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Collusion in palliative care: an exploratory study with the Collusion Classification Grid

Short title: Collusion in palliative care

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Abstract

Objectives: collusion is a largely unconscious, dynamic bond, which may occur between patients and clinicians, between patients and family members or between different health professionals. It is widely prevalent in the palliative care setting and provokes intense emotions, unreflective behaviour and negative impact on care. However, research on collusion is limited due to a lack of conceptual clarity and robust instruments to investigate this complex phenomenon. We have therefore developed the so-called Collusion Classification Grid (CCG), which we aimed to evaluate with regard to its potential utility to analyse instances of collusion, be it for the purpose of supervision in the clinical setting or research.

Methods: situations of difficult interactions with patients with advanced disease (N = 10), presented by clinicians in supervision with a liaison psychiatrist were retrospectively analysed by means of the CCG.

Results: (i) all items constituting the grid were mobilized at least once; (ii) one new item had to be added; (iii) the CCG identified different types of collusion.

Significance of results: this case series of collusions assessed with the CCG is a first step prior to the investigation of larger samples with the CCG. Such studies could search and identify setting-dependent and recurrent types of collusions, and patterns emerging between the items of the CCG. A better grasp of collusion could ultimately lead to a better understanding of the impact of collusion on the patient encounter and clinical decision-making.

Keywords: collusion, collusion classification grid, countertransference, palliative care

1. Introduction

In psychology, collusion is defined as an unconscious bond: the associated persons are tied together by a strong relational dynamic, which is triggered by a situation mirroring a common unresolved psychological issue. The situation is handled by the participants in either the same way (positive collusion) or in an opposite way (negative collusion) (Fox & Carey, 1999; Petriglieri & Wood, 2003; Nivoli et al., 2014, Stiefel et al., 2017a). The denominations “positive” and “negative” characterizing the type of collusion (see below) are by no means judgments or moral considerations. The shared and unresolved issue produces an emotional echo in the colluders and can provoke suffering, unreflective behaviours and an adverse effect on their relationship and medical care.

To illustrate the phenomenon of collusion, an example from the palliative care setting may serve. A patient with advanced cancer, who has great difficulties coping with separation since the time he experienced painful losses of loved ones during his childhood, now faces death, and thus separation again. The unresolved issue, separation, provokes intense anxiety, which pressures him to request assisted suicide as a way to hasten the process of separation he fears most (to “get it over with”). However, he does not conceive his request as such and denies the associated anxiety by arguing that he is “just tired of life”. If this patient encounters a clinician who is also haunted by separation anxiety, the clinician may either harshly reject the patient’s request (“it’s against the law and it’s unmoral…”), thus distancing himself from the threatening issue (he also wants to “get it over with”), or blindly endorse the request and even take action to fulfil the patient’s wish. Not conscious of the underlying dynamic, the physician defends his stance by arguing that “assisted suicide is not part of medical treatment” or that he “just tries to help the patient”. In the first case, the

collusion is a “negative collusion”, since the patient and the clinician have adopted opposite ways to conceive the request, and in the second case, it is a “positive collusion”, since they agree on how to handle the situation. In neither of the two situations, a clinically meaningful and empathic exploration of the patient’s underlying motivations takes place, and collusion hampers adequate care.

Collusion is related to transference-countertransference phenomena as they are described in the psychoanalytic literature. However, transference-countertransference operate on an extended field, their notions are somehow fuzzy and definitions with regard to countertransference have evolved over time and are multiple (Jacobs, 1999). Collusion can be understood as one specific modality of the broader category of transference-countertransference, but collusion (i) has a clear definition (Willi, 1984; Frankel, 1993; Nos, 2014; Stiefel et al., 2017a), (ii) is characterized by a reciprocal reaction, which fuels the relational dynamic, and (iii) leads to a binary outcome, with (iv) the colluding clinician not only reacting to a patient’s relational attitude, but also to his own unresolved issue.

