.1. Delineating collusion from other transference-countertransference reactions

Collusion does not equal transference-countertransference because non-collusive transference-countertransference reactions exist, which are not provoked by a shared unresolved issue [34,35]. For example, a patient's separation anxiety (unresolved issue), expressed by his tendency to cling to the therapist, may provoke countertransference anger, motivated by the therapist's feelings of being invaded (unresolved issue related to intimacy). In such a situation, one cannot speak of a collusion.

We regularly face doubts about the specificity of collisions as a psychoanalytic concept. Such a critique is based on one or more of the following arguments: (i) collusions are just usual transference-countertransference phenomena; (ii) unresolved issues in patients and analysts were recognized decades ago, and the concept of collusion does not bring anything new; and (iii) collusion is equivalent to projective identification or (iv) enactment. We disagree: (i) non-collusive transference-countertransference experiences have different functions and clinical qualities. The protagonists are not interlocked in an activated defensive loop, which makes it easier for them to free themselves from their experiences and start thinking again. In colluders, even if their situation feels very distressing, the relational bond is entertained by both protagonists, who "pour oil into the fire." The same holds true for (ii) an unresolved issue; it makes a difference if an unresolved issue is shared or not; the blind spots of the colluders concern the same issue, which diminishes the chances of seeing what ties them together. Some authors reduce collusion to a manifestation of (iii) projective identification, and it is true that the two are frequently associated. However, not all projective identification leads to collusion, and not all collusions are based on projective identification. Other defenses may also be at work. An example is denial, which can be shared by patients and therapists. Finally, (iv) enactment is a non-specific reaction, manifesting a wide range of phenomena and motivations to diminish intrapsychic pressure through action.

1.2. The clinics of collusion

The clinics of collusion can be described by the triggers, relational modalities, manifestations, primary and secondary gains, effects and facilitating and maintaining factors. Triggers related to unresolved issues. In a psychotherapeutic setting, triggers can emerge from the therapeutic frame (e.g., a break in sessions due to holidays can activate unresolved issues related to separation) or from contents addressed in therapy (e.g., the investigation of traumatic events can activate unresolved issues related to intimacy). In the medical setting, triggers can be health issues, diagnostic procedures, bodily symptoms, or delivery of bad news, which can provoke the eruption of unresolved issues, such as intimacy, loss, and self-worth. In couples, life events can be triggers: the occurrence of a disease in one of the partners may, for example, lead to unresolved issues concerning dependency.

A collusion related to attachment is derived from psychotherapy conducted by one of the authors. The patient peppered the therapist with questions. This provoked a growing irritation in the therapist who started to distance from the patient, with the result that the patient accused him of being "cold." During the session, the therapist recognized that the patient's multiple questions were an expression of her clinging tendencies (anxious-preoccupied attachment), and that his irritation was a defensive reaction due to his own attachment difficulties (dismissive avoidant). Indeed, the patient's development was marked by a conflictual relationship with her mother and a rather absent father, resulting in attachment difficulties and a functional bowel disorder. The therapist's development was marked by intense and chronic intergenerational conflict, leading to attachment difficulties and panic attacks in early adulthood, which resolved after psychoanalysis.

With regard to the relational modalities of collusions, Willi proposed a meta-psychology by classifying complementary collusions as narcissistic, oral, anal-sadistic, phallic, or narcissistic [34,35]. For example, in oral collusions, the unresolved issue concerns "nurturing." The so-called progressive caregiver represses oral needs and vicariously experiences them through the receiver, who occupies a regressive position. Another possible classification could be based on fundamental elements, which shape human relationships such as attachment styles, or on psychic instances (e.g., superego) involved in collusion or associated predominant emotions.

Collusions manifest themselves through thoughts, attitudes, behaviors, or intense emotions [20]. By definition, collusion can only be recognized in retrospect, for example, after enactments or when therapists feel estranged by their own reactions [7]. Supervision is therefore an ideal mean to identify collusions; while supervisees often recognize that "something happens", they often rationalize their own contributions to the collusive dynamics and lack awareness of the shared underlying unresolved issue.

