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

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Abstract

Objective. 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 behavior, 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 Collusion Classification Grid (CCG), which we aimed to evaluate with regard to its potential utility to analyze instances of collusion, be it for the purpose of supervision in the clinical setting or research.

Method. Situations of difficult interactions with patients with advanced disease ($N = 10$), presented by clinicians in supervision with a liaison psychiatrist were retrospectively analyzed by means of the CCG.

Result. 1) All items constituting the grid were mobilized at least once; 2) one new item had to be added; and 3) the CCG identified different types of collusion.

Significance of results. This case series of collusions assessed with the CCG is a first step before 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.

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; Nivoli et al., 2014; Petriglieri & Wood, 2003; Stiefel et al., 2017a). The denominations "positive" and "negative" characterizing the type of collusion 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 behaviors, 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 fulfill the patient's wish. Not conscious of the underlying dynamic, the physician defends his or her 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," because the patient and the clinician have adopted opposite ways to conceive the request; in the second case, it is a "positive collusion," because 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

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one specific modality of the broader category of transference-countertransference, but collusion 1) has a clear definition (Frankel, 1993; Nos, 2014; Stiefel et al., 2017a; Willi, 1984); 2) is characterized by a reciprocal reaction, which fuels the relational dynamic; and 3) leads to a binary outcome; with 4) the colluding clinician not only reacting to a patient's relational attitude, but also to his or her own unresolved issue.

Collusion is also distinguished from empathy. Although a certain resonance of the patient's lived experience within the clinician may help to stimulate 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 or her judgment and impedes the 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 (Fox & Carey, 1999; Frankel, 1993; Nivoli et al., 2014; Nos, 2014; Petriglieri & Wood, 2003; Willi, 1984), where intense interpersonal relationships and unresolved psychological problems are prevalent. In the somatic setting, it has been described in oncology (Faulkner, 1998; Gosney, 2007; Helft, 2005) and palliative care (Chaturvedi et al., 2009; Davis et al., 2013; Low et al., 2009; Schwarz, 2004; The et al., 2000), where sensitive psychological issues, such as "separation," "control," "intimacy," or "dependency," are frequently put into play by the disease or its treatment. Although the clinician may be aware of the associated emotions of collusion, such as anger or overwhelming sympathy, he or she ignores the underlying issue at stake, which he or she shares with the 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): 1) most often a definition of collusion is not provided; 2) collusion is erroneously conceived as a conscious phenomenon or 3) reduced to situations of information exchange; 4) the impact of collusion on the patient-clinician interaction and on clinical decision making is neglected; 5) no strategies for its detection and working through are proposed; and 6) the role of the clinician in collusion is not addressed (Stiefel et al., 2017a, 2017b). In other words, in the current palliative care literature on collusion are listed phenomena that do not correspond to collusion. At the same time, although we have not searched the literature, it might be that some authors discuss collusion without naming it as such.

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 (Tables 1 and 2; for further details, refer to the CCG publication). As mentioned, thematic triggers are situations symbolizing sensitive, unresolved psychological issues such as "loss," "control," "dependency," "intimacy," which trigger collusion. The trigger may be situated in the practical context; for example, a patient with difficulties to face authoritarian figures refuses medication and 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 that have not been metabolized can also lead to collusions.

The expressions of collusion may be silent, for example shame-induced avoidant behavior, or expressive, for example anger-induced verbal and behavioral 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 1) provoke collusion in certain members of a team who share a same unresolved problem; 2) with the whole team, which has, for example, been recently traumatized by a recent medical event; or 3) 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 behavior, 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, such as 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 toward patients "to fight against the disease," or injunctions for the dying (Armstrong, 1987; Bell, 2014; Yamazaki, 1996; Zimmermann, 2004).

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

Methods

The case material consists of 10 cases of collusion, two of which are detailed in a previous article on collusion (Stiefel et al., 2017a) and another 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 has worked for many years as a 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 which have already been published (Stiefel et al., 2017a), and all of which involved the second author.

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

Because the CCG is not a psychometric instrument, but closer to clinimetrics, filling in the grid depends on how comprehensively the supervisor investigates the presented situation, on his or her understanding (and naming) of the trigger, ability to identify the associated emotions and the way collusions are expressed, and his or her ability 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. That all supervisees were highly motivated and introspective clinicians may explain this result; in some situations, one might expect that

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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 (e.g., anger, shame, anxiety, sadness, joy, surprise, disgust) – Secondary emotions (e.g., 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 behavior. The triggers may be activated by situations in the clinic, for example, such as the refusal of treatment, which symbolizes the patient's ambivalence toward authority or on a psychological level, for example by certain emotions.
Life events: 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 nonverbal 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 coexist 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: Institutional or social context contributes to collusion.

clinicians' defenses might make it delicate to comment the collisional aspects of the presented situation.

