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Collusion Revisited: Polyadic Collusions and Their Contextual Determinants

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Abstract
At the core of collusions are unconscious unresolved issues shared by two or more participants, interlocked in a defensive maneuver. The issue at stake is avoided at an intrapsychic level and externalized in the interpersonal space. Unresolved issues may pertain to control, intimacy, loss, dependency, domination, boundaries and so on.

This critical narrative review is based on a comprehensive consultation of the psychoanalytic, general system theory, family therapy and social psychology literature and is informed by our experience as psychotherapists, supervisors, and researchers. When working with the concept of collusion, be it as a clinician, supervisor or researcher, collusions must be delineated from other group dynamics. This might not always be easy. Moreover, reports on polyadic collusions and their contextual determinants are scattered in the literature of different psychotherapeutic approaches and lack precision at times. We therefore engage in a critical dialog with the literature and define different types of polyadic collusions, helping the reader gain a quick overview of this somehow neglected concept. Collusions occur in the psychiatric, psychotherapeutic, and medical setting, but especially in settings which ignore the unconscious and the impact of the wider social determinants on collusions.

Collusion is a very useful concept since it brings together different therapeutic orientations but also patients and clinicians, the personal and professional of the caregiver, as well as psychotherapy, psychiatry, medicine, and the social sciences.

Keywords Polyadic collusion · Groups · Institution · Social determinants · Supervision · Research

We introduce this article with a short presentation of how we produced this narrative review, followed by a working definition of collusion and an example illustrating how polyadic collusions operate and how contextual factors can influence collusion formation.

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The Narrative Review: Proceedings

This narrative review relies on a corpus of articles we selected for a prior manuscript that focused on collusion in the palliative care/oncology setting (Stiefel et al., 2017). The corpus grew as we constantly screened these articles and subsequently retrieved additional references. We also conducted specific searches of the English, French and German literature in the MEDLINE (OVID and PUBMED), EMBASE, PSYCHINFO and Web of Science databases using keywords such as “polyadic collusions”, “collusions and groups” or “groups and projective identification”. We reviewed over 250 articles from the psychoanalytic, systemic, social psychology and system psychodynamics literature, of which most dealt with dyadic collusions, as summarized in another article (Stiefel et al., 2023). Compared to systematic and scoping reviews that address a question and follow a structured and predefined method with inclusion and exclusion criteria, narrative reviews are

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not based on a predefined search strategy, cover broader topics, include related topics (e.g., the delineation of collusion from other phenomena in our review), and provide the authors' subjective perspective (e.g., our critical stance concerning the articles of some scholars on collusion). Our objective was to obtain a comprehensive perspective on polyadic collusions and their contextual determinants based on the literature and informed by our experiences as psychodynamic-oriented psychotherapists and supervisors (FS and MS) and as a social scientist (CB) working in the same psychiatric liaison service as the first author. A critical stance led us to question some propositions in the literature, add new thoughts and situate, define, and delineate polyadic collusions. The manuscript thus qualifies as a critical review and does not, as do theoretical articles, propose a new theory; however, we challenge some assumptions about polyadic collusions and identify their contextual determinants, a neglected topic that is addressed in the system psychodynamic and management literature.

Collusion: A Working Definition

At the core of collusions is an unconscious, unresolved issue shared by two or more participants interlocked in a defensive maneuver (Bagarozzi, 2011). The issue at stake is avoided on an intrapsychic level by externalizing it into the interpersonal space (Stiefel et al., 2023). Unresolved issues are unconscious and may pertain to control, intimacy, loss, harm, dependency, domination, boundaries, exigency, and so on (Stiefel et al., 2017). For an in-depth discussion of the "unresolved issue", see Stiefel et al. (2023). In collusion, participants ward off negative feelings associated with such unresolved issues and resort to crossed projective identifications or other defense mechanisms. Dicks, to whom the conceptual foundation of collusion is attributed (Dicks, 1967) remarked the phenomenon that colluders externalize and thereby reveal the unresolved issue and on the same time hide it from themselves (Dicks, 1963).