The primary gain of the collusive interpersonal maneuver is the avoidance of an unresolved issue at the intrapsychic level. Possible secondary gains are gratifications associated with the attributed roles, vicarious participation, and control over the object. Vicarious gratification is especially at work in family and couple dynamics. However, there is a price to pay for these gains. Possible consequences of collusion exist: among them are distortion of reality, repression of parts of the self, and loss of self-object differentiation and distress.

Some authors argue that collusion may strengthen the therapeutic alliance at the beginning of the treatment, allowing patients and therapists to avoid that disillusion arises too rapid. However, even in psychoanalysis, collusion may remain unrecognized and have negative effects: they can limit reverie, lead to therapeutic ruptures or immobility [5], imprison the therapist and impede creativity, or break the barriers between the conscious and the unconscious [29–31].

Finally, factors unrelated to unresolved issues may facilitate or maintain the collusions. Institutional rules, for example, can facilitate and maintain collusion. Rules represent limits towards which one can relate with blind obedience or transgressive desires. Institutional atmospheres such as high competiveness can facilitate collusions related to rivalry. On an individual level, therapist's role responsiveness or behavioral responsiveness, a mainly unconscious tendency to comply with the expectations of the other may be a facilitating and maintaining factor. Role responsiveness is part of a therapeutic attitude but can, when being excessive, facilitate collusions.

1.3. Research on collusion

Research on collusion has been impeded due to the methodological challenges of identifying collusion [29–31]; this has also been the conclusion drawn by the only two empirical studies on collusion, both using questionnaires, we identified in the literature [8,15]. Given these methodological difficulties and our doubts that collusion is identifiable or "measurable" by means of questionnaires (which cannot take into account unconscious dimensions of human interaction), we decided to specifically search for and identify collusion by means of supervision. We chose within our supervisory activity as liaison psychiatrist the oncology setting, where we have previously described collusions [removed for masked review], and where the existential threat provokes an intense emotional climate and the emergence of unresolved issues related, for example to separation, limits or omnipotence and impotence.

We used a case series approach [1,24], which provides the necessary thickness of description to illustrate the methodological challenges to delineate collusion from other transference-countertransference reactions.

Our study is based on the following working definition [28]. First, collusion is triggered by shared unresolved issues, such as relations to limits, domination, intimacy, orality, control, loss, and so on [3,14,20,29]. Second, the unresolved issue at stake is externalized and circulates in the interpersonal space eliciting reciprocal defensive maneuvers, while being avoided at the intrapsychic level [7,10,29,34,35]. Third, collusion is symmetrical when the colluders' stance towards the issue is the same (e.g., colluders sharing a desire to transgress rules), and complementary when the issue is handled in an opposite way (e.g., one colluder rigidly institutes and defends rules and the other tends to transgress them [29]).

2. Methods

2.1. Material

Four supervisions were purposively selected from a collection of audio-recorded supervisions ($n = 30$) of medical oncologists ($n = 10$) by a liaison psychiatrist (the last author, [removed for masked review]). The supervisions were part of a one-day "Clinical Reflexivity Training", certified by the University of [removed for masked review], which aimed to enhance insights into relational and contextual dimensions of the medical encounter. After training, all participants benefited from three supervisions, we call physician-centered supervisions, which rapidly involve the supervisee's experiences in the supervisory process (see below). Having the Vienna-Berlin-Budapest controversy on analytic supervision [27] and the pitfalls of addressing clinicians' own issues during supervision in mind, we carefully took necessary precautions. There were no hierarchical or professional relationships between supervisor and supervisees, a preliminary information was provided of what supervisees have to expect indicating that they are free to share or not certain issues, and clinicians provided consent within the framework of a study. Moreover, the experiences of the supervision by the supervisees were evaluated in a separate study [removed for masked review]; the experience of the supervisees was positive, except for one participant, who felt that the supervisions were quite confronting. The detailed proceeding of the supervisions is described below.