Collusion is also distinguished from empathy. While a certain resonance of the patient’s lived experience within the clinician may help to stimulate his empathy, in collusion, the clinician undergoes psychological pressure, and resonance is not provoked by the patient, but by the unresolved psychological issue, which haunts the clinician, hampers his judgement and impedes on his capacity to care. The struggle of the patient and clinician with the shared unresolved issue thus becomes the overriding principle of the encounter and determines its dynamics.

Collusion occurs everywhere and can be at the origin of intense relationships of attraction or hate (Willi, 1984). Collusion has first been described in the psychiatric

setting (Willi, 1984; Frankel, 1993; Fox & Carey, 1999; Petriglieri & Wood, 2003; Nivoli et al., 2014; Nos, 2014), where intense interpersonal relationships and unresolved psychological problems are prevalent. In the somatic setting it has been described in oncology (Faulkner, 1998; Helft, 2005; Gosney, 2007) and palliative care (The et al., 2000; Schwarz, 2004; Chaturvedi et al., 2009; Low et al., 2009; Davis et al., 2013), where sensitive psychological issues, such as “separation”, “control”, “intimacy”, or “dependency”, are frequently put into play by the disease or its treatment. While the clinician may be aware of the associated emotions of collusion - such as anger or overwhelming sympathy -, he ignores the underlying issue at stake, which he shares with his patient. A colluding clinician may thus explain his attitudes and rationalize his stance, but he is unable to identify the underlying dynamics, which ties him so strongly to his patient. However, retrospectively, and especially by means of supervision, collusion can be identified.

We have previously demonstrated, that the concept of collusion has been blurred in the palliative care literature (Stiefel et al., 2017a): (i) most often a definition of collusion is not provided; (ii) collusion is erroneously conceived as a conscious phenomenon or (iii) reduced to situations of information exchange; (iv) the impact of collusion on the patient-clinician interaction and on clinical decision making is neglected; (v) no strategies for its detection and working through are proposed; and (vi) the role of the clinician in collusion is not addressed (Stiefel et al., 2017a; Stiefel et al., 2017b). In other words: in the current palliative care literature on collusion are listed phenomena, which do not correspond to collusion. On the same time, but we have not searched for in the literature, it might be, that some authors discuss collusion, without naming it as such.

In order to obtain conceptual clarity and to initiate empirical research, we have developed the Collusion Classification Grid (CCG), based on a sound theoretical framework and our experience from clinical supervision (Stiefel et al., 2018).

The CCG aims to identify different components of collusion (see Table 1 and the Glossary; for further details we refer to the publication of the CCG). As mentioned, *thematic triggers* are situations symbolizing sensitive, unresolved psychological issues - such as “loss”, “control”, “dependency”, “intimacy”, etc,, - which trigger collusion. The trigger may be situated in the practical context, for example, a patient with difficulties to face authoritarian figures refuses medication colludes with an authoritarian physician who reacts with anger. At other times, the trigger may be situated on a mental level, for example as an excessive need of a patient and a clinician to control emotions. Among the unresolved psychological problems, life events, which have not been metabolized can also lead to collusions. The *expressions* of collusion may be *silent*, for example shame-induced avoidant behaviour, or *expressive*, for example anger-induced verbal and behavioural outbursts. *Outcome* (or consequences) of collusion affects the involved participants, who may be individuals or collectives. Collusions implying *collectives* might be due to situations, which (i) provoke collusion in certain members of a team who share a same unresolved problem, or (ii) with the whole team, which has for example been recently traumatized by a recent medical event, or (iii) with a team characterized by a dominant spirit, which leads to collusion. Finally, *context-dependent collusions* occur between individuals and the institution or society. For example, the hierarchical organization of medicine might provoke in a patient oppositional behaviour, which in turn is responded by the colluding medical apparatus by a harsh recall of rules and law that govern the institution, leading to an

escalation of the situation. Or the oppressive institutional culture provokes a collusion with a clinician who blindly executes orders without an attempt to understand or negotiate them. Society's dominant discourses, for example on how to face illness and death, conveyed through expressed opinions and attitudes, the media or other channels, can also provoke collusions or at least potentiate collusions by "putting oil into the fire". Examples are the widespread conception of "cancer treatment as a battle", the expectations towards patients "to fight against the disease", or injunctions for the dying (Armstrong, 1987; Yamazaki, 1996; Zimmermann, 2004; Bell, 2014).