Case Vignette

A palliative care team presented the case of a man with advanced lung cancer who struggled with his increasing vulnerability and limited life expectancy and asked for further chemotherapeutic treatment. Some team members advocated confronting the patient with the rapid evolution of his disease and discouraging him from undergoing further treatment. In contrast, others suggested avoiding a confrontation and accepting his request. During supervision, the polarization of these stances intensified and culminated in mutual accusations. The "confronters" accused the "avoiders" of potentially harming the patient with futile treatments, and the "avoiders" accused the "confronters" of potentially depriving the patient of his decisional rights. The "confronters" focused on the patient's diminishing force, provided examples confirming their views ("when he went to the cafeteria, his pants felt down, and he didn't even notice it") and denied his remaining capacities. The "avoiders" focused on the patient's strength, provided examples confirming their views ("he knows exactly where he stands, he is a fighter") and denied his diminishing forces. The supervisor commented that some seemed to respond to the patient's apparent strengths to protect his psychological state, while others seemed to respond to his repressed weaknesses to protect his physical state. This intervention allowed a discussion and a reflection on how the issue of "do not harm", essential in palliative care, medicine and ethics, resonates in a singular way in each of us.

The patient's request split the team into two colluding subgroups that projected undesirable self-representations (to harm the patient) onto each other. The team had entered a defensive deadlock of crossed projective identifications and mutual accusations, which allowed them to ward off anxiety or guilt created by this situation "with no way out". Collusion prevented the team from an empathic exploration of the patient's request and thereby deprived him of the possibility of mourning and maturing. In other words, the patient disappeared from the attention of the staff preoccupied by collusion while collusively engaging with the subgroups himself. Indeed, the "confronter subgroup" engaged with the patient through what we call a complementary collusion, in opposition with the patient's stance of denial. The "avoider subgroup" engaged in a symmetrical collusion, adopting the patient's stance (Stiefel et al., 2023).

The supervision also addressed social determinants favoring this collusion, such as professional identity. For instance, medical career choice, unconsciously driven by past experiences of passively endured situations of suffering of self or significant others (Elliott & Guy, 1993), can contribute to unresolved issues related to inflicting harm. Moreover, favoring such collusions are settings where patients' vulnerability is important, and carers are very sensitive to do no harm, as is the case in palliative care. This sensitivity, society's defensive attitudes toward death and discourses honoring a fighting spirit may have favored this collusion.

A sole focus on the patient's functioning and his power to split the team, for example, would have exempted the carers from self-reflection and their collusive resonances.

Collusions Involving Groups

We will now summarize conceptual developments of group psychology relevant for polyadic collusions and then present different types of collusions involving groups.

Group Psychology Paving the Way for Polyadic Collusion

Mass phenomena were first described in the late nineteenth century by Le Bon (2013), who introduced a psychological perspective on groups and observed an alteration of the individual when joining the group, such as the obliteration of singular particularities, diminished sense of responsibility and increased suggestibility. Freud believed that identification among group members is essential for its functioning (Freud, 1921) and that social groups may be linked to sexual jealousy (Freud, 2013); he thus introduced the notion of unconscious group dynamics.

Bion proposed studying the group as a whole (Bion, 1969) and found that groups function as work groups, collectively executing what is equivalent individual ego functions, and with "basic assumptions". He divided basic assumptions, which are driven by powerful unconscious dynamics, into assumptions of dependence (between group and leader), pairing (between group members) and action (e.g., to fight against someone or something or to flee). In this last group, especially relevant for collusions involving a scapegoat, Bion assumed that the group focuses on its own preservation: the focus on an enemy diminishes infighting and fosters its cohesion. Basic assumptions can help us understand certain types of polyadic collusions.

Later, other group phenomena, such as group illusion (Anzieu, 1990) or anxieties (Stephan, 2014), were described. Anxieties about real or fantasized dangers, for example "to harm" in the supervision of the palliative care team described above, may lead to collusions. More recently, the concept of valence shed light on how individuals might be attracted to groups. Valences are affective qualities the individual experiences—dichotomized in attractiveness and aversiveness—when facing an event, an object, an environment, or a situation. Valences orient judgment (Shuman et al., 2013) and can thus favor that a person collusively joins a group.

Regarding the wider context, Foulkes and followers view individuals as nodes at the intersection of groups and parts of a larger matrix, subjected to a communicating system, which includes supra-individual elements such as a socio-historical context (Foulkes, 1975). He thus articulated psychopathology within the larger social context, which also operates in collusions.

Types of Collusions Involving Groups

We propose to classify polyadic collusions into group collusions, collusions between a group and an individual, and collusions within and between groups.

Group Collusions

Collusions can occur at the origin of group formation. Group members share an unresolved issue, constitutive of the group, which motivates a basic assumption (e.g., pairing in a sect, unresolved issue: separation) that exceeds the work group tasks. Members may share characteristics such as weak ego boundaries, dependent personality traits or the use of projective identification to evacuate shared and unwanted self-representations projected on individuals outside the group. The formation of sects is not comprehensible from a mere psychological perspective, but we consider that shared dependency issues may be operant and that the concept of collusion may thus help us understand such formations. In comparison, groups not forged by collusion such as religious movements or football clubs primarily execute the tasks of the work group (charity or to win), and their members are not united by a shared and unresolved issue.