Physicians participated on a voluntary basis, they were informed about the aims of the study and the way the supervision will be conducted, and they provided consent. All oncologists involved in the supervisions described in this manuscript received the corresponding text prior to its submission and provided again consent for publication.

2.2. Collusion-centered supervision

The supervisions were conducted by the last author (FS), who has a long-standing clinical experience in supervision of oncologists. The three supervisions were structured in the following way. In the first supervision, the supervisee was (i) invited to comprehensively present an encounter with a patient who strongly affected her/him in a very negative way (e.g., feelings of rejection, anxiety, anger) or lead to words (e.g., outbursts, impoliteness) or actions (e.g., avoidance of the patient, forgetting appointments). Then, the oncologist was asked (ii) to describe her/his own feelings and reactions. If a shared unresolved issue was suspected to be at the origin of the relational dynamic, the supervisor (iii) presented his hypothesis of the unresolved issue and (iv) of the relational dynamics at work to the supervisee. The supervisor then (v) investigated if the shared issue was particularly sensitive for the supervisee, playing also a role in his/her personal

life. If the answer was positive, the supervisor finally (vi) explored, whether the supervisee had some thoughts on the origins of the unresolved issue (biography, life events and experiences). If the supervisor did not consider that the presented situation was a collusion, he also continued to explore the relational dynamics at work and searched for eventual links between the oncologist's reactions and his personal life and biography.

In the second supervision, the same proceeding took place, with the exception that the oncologist was invited to present an encounter with a patient, who strongly affected her/him in a very positive way (e.g., feelings of intense closeness, pronounced mourning after the patient's death), or lead to words (e.g., self-disclosure, sharing of experiences not related to the medical situation) or unusual actions (e.g., special favors, difficulties to end treatment).

In the third supervision, the oncologist was invited to freely choose a situation of particular interest or concern.

2.3. Data analysis

Two of the authors, SD, a junior liaison psychiatry resident, and GL, a senior liaison psychologist with a psychodynamic background and research experience, iteratively listened to the audio-recorded supervisions, focusing on the identification of the core components of collusion. These components were, according to the working definition provided above: (i) an unresolved issue shared by patient and clinician and (ii) an interactional pattern (externalization) suggesting the presence of a defensive loop tying colluders together. Four selected supervisions were then listened individually by [removed for masked review], a senior social scientist researcher working since 15 years in the same psychiatric liaison service, who has extensive experience with qualitative studies in the medical and psychiatric field, and [removed for masked review] and [removed for masked review], senior liaison psychiatrists with psychodynamic backgrounds, [removed for masked review] who have already worked together on theoretical, conceptual and empirical issues concerning collusion. The supervisions were then discussed within the research team until a consensus was reached on whether collusion was at work.

2.4. Selection of the case series

The case series methodology adopted for this study involved the systematic examination of a purposive sample of supervision situations, with the aim to understand how and why they differ from one another with respect to the relational dynamic between the physician and his/her patient. Cases were selected based on the comprehensiveness of information provided by the oncologist, on their emblematic quality and their suitability to delineate collusion from other transfer-countertransference reactions.

3. Results

3.1. "Passing the buck"

A female resident oncologist presented her encounter with an elderly male patient suffering from a rare cancer. He was described as being without any psychological or social particularities. The initial relationship was characterized as professional and somehow neutral. The diagnostic workup proceeded without problem, until the oncologist announced that the cancer, because of its rareness, required a referral to a tertiary care center. The patient reacted by commenting, "Oh, you are passing the buck, aren't you?". The oncologist interpreted the patient's remark as "you are abandoning me", and without further questioning, felt criticized, attacked and hurt. When the patient came back for follow up, he seemed not angry at all and was rather satisfied with the referral and the quality of the care he had received. The oncologist, however, still hurt, struggled to overcome her feelings and continued to consider the relationship as disrupted.