Results

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

The description of the 10 situations of collusion with the CCG showed that 1) all items listed in the grid were mobilized at least once; 2) variation existed between collusions on an item level (e.g., type of associated emotions, means of expression, triggers); 3) 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 4) 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 that follow distinct patterns on an item level.

Discussion

These results indicate that the CCG might be of help for the further investigation of collusion. One could, for example, hypothesize that the prevalence of subtypes of collusions may vary according to the medical setting: collusions around "loss and separation" might be more prevalent in oncology and palliative care, whereas in diabetes care, triggers such as "autonomy and control" might be more frequent. It might be that distinct patterns that cluster specific items emerge in larger samples; for example, "loss and separation" might be more often associated with anxiety and positive collusion, leading to avoiding addressing 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 centers, 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 to 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), including 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).

That we could identify context-dependent collusions confirms our view that collusion should not be restricted to the patient-clinician relationship. Indeed, medicine is not a two-person affair

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Table 3. Study material and related results obtained with the Collusion Classification Grid

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: Expression: Emotion: Result: Participants: Context:	(need for) control (of emotions), life event (own disease) silent, behavioral (avoidance) anxiety positive collusion patient, clinician 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: Expression: Emotion: Result: Participants: Context:	(facing) loss silent, behavioral anger negative collusion patient, clinician 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: Expression: Emotion: Result: Participants: Context:	(facing) loss, life event (loss of a parent) expressive, verbal anxiety positive collusion patient, clinician 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 videotaped 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 toward cancer might have contributed to the collusion.	Trigger: Expression: Emotion: Result: Participants: Context:	(dealing with) hierarchy (and obedience) expressive, verbal anxiety positive collusion patient and clinician obey to real and imagined injunctions despite otherwise convictions clinician, institution 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: Expression: Emotion: Result: Participants: Context:	(stance towards) exigency expressive, verbal, behavioral, silent (mixed) frustration, guilt, anger, anxiety positive collusion patient, clinician, team 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: Expression: Emotion: Result: Participants: Context:	(dealing with) ordinance (adherence), life event (own illness) expressive, verbal anger, guilt, anxiety negative collusion clinician, patient 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: Expression: Emotion: Result: Participants: Context:	(facing) loss (and separation) expressive, verbal sadness positive collusion patient, team 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: Expression: Emotion: Result: Participants: Context:	(handling) intimacy expressive, behavioural anger negative collusion family member, clinician 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: Expression: Emotion: Result: Participants: Context:	(facing) loss (and separation) expressive, verbal anxiety, sadness positive collusion patient, family, clinician 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: Expression: Emotion: Result: Participants: Context:	(facing) separation (and loss), life events (separation anxiety) expressive, verbal anxiety positive collusion patient, clinician society

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Table 4. Synopsis of the 10 situations assessed with the CCG (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)

behind closed doors. This has already been underlined by Michael Balint (1955), 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." Although 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 commonsense realities, notably by means of metaphors), in clinical supervision, 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 audiotaped supervisions, focusing on collusions, which are then separately assessed with the CCG by two or more researchers. Because 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 intense negative or positive emotions. Validity testing is a more difficult task because no instrument for comparison exists; therefore, validity might be tested, for example, by questioning the supervisee if he or she has gained insight when confronted with the different facets of collusion mapped by means of the CCG. Or validity could be evaluated by testing hypotheses, such as the previously mentioned relationship between overtreatment and CCG documented collusion between patients and clinicians.

Study limitations

Given that this is a retrospective study, recall bias may be an issue; however, three of the 10 situations were comprehensively documented and published, and the others were analyzed 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 therefore was 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.

Conclusions

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

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

References

Armstrong D (1987) Silence and truth in death and dying. *Social Science & Medicine* **24**(8), 651–657.

Balint M (1955) The doctor, his patient, and the illness. *Lancet* **268**(6866), 683–688.

Bell K (2014) The breast-cancer-ization of cancer survivorship: Implications for experiences of the disease. *Social Science & Medicine* **110**, 56–63.

Chaturvedi SK, Loiselle CG and Chandra PS (2009) Communication with relatives and collusion in palliative care: A cross-cultural perspective. *Indian Journal of Palliative Care* **15**(1), 2–9.