The aim of this study was to evaluate the potential utility of the CCG for supervision and research.

2. Methods

The case material consists of ten cases of collusion, two of them are detailed in a previous article on collusion (Stiefel et al., 2017a), and one in a book chapter on communication in cancer care (Stiefel & Krenz, 2013). All cases were presented in clinical supervision to the first author, a liaison psychiatrist, who works since many years as supervisor of oncology and palliative care clinicians.

The ethics committee of the University Hospital Lausanne, invoked by the Swiss authors, cleared the study given that the material (supervised clinicians) was obtained from healthy and volunteering clinicians and anonymized. The material from clinical supervisions in Japan concerns three situations, two of them have already been published (Stiefel et al., 2017a), and all of them involved the second author.

The first author, who co-developed the CCG, conducted the analysis of the situations and filled in the grid.

Since the CCG is not a psychometric instrument, but closer to clinimetrics, filling in of the grid depends on how comprehensively the supervisor investigates the presented situation, on his understanding (and naming) of the trigger, his ability to identify the associated emotions and the way collusions are expressed, and his sensitivity to take into account contributing contextual factors. In the situations described, collusion was directly addressed and discussed during supervision; in all cases, the supervisee(s) agreed to the interpretation of the supervisor that collusion was at work in the presented situation. The fact that all supervisees were highly motivated may explain this result; in some situation, one might expect that clinicians' defences might make it delicate to comment the collisional aspects of the presented situation.

3. Results

The summary of the supervised situations and the related CCG is detailed in Table 3.

Table 3: Study material and related results obtained with the CCG

1. Controlling patient (with regard to emotional expression), who suffers from advanced lung cancer, treated by a controlling physician who is himself threatened by a potentially serious disease. Both adopt an anxiety-induced avoidant behavior, unable to address the emotional stress, which leads to an aggravation of the psychological state of the patient. The situation takes place in a society, which expects its members to control their emotions. Supervision allowed the clinician to identify collusion, to acknowledge the role of the associated life event and to recognize his avoidant stance as a general pattern of his relationship with patients (Stiefel et al., 2017a).	Trigger:	(need for) control (of emotions), life event (own disease)
	Expression:	silent, behavioural (avoidance)
	Emotion:	anxiety
	Result:	positive collusion
	Participants:	patient, clinician
	Context:	society

2. Patient with a strong desire to live and difficulties to face death, admitted to a palliative care unit for advanced prostate cancer, treated by a physician who expects patients to face death with serenity and to submit to the inevitable. The anger of the physician when confronted with the patient's struggle for life, potentiated by an institutional context and a society, which also expect that patients accept death, leads to an unexpressed conflictual situation between the two. Supervision enabled the clinician to recognize the collusion and to understand the patient's need for hope, and lowered the relational tensions (Stiefel et al., 2017a).	Trigger: (facing) loss Expression: silent, behavioural Emotion: anger Result: negative collusion Participants: patient, clinician Context: institution, society

3. Patient with advanced lung cancer first accepting and then refusing treatment encounters a physician, who has lost as a child his mother, and who repeatedly pushes during the consultation for potentially life-prolonging treatment. The patient is a father of two small children. Society's discourses on the value of a fighting spirit when affected by cancer might have contributed to the collusion between the two. During supervision of this filmed encounter, the clinician recognized his anxiety and projective stance and related it to his biography.	Trigger: (facing) loss, life event (loss of a parent) Expression: expressive, verbal Emotion: anxiety Result: positive collusion Participants: patient, clinician Context: society