In the absence of a specific relational dynamic, the supervisor asked the oncologist if she recognized herself as a sensitive person. The supervisee acknowledged a psychic fragility with an important impact on her life as a mother, wife and physician. Throughout her development, she reported having been affected by her emotionally labile and unpredictable father and her agitated brothers (her mother was silent, self-effacing and often withdrawn). She further related that she easily feels overwhelmed by emotions, especially when facing unexpected situations, and that she regularly needs to isolate herself and to wear earplugs in public transportation to reduce stimuli. At the time of the encounter with the patient, she already felt emotionally drained because her daughter encountered learning difficulties at school, which provoked a considerable amount of sorrow, and distressed by the fact that she had a disagreement with a general practitioner about the care of a patient. The supervisee concluded that her difficulty to cope with emotions and emotional regulation could at times impair her judgment and provoke erroneous interpretations, as was the case with the situation she had presented.

Commentary: while the motives of the patient's statement remain obscure (e.g., expression of a certain anxiety, humor, or slight provocation motivated by feeling abandoned), the fact that he returned to the oncologist without showing resentments indicates that he was not lastingly affected by the referral. One could argue that the clinician reaction to the patient's statement is a transference-countertransference phenomenon. However, the intensity of the physician's emotional reaction seems quite disproportionate, prematurely interpretative, not attuned to the patient, needlessly enduring and thus rather related to the oncologist's sensitivity. We thus concluded that the clinician's experience is a countertransference reaction.

3.2. "What about your holidays?"

A senior oncologist reported her encounter with a 50-year old woman with advanced cancer she finally referred to palliative care. The supervisee described the patient as a beautiful, delicate, smiling, and respectful woman, who impressed her by her dignity ("always without complaints"), despite severe treatment side effects, behaving like a "good little soldier", with whom she established a warm, rewarding and trustful relationship. The patient's family was described as a "perfect family", accompanying the patient, at ease with emotions, sharing love and respect, and communicating easily with each other and the staff. The oncologist stated that she felt privileged and compared the patient with personalities like Nelson Mandela. Contemplating this family led her to question how she and her family would react, how solid her couple was, or what her children would say if she became ill? She finally reported that, during their last encounter in the palliative care unit, after she had returned from vacations, the patient asked her "what about your holidays?". These words moved her very much and she cried when leaving the room. Thereafter, she avoided to visit her patient again, reassuring herself that she was "in good hands" with the palliative care team.

Asked if she had in her private life similar experiences and reactions, the physician answered that her experiences had been almost the opposite: her mother, a head teacher, never showed this kind of respect and caring for her. She described her as powerful, demanding, and acting as if she always knew best, leaving her with the impression that she was never up to the task. Even nowadays,

she still struggles with the way her mother behaves without being able to confront her.

Commentary: The described relationship seemed particularly intense, with an oncologist who is very sensitive to the patient's attentions and a patient who is inclined to reward the physician and care about her well-being, even during the last days of her life. A sharp contrast exists between the patient's and the oncologist's families. One might wonder if the oncologist's idealization of the patient and the family explains part of this contrast (the oncologist stated at the end of the supervision, that "she [the patient] was too perfect to die"). The attention paid to the oncologist by the patient can be considered as a pattern of their relationship. Indeed, the patient offered what the oncologist's mother could not provide, and consequently the oncologist attempted to avoid the painful impending separation from her patient by avoiding to visit her in the palliative care unit. One cannot speak of a somehow neutral relationship as in the previous case. A dynamic is at work, and the experiences of the oncologist cannot be explained without the patient. In other words, a transference-countertransference dynamic seems to operate. One might hypothesize an unresolved issue concerning recognition being at the root of the oncologist's reactions, but there is no indication that this issue also concerns the patient, who seems to have had an adequate relationship with her own family, probably somehow idealized in the clinician's narrative. As an alternative, one might consider that the patient's somehow exaggerated interest in the oncologist's holidays might be a reaction formation, given the fact that finally the oncologist was not able to cure her.