Crowe S, Clarke N and Brugha R (2017) 'You do not cross them': Hierarchy and emotion in doctors' narratives of power relations in specialist training. *Social Science & Medicine* **186**, 70–77.

Davis MP, Bruera E and Morganstern D (2013) Early integration of palliative and supportive care in the cancer continuum: Challenges and opportunities. *American Society of Clinical Oncology - Educational Book*, 144–150.

Faulkner A (1998) ABC of palliative care. Communication with patients, families, and other professionals. *British Medical Journal* **316**(7125), 130–132.

Fox R and Carey LA (1999) Therapists' collusion with the resistance of rape survivors. *Clinical Social Work Journal* **27**(2), 185–201.

Frankel J (1993) Collusion and intimacy in the analytic relationship. In *The legacy of Sandor Ferenczi*. L Aron and A Harris (eds.), pp. 227–247. Hillsdale, NJ: Analytic Press.

Gosney M (2007) Contribution of the geriatrician to the management of cancer in older patients. *European Journal of Cancer* **43**(15), 2153–2160.

Helft PR (2005) Necessary collusion: Prognostic communication with advanced cancer patients. *Journal of Clinical Oncology* **23**(13), 3146–3150.

Jacobs TJ (1999) Countertransference past and present: A review of the concept. *International Journal of Psychoanalysis* **80**, 575–594.

Lempp H and Seale C (2004) The hidden curriculum in undergraduate medical education: Qualitative study of medical students' perceptions of teaching. *British Medical Journal* **329**(7469), 770–773.

Low JA, Kiow SL, Main N, *et al.* (2009) Reducing collusion between family members and clinicians of patients referred to the palliative care team. *The Permanente Journal* **13**(4), 11–15.

Montgomery SL (1991) Codes and combat in biomedical discourse. *Science as Culture* **2**(3), 341–391.

Nivoli GC, Lorettu L, Milia P, *et al.* (2014) Il contagio e la collusione suicidaria tra terapeuta e paziente [Suicidal contagion and collusion between therapist and patient]. *Rivista di Psichiatria* **49**(6), 279–287.

Nos JP (2014) Collusive induction in perverse relating: perverse enactments and bastions as a camouflage for death anxiety. *International Journal of Psychoanalysis* **95**(2), 291–311.

Petriglieri G and Wood JD (2003) The invisible revealed: Collusion as an entry to the group unconscious. *Transactional Analysis Journal* **33**(4), 332–343.

https://doi.org/10.1017/S1478951519000142 Published online by Cambridge University Press

Schaad B, Bourquin C, Bornet F, *et al.* (2015) Dissatisfaction of hospital patients, their relatives, and friends: Analysis of accounts collected in a complaints center. *Patient Education and Counseling* **98**(6), 771–776.

Schwarz JK (2004) Responding to persistent requests for assistance in dying: A phenomenological inquiry. *International Journal of Palliative Nursing* **10** (5), 225–235.

Stiefel F, Nakamura K, Terui T, *et al.* (2017a) Collusions between patients and clinicians in end-of-life care: Why clarity matters. *Journal of Pain and Symptom Management* **53**(4), 776–782.

Stiefel F, Nakamura K, Terui T, *et al.* (2017b) A comment to Shinjo T et al.: collusion in VSED. (Response to Shinjo T, Morita T, Kiuchi D, *et al.* Japanese physicians' experiences of terminally ill patients voluntarily stopping eating and drinking: a national survey. *BMJ Supportive & Palliative Care*. Published Online First: 08 November 2017. doi: 10.1136/bmjspcare-2017-001426).

Stiefel F, Nakamura K, Terui T, *et al.* (2018) The Collusion Classification Grid: A supervision and research tool. *Journal of Pain and Symptom Management* **55**(2), e1–e3.

Stiefel F and Krenz S (2013) Psychological challenges for the oncology clinician who has to break bad news. In *New Challenges in Communication with Cancer Patients*. S Antonella (ed.), pp. 51–62. New York: Springer.

The AM, Hak T, Koeter G, *et al.* (2000) Collusion in doctor-patient communication about imminent death: An ethnographic study. *British Medical Journal* **321**(7273), 1376–1381.

Willi J (1984) The concept of collusion: A combined systemic-psychodynamic approach to marital therapy. *Family Process* **23**(2), 177–185.

Yamazaki F (1996) *Dying in a Japanese hospital*. Tokyo: Japan Times.

Zimmermann C (2004) Denial of impending death: A discourse analysis of the palliative care literature. *Social Science & Medicine* **59**(8), 1769–1780.

https://doi.org/10.1017/S1478951519000142 Published online by Cambridge University Press