Other examples of whole group collusions, due to prevailing of basic assumptions, are members who forget their working tasks due to the joy of being together (basic assumption of pairing), which can sometimes be observed among health care professionals working in a hospital who momentarily forget that patients are present, or political protesters who become violent when intergroup divisions appear (basic assumption of fighting, fostering cohesion).

In suicide research, shared projective identification—a superglue that welds members of a group (Young, 1992)—is related to suicide clustering among adolescents (Goldblatt et al., 2015). Suicidal wishes in adolescents can be understood as a fantasized means to hurt the parents and have them experience the pain the adolescent feels in this period of desired and feared separation. This desire to "communicate to the parents the pain they experience" can become a fatal "suicidal collusion" when a member acts out the fantasy of the group.

Collusions Between Individuals and Groups

Collusions between a group and a leader or a scapegoat or other individuals, such as group therapists, are often but not exclusively mobilized by narcissistic issues.

Collusions between groups and their leaders can be symmetrical, when a group and its leader resort to mutual idealization and crossed projective identification to defend against an unresolved issue related to self-worth. Such collusions

can occur in families with very hierarchical organizations (Petriglieri & Stein, 2012) or in politics. Messianic hope in times of loss of confidence, collusively produced between narcissistic group members and their narcissistic leader (Bateman, 1998), was exemplified by the Trump presidency in the USA. Mentzos classified such collusions as "narcissistic-reparative", "narcissistic boosting" and "narcissistic-destructive collusions". In the last subtype, unwanted parts of the self are projected onto others outside of the group who are devaluated, desingularized and described with stereotypes (Mentzos, 1988). Such collusions are especially dangerous when the leader incorporates not only the ego ideal but also the superego, "assumes" responsibility, and frees group members of guilt (Main, 1975). Trump's famous words that he could shoot someone on Fifth Avenue and get away with it and his cheered devaluations of individuals and subgroups within and outside the USA are the manifestation of a narcissistic-destructive collusion. An example of a complementary collusion is a leader idealized by a group he despises (as has been reported regarding Hitler, who stated when war was lost that Germany did not deserve him). In both cases, the idealized leader incorporates the ego ideal of group members, who vicariously experience grandiosity and ward off low self-esteem and shame. In both symmetrical and complementary collusions, the leader needs the group's admiration to prevent the erosion of their own self-esteem. The addictive call of some politicians for rallies to take in the experience of a crowd can be a manifestation of such a need. A recent psychoanalytic perspective on leaders convincingly described how different types of leaders (e.g., "controller", "therapist", or "messiah") endowed with different qualities (e.g., pragmatic, romantic, or rebellious) can coexist in the same person or be distributed among different leaders (Western & Wilkinson, 2010).

Collusions also occur between a *group and a scapegoat*. Scapegoating may or may not be collusive, with collusive scapegoating being much less frequent and requiring a different therapeutic approach. The victim of ordinary scapegoating needs to be recognized, protected, and compensated; the victim of collusive scapegoating needs therapeutic intervention. In collusive scapegoating, the targeted individual shares with the group an unresolved issue and introjects the unwanted parts projected from the group, providing opportunities, through projective identification or behaviors provoking reactions from the group, to confirm the group's view and to continue scapegoating. Collusive scapegoating circulates under different terms, such as "identified or designated patient", "scapegoat" or "symptom carrier", with or without reference to collusion (Wangh, 1962). Children do not have inborn unresolved issues, but when they—out of feared or real danger of separation—internalize the projected self- or object-representation of their parents, they may become participants of a collusion.

In the therapeutic setting, polyadic collusions are observed in *group therapy*. A therapist officially called to solve a problem may serve to ease inner-group tensions, increase group cohesion and externalize conflicts: the group avoids the unresolved issues regarding aggression (and separation anxiety). Collusion is at work if a therapist integrates the projected aggressive feelings and—paralyzed by own unresolved issues regarding aggression—reacts by distancing him or herself from the group, herby fueling the collusive spiral (Loeser & Bry, 1953). Such phenomena also occur in group supervision when supervisors collude aggressively with the supervisees who consider the supervisor insufficient (collusion over feelings of impotence).

Collusions Within and Between Groups

Collusions within groups (Gemmill & Elmes, 1993) may manifest as splitting, as described in the introductory example of supervision: crossed projective identification with increased tensions provoked aggressive attitudes between the two subgroups, confirming their view that the other's position is aggressive and potentially harmful to the patient.