3.3. *"Take this candy"*

A senior oncologist presented her difficult interaction with the daughter of an elderly patient suffering from a slowly progressive cancer. The patient lived with her daughter, who systematically accompanied her to the consultations. They always arrived too late to the appointments with the daughter complaining about her mother's slowness. During the consultation, the patient remained silent while the daughter took the lead, answering in the place of the patient. The oncologist also noticed that the daughter complained about having to assist her mother in daily life, but refused practical support or a referral to a nursing home stating offensively "I can take care of my mother". The decline of her propositions to optimize the care of the patient regularly infuriated the oncologist, who suspected a financial interest of the daughter in keeping her mother at home. The oncologist insisted, during supervision, that "if this elderly lady would be her mother, she would have certainly done better". The relationship became even tenser when the daughter claimed that the medical appointments were useless, since there were no diagnostic or therapeutic task to perform. The physician again enraged without expressing it, attempted to justify the consultations stating that this was a way to monitor the patient's physical and psychosocial state. After this episode, on the way out of the office, the patient's daughter proposed a candy to the oncologist and, when the oncologist refused, insisted awkwardly; the doctor, still mad about the daughter's remark, refused categorically to accept the candy.

Invited to elaborate on the issue of caring/not caring and how this issue play a role in her life, the oncologist realized that taking care of people is a key ingredient of her life. Indeed, during her studies to become a teacher, her father was diagnosed with cancer and she took care of him, until his death. This event triggered her decision to change her career and to start studying medicine, despite the familial pressure to marry and have children. As her patient's daughter, she is single without kids.

Commentary: the relationship between the oncologist and the patient's daughter was colored by anger, and a conflict about how to care for the patient, with both protagonists behaving rather defensively. The daughter somehow communicated that she would be a better doctor for her mother (e.g., by questioning or refusing the oncologist's propositions), whereas the oncologist communicated that she would be a better daughter for her patient (e.g., by proposing to improve the patient care sending her to a nursing home). While the oncologist did not dare to express her anger, the patient's daughter expressed her irritation more freely, but finally tried to placate the oncologist with a candy (undoing) after having doubted her professional competence. The relationship seemed complementary putting into play the issue of nurturing, but we do not know if the protagonists really shared this unresolved issue. However, a rivalry over nurturing is plausible, with an oncologist driven by a furor sanandi [16] and an apostolic stance [4] based on her life experiences with her sick father, and the patient's daughter having some difficulties to adequately care for her mother. An oral collusion with a nurturing oncologist and a depriving daughter can thus be hypothesized. However, it remained unanswered if the patient's daughter struggled with an unresolved issue concerning orality. One could say that in this situation, collusion seems to be within reach, but one of the key elements, a shared unresolved issue, is lacking to solidify this hypothesis, mainly because we have to solely rely on the oncologist's narrative, which may be colored by countertransference. We thus concluded that the situation is due to a transference-countertransference dynamic.