4. Elderly woman with advanced breast cancer, clearly indicating the wish to stop treatment, is persuaded by a resident to accept palliative chemotherapy. Supervision of the video-taped consultation allowed the physician to express his anxiety related to an institutional context, which he considers advocating active treatment in such situations, and to reflect on his conformist stance. Hierarchical organization of the hospital and society's discourses on the need to adopt a fighting spirit towards cancer might have contributed to the collusion.	Trigger: (dealing with) hierarchy (and obedience) Expression: expressive, verbal Emotion: anxiety Result: positive collusion (patient and clinician obey to real and imagined injunctions despite otherwise convictions) Participants: clinician, institution Context: institution, society

5. Patient, hospitalized in a palliative care unit, who has extremely high expectations towards medicine and health care professionals, encounters a young nurse who reacts with increasing frustrations to the unlimited demands of the patient. The collusions culminates with her verbal insults towards the patient and subsequent avoidant behavior and feelings of guilt and anxiety. In supervision the nurse recognized that she has very high expectations towards herself, an idealized representation of care and that an atmosphere of striving for "permanent excellence" is promoted within the team.	Trigger: (stance towards) exigency Expression: expressive, verbal, behavioral, silent (mixed) Emotion: frustration, guilt, anger, anxiety Result: positive collusion Participants: patient, clinician, team Context: institution

6. A nurse on night shift harshly confronts an elderly woman with advanced cancer, who requests pain relief, but refuses medication. Supervision enabled the nurse to recognize the "contradictory stance" of the patient as an ambivalence towards medical advice, which might provide the patient a feeling of autonomy. The nurse reported that behind her anger, she felt profound anxiety, which she related to her prior treatment for melanoma and states "I wouldn't have survived if I'd refused treatment" (Stiefel & Krenz, 2013).	Trigger: (dealing with) ordinance (adherence), life event (own illness) Expression: expressive, verbal Emotion: anger, guilt, anxiety Result: negative collusion Participants: clinician, patient Context: no influence of context

7. Patient with advanced cancer, reacting towards the existential threat with hypomanic defences, encounters a team who is not familiar with the support of patients (radiotherapy) and who reinforces his "over-optimistic" attitude. Team supervision allowed clinicians to recognize their attitude as mirroring the patient's attitude, and as a protection from feelings of sadness. Society's difficulty of dealing with loss is also discussed during supervision.	Trigger: (facing) loss (and separation) Expression: expressive, verbal Emotion: sadness Result: positive collusion Participants: patient, team Context: institution, society

8. A phobic husband of a dying patient avoids contacts with staff; a nurse reacts with inadequate behaviour, insisting to speak with the man in order to "support him". During individual supervision the nurse recognized that she is angered by this man, who does "not appreciate her offer to help". She also recognized that she seeks intimacy in professional relationships, and that in this case, the best way to support the husband is to respect his need for relational space.	Trigger: (handling) intimacy Expression: expressive, behavioural Emotion: anger Result: negative collusion Participants: family member, clinician Context: no influence of context

9. Family and a patient with advanced pancreatic cancer, showing great difficulties to cope with rapid progression of disease. The endless discussion with the physician about the lack of different other treatment options obscures the main issue, identified during supervision of the videotaped consultation: facing loss and separation of a loved one and dealing with sadness and anxiety. The physician reported great difficulties to face death of patients, which provokes in him feelings of diffuse anxiety and uneasiness. Society's difficulties dealing with finitude might have contributed to this collusion.	Trigger: (facing) loss (and separation) Expression: expressive, verbal Emotion: anxiety, sadness Result: positive collusion Participants: patient, family, clinician Context: society