3.4. *"I cannot follow you...!"*

In this supervision, a chief resident shared his encounter with a seventy-year old entrepreneur. He described the patient, as a tall, fit and energetic man with a deep voice and a natural authority, married and father of two daughters. The patient consulted for prostate cancer, diagnosed by his general practitioner. Based on the clinical and para-clinical exams, the oncologist concluded that the cancer was less advanced than initially feared, an information which was most welcomed by the patient, who grasped the oncologist's hands, expressing his deepest gratitude, while discrediting harshly his general practitioner for having been unable to correctly assess his medical situation. The subsequent consultations were marked by the very controlling and authoritarian attitude of the patient, who determined the days and hours of the appointments, and had the habit of rushing in and out of the consultation. Moreover, he refused investigations and specialist referrals, and announced that he would never accept a hospitalization, even if he suffered from symptoms or severe complications of his disease: his primary concern was to be able to keep working at any cost. The patient also adopted a dominant attitude towards the nurses, his wife, whom he interrupted systematically in the consultation, and his two adult daughters, whom he treated like inferior human beings. After a meeting, during which the patient was particularly condescending towards his family, the two daughters approached the oncologist and stated "We don't know how you can stand him". While the oncologist was honored by the trust demonstrated by his patient, he was also angered by his authoritarian attitude, feeling like being one of his employees. However, he always remained calm, adopted a submissive attitude and never dared to confront the patient. In addition, the oncologist felt pressured by the nurses, who complained about the patient's attitude, and deplored that the oncologist let the patient impose his agenda. While admiring the patient's vitality and power, the oncologist felt exasperated and one day stated to his patient, who was rushing out of his office, "I cannot follow you...!". The supervisee also reported that he behaved differently with this patient, compared to his usual professional stance: unlike with other patients, with whom he first explores the underlying reasons

for requesting information, the oncologist answered immediately the patient's questions about his prognosis. Moreover, he accepted to manage the challenging clinical situation without resorting to specialist's help, as wished by the patient, and he gave him his private telephone number. Consequently, the oncologist had to deal with the patient's repetitive calls during weekends and vacations. Feeling saturated, the oncologist finally expressed his anger in a medical report for the general practitioner, in which he underlined the controlling attitude of the patient, qualified as an obstacle to good medical practice. However, when the patient asked for a copy, the oncologist attenuated this paragraph before handing him the letter. After this indirect confrontation, the oncologist felt relieved, despite the fact that the patient continued to treat him with a bossy attitude.

The oncologist agreed with the supervisor that the patient has an unresolved issue concerning domination and submission. Asked if this was also a topic of concern for himself, he replied that he is known as being a "nice guy", but that he also feels very quickly constrained, and can react sometimes with a stubborn attitude of refusal to comply. This happened once in his professional career when a superior treated him with disrespect; after having endured for a long time this situation, the supervisee stopped working, consulted the human resources and engaged in an institutional procedure for mobbing against his boss. The case ended without winners and without consequences for his superior. Encouraged to link his characteristics to his biography, the supervisee reported that the patient's attitudes and relational mode reminded him of his stepfather, who was bossy and condescending, especially towards his mother and sister, and often made him feel helplessness and enraged, a link he did not realize prior to the supervision. Moreover, he reported that after his parents' divorce, he was forced to live alternatively with one of them, without ever been asked about his desires. He often felt angry, but on the same time impotent and silenced.

Commentary: here, an authoritarian patient meets a submissive oncologist. We do not know any biographical elements of the patient, which could explain his behavior. However, their relationship can be considered as a complementary collusion. They adopted a polarized stance with regard to their shared, unconscious issue related to domination and submission. Moreover, oncologist and patient were interlocked in a defensive loop, illustrated by repetitively putting into play the unresolved issue, captured by a script they could not modify; the patient behaved like a boss and the oncologist like his submissive employee (externalization). The modification of the physician's behavior and the nurses' observation as a third party are also confirmatory elements for the existence of a collusive bond.

4. Discussion

After briefly commenting the clinical and supervisory aspects of the results, we will focus our discussion on the methodological challenges of identifying collusion and terminate with some thoughts about future research.

The case series illustrates how the private invades the professional in the medical encounter. The social contract between physicians and patients, as well as the legal and deontological frameworks contribute to regulate their interactions, but they do not silence intrapsychic and interpersonal dynamics. Such dynamics, especially in settings where the unconscious is not a central preoccupation, may cause suffering, in physicians and patients, and lead to clinical misjudgments or enactments [7]. Regular supervision for clinicians who work with the medically ill is therefore important [29]. Identifying collusion in supervision, and explicitly sharing the observation with the supervisee, is particularly useful to demonstrate how unconscious forces may be at work in the patient encounter and to encourage clinicians to recognize own contributions to the interpersonal dynamic and to broaden the gaze beyond the patient. Moreover, in certain clinical settings specific issues may regularly be put into play. In the medical setting issues may relate to separation and loss, intimacy or impotence. In psychiatric settings with intense emotional charges, such as the clinics of trauma or suicide, issues related to integrity or aggression may be prevalent. As mentioned, in psychoanalytic settings, collusion may be a mean to enter into unconscious communication. However, even in these settings, collusions with negative effects on the therapeutic relationship and outcome have been described [5,7,20].

The collusion-centered approach chosen for these supervisions is a powerful mean to rapidly access the intrapsychic world of clinicians and to establish links with their development and biography. We are well aware of the risks of this approach and therefore took the before mentioned precautions. The positive experience of most of the supervisees, however, question the stance of some supervisors, who consider that countertransference reactions and their relationship to the biography has to be dealt with in the psychotherapist's own psychotherapy [37].

As the case series illustrates, it was at times difficult to reach a definitive conclusion as regards the occurrence of collusion. This difficulty is due to several reasons. First, in the setting of public oncology, patients and therapists do not choose each other. It may thus be hard to determine, whether the protagonists are locked in a defensive loop, or tied by their medical contract. Second, without direct information on the patients, we had to rely on the clinicians' descriptions, which may be colored by countertransference. Third, we observed an important variability concerning the thickness of the patient description by the supervisees. This is all the more problematic, since collusion may especially occur in clinicians who have difficulties to perceive the psychological aspects of their work. For all these reasons, an approach based on materiel gathered from supervisions is limited to identify collusion.

An alternative way to identify and empirically explore collusion would be to interview both clinician and patient, analyzing video-recordings of consultations or to conduct ethnographic studies or retrospective case studies, taking as starting points suspected collusive enactments. However, such studies are much more ambitious. The present study is a first step to grasp collusion empirically and will hopefully contribute to further investigate collusion.

Research on psychoanalytic concepts are a difficult endeavor. Psychoanalysis is a clinic, which addresses the singularity of the patient, and each encounter between patients and therapists is a new encounter and unique. There has been some resistance by psychoanalysts to conduct empirical research, and we do understand their motives. One of the negative effects of this resistance was the raise of other therapeutic approaches, which claimed evidence-based superiority over psychoanalysis with regard to outcome of treatment. This claim has meanwhile been deconstructed. We consider that psychoanalytic concepts have great value, not only in the psychoanalytic setting, but also in other settings such as the medical field. Psychoanalytic research, which addresses other topics than outcome are therefore meaningful to conduct. Given the central issue of the unconscious in psychoanalytic theory, qualitative research can contribute to the empirical investigation of psychoanalytic phenomena. Such research has not to be driven by a preconceived method, but has to be oriented by the questions, which await to be answered, and by the data at hand. Such research needs competences in psychoanalytic theory and in qualitative research, which belongs to the realm of the social sciences. Interdisciplinary collaboration may thus be the key to conduct such research, which is demanding and requires a rigorous approach.

5. Conclusions

This study confirms that our working definition of collusion can be utilized for empirical research, which paves the way for future investigations. Collusion can be considered as boundary object, which brings together psychotherapeutic orientations, patients and clinicians, and the private and the professional. As an assimilated concept, used in different psychotherapeutic orientations and settings, collusion deserves a specific attention in clinics and supervision.

Ethics statements

The Human Research Ethics Committee of Canton de Vaud certified that the study was exempt from human subjects ethic review (since no patient identifier or health information was recorded).

Informed written consent

Participants informed written consent to take part in the research have been obtained prior to the commencement of the study. Participants data have been anonymized; we confirm that these alterations have not distorted the scholarly meaning. Prior publication, we obtained written informed consent to publish the vignettes from the described participants.

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Disclosure of interest

The authors declare that they have no competing interest.

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