10. Middle-aged patient with advanced cancer, showing signs of separation anxiety (still lives with his mother), encounters a physician who avoids to assess the patient's emotional state. During supervision the physician reports to have experienced similar difficulties in his life. Society's prudence to express and investigate emotional states may have contributed to this collusion.	Trigger: (facing) separation (and loss), life events (separation anxiety) Expression: expressive, verbal Emotion: anxiety Result: positive collusion Participants: patient, clinician Context: society

The description of the ten situations of collusion with the CCG showed that (i) all items listed in the grid were mobilized at least once; (ii) variation existed between collusions on an item level (e.g.: type of associated emotions, ways of expression and triggers); (iii) there seems to be no need to add new items to the original CCG (Stiefel et al., 2018), except for the reported personal life events; and (iv) some specific items, for example “anxiety” among the emotions and “loss” among the triggers, were more frequent than others (Table 4). The results illustrate that the CCG identifies different facets and types of collusions, and that it might differentiate subtypes, which follow distinct patterns on an item level.

4. Discussion

The above-mentioned results indicate that the CCG might be of help for the further investigation of collusion. One could, for example, hypothesize that the prevalence of sub-types of collusions may vary according to the medical setting: collusions around “loss and separation” might be more prevalent in oncology and palliative care, while in diabetes care, triggers such as “autonomy and control” might be more frequent. It might be that distinct patterns, clustering specific items, emerge in larger samples: for example, the trigger “loss and separation” might be more often associated with anxiety and positive collusion, leading to the avoidance to address in oncology the transition to palliative care; or one might find that specific contextual elements, such as the metaphor of “the war on cancer” and the injunctions of having a “fighting spirit”, or institutional characteristics (e.g. tertiary care centres, which promote a more aggressive therapeutic stance) might contribute to collusions.

We have considerably enlarged the concept of collusion, which in the psychiatric and medical literature is restricted to a dynamic between patients and clinicians. We include contextual factors, such as dominant social discourses - for example with regard of how to face death (Zimmermann, 2004), how to survive cancer (Bell, 2014) or what can be expected from the medical sciences and physicians (Schaad et al., 2015) - and injunctions from the medial apparatus and the institution (Crowe et al., 2017), such as the hidden curriculum in medical school conveying specific representations about medicine (Lempp & Seale, 2004). The fact that we could identify context-dependent collusions confirms us in our view, that collusion should not be restricted to the patient-clinician relationship. Indeed, medicine is not a two-persons affair behind closed doors. This has already been underlined by Michael Balint, who is the only author we identified as working with an enlarged concept of collusion. He included the institution, when he commented on the dilution of responsibility in cases of patients, who mobilize their general practitioner and simultaneously different specialists, and called these situations “collusion of anonymity” (Balint, 1955). While the social science literature abundantly addresses the different ways diseases are framed by processes of anchoring (to make something unfamiliar understandable by linking it to something familiar, using analogies) and objectification (abstract objects are transformed into concrete and common-sense realities, notably by means of metaphors), in clinical supervisions such elements are less often addressed, despite their well-known capacity to produce resonance and effects as do discourses articulated by individuals (Montgomery, 1991).

If the CCG is meant to be used for research, a necessary next step will be to test its reliability and validity. Reliability testing could be conducted by means of video- or

audio-taped supervisions, focusing on collusions, which are then separately assessed with the CCG by two or more researchers. Since collusion does not operate in all cases presented in supervision, instruction will have to be provided to present a case in which the clinician has been strongly involved with a patient and has felt very intense, negative or positive emotions. Validity testing is a more difficult task, since no instrument for comparison exists. Therefore, validity might be tested, for example, by questioning the supervisee if he has gained insight when confronted with the different facets of collusion mapped by means of the CCG. Or validity could be evaluated, for example, by testing hypotheses, such as the above mentioned relationship between over-treatment and CCG documented collusion between patients and clinicians.

5. Study limitations

Given the fact that this is a retrospective study, recall bias may be an issue. However, three of the ten situations were comprehensively documented, and published, and the others were analysed based on the supervisor's notes. The limited number of cases also limits the informative value. As mentioned, the first author has co-developed the CCG, and he therefore was certainly familiar with it, which might not be the case for other supervisors. Reliability testing will answer the question, whether additional explanations or a coding system have to be associated to the CCG.

6. Conclusions

Given the fact that collusion is a relevant phenomenon in daily clinics, we consider that it merits more attention. The results of this exploratory study encourage the further evaluation of the CCG, especially with regard to reliability and validity.

7. Conflicts of interest

The authors hereby declare that they have no conflicts of interest to disclose.

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Table 1: The Collusion Classification Grid (CCG)

• Thematic trigger	- Type (e.g., loss, intimacy, control…) - Presence of a life event* (e.g., clinician's own illness, death of a parent in childhood …)
• Expressions of collusion	- Silent (e.g., to disregard a topic, to hold back …) - Expressive (e.g., crying in front of the patient, overt infighting with colleagues …) - Verbal (e.g., lengthy explanations, deviating from a question…) - Behavioral (e.g., to avoid a patient, to take action ...) - Mixed (e.g., expressive-verbal-silent-behavioral: an outburst of anger, followed by guilty avoidance of the patient…)
• Types of associated emotions	- Primary emotions (anger, shame, anxiety, sadness, joy, surprise, disgust ….) - Secondary emotions (relief, frustration, resentment, hope …)
• Result	- Positive collusion - Negative collusion
• Participants	- Patient – Clinician - Family member – Patient - Family member – Clinician - Clinician – Clinician
• Collective collusions	- Between an individual and groups (e.g., a patient and family, team member and team…) - Between groups (e.g., between nurses and physicians, patients' advocacy groups and physicians….)
• Context dependent collusions	- Institution (e.g., collusions between patient and characteristics of the setting, physician and the hierarchical organization of medicine…) - Society (e.g., patient or physician's attitudes and society's discourses…) - Institution – Society (e.g., proclaimed hospital values and society's expectations …)

*added to the original grid

Table 2: **Glossary**

Thematic trigger: a specific unresolved psychological issue provoking collusion and strong emotions and/or unreflective behaviour. The triggers may be activated by situations in the clinic, for example, such as the refusal of treatment, which symbolizes the patient's ambivalence towards authority or on a psychological level, for example by certain emotions. Life event is specified if the clinicians identifies a life event as being a contributor to the collusion (e.g., own losses).

Silent collusion: denotes that the colluding clinician adopts a passive role or that the collusion is not audible or visible.

Expressive collusion: denotes that the colluding clinician shows an identifiable verbal or non-verbal behavior or emotions.

Verbal expression: collusion manifests itself by the content or form of speech.

Behavioral expression: collusion manifests itself by actions.

Mixed expression: different forms of expression of collusion co-exist or unfold subsequently.

Positive collusion: collusion leads to the same stance of the participants.

Negative collusion: collusion leads to an opposite stance of participants.

Collective collusion: participants of collusion are not individuals, but whole groups.

Context dependent collusion: the institutional or social context contributes to collusion.

Table 4: Synopsis of the ten situations assessed with the CCG (N = number of occurrences)

• Triggers	Loss and separation (5), hierarchy (1), ordinance (1), control (1), intimacy (1) and exigency (1) Personal life events (4); own diseases, losses, separation
• Expressions of collusion	Expressive (8), silent (2) Verbal (7), behavioral (4), mixed (1)
• Types of emotions	Anxiety (7), anger (3), sadness (2), guilt (2), frustration (1)
• Result	Negative collusion (3), positive collusion (7)
• Participants	Patient (9), clinician (9), team (2), family members (2)
• Collective collusions	Patient and health care team (2), patient-family-clinician (1)
• Context dependent collusions	Society (7), institution (5)