In *collusions between groups*, the same unresolved issue is avoided by crossed-projective identification (Young, 1992). For example, the unresolved issue concerning separation (anxiety) prevents intragroup aggression and conflicts, which are collusively externalized with the help of another group that operates in the same way for the same reasons. Mutual accusations of therapeutic inefficacy between psychoanalysts and cognitive therapists may serve as an example (of repressed anxiety related to being inefficient). In addition to collusive intergroup aggression, unresolved narcissistic issues might come into play through collusive rivalry. Collusive rivalry may be observed in the hospital setting, with members of medical disciplines viewing members of other disciplines as inferior and vice versa. From a general point of view, collusions occur more easily in settings where the unconscious is not part of the work or neglected. In the psychoanalytic setting, collusion is seen as a way of entering into communication to gain a deeper understanding. However, collusions with negative effects on the therapeutic relationship have been described even in the psychoanalytic setting.

Mentzos stretched the concept of polyadic collusion to suggest that externalizations by means of cross-projective identifications between nations may explain certain wars (Mentzos, 1988). He conceived wars as narcissistic crises in which shame (low self-esteem) is avoided through collusive intergroup aggression: revenge takes the place of shame, and blood the place of tears. We find it questionable

to understand wars solely from a psychological perspective, thereby anthropomorphizing nations (Petriglieri & Petriglieri, 2020).

Collusion in Context

We will now address some general aspects of the role the context plays in the formation of collusions and then discuss some examples, focusing on the medico-psychiatric setting.

Setting, Institution and Society

Any *setting* with a caring mission shares some characteristics with the child–parent relationship and thus favors the acting out of past developmental difficulties. As mentioned, the mission of medicine may attract individuals who have a valence for repairing and caring due to their own past experiences (Elliott & Guy, 1993). Balint's apostolic function" of the physician (Balint, 2005) or Freud's "furor sanandi" can be understood in this manner. Moreover, specific clinical settings mobilize specific issues; for example, separation and loss in palliative care (Low et al., 2009; Stiefel et al., 2017), omnipotence and impotence and separation in oncology (Stiefel, 2007), shame and self-esteem in obesity (Atkinson & McNamara, 2017), intimacy in gynecology and control in diabetology. Collusive acting may occur, for example, in the form of aggressive overtreatment in oncology (collusion over separation anxiety between a patient and a physician). Psychiatric settings with intense countertransference reactions, such as in the care of the suicidal (Nivoli et al., 2014), traumatized (Holmqvist & Andersen, 2003) or perverse patient (Wood, 2014), may favor collusions. Clinicians' lack of experience or a too marked role responsiveness may contribute to the formation of collusions. Finally, the high prevalence of psychological dysfunction in families of mental health specialists (Elliott & Guy, 1993) may favor collusions.

Institutions, in the system psychodynamic perspective of Petriglieri and Petriglieri (2020), are networks of social interactions and practices governed by agreed-upon and more or less formal rules that provide guidance and predictable manners of working together. Institutional defenses are collective arrangements, such as organizational structures, work methods or prevalent discourses, which may palliate the anxiety or envy of their members (Vince, 2019). Institutions have the power to shape the individual to fit in, especially when so-called neurotic styles—paranoid, compulsive, histrionic, depressive and schizoid–predominate (Kramer, 2001; Petriglieri & Petriglieri, 2020). However, some individuals already have the necessary psychological makeup to fit the institution. Parin suggested the term "adaptation mechanisms", in analogy to "defense mechanisms", to describe the psychopathological characteristics of individuals who match with roles provided by the institution (Parin & Parin-Matthèy, 1978). Institutions with contrasting figures tend to favor collusions (Main, 1975): in medical institutions, the figures of caring clinicians (expert) and dependent patients (ignorant) (Stiefel et al., 2017) favor oral (or narcissistic) collusions (Willi, 1975). The psychiatric asylum, as described by Goffman (1968), is a classic example of such institutional effects. Moreover, territorialization (e.g., areas in a hospital that patients are not allowed to enter) and segregation (e.g., patients, physicians and nurses wear clearly distinguishable "uniforms") accentuate real and fantasized differences between and thereby also contribute to collusions (Stiefel et al., 2018).

Elements of the wider social context may also play a role. Among them are dominant discourses circulating in *society* (Petriglieri & Petriglieri, 2020). For example, cancer care is colored by discourses such as the "war on cancer", first declared by Richard Nixon. This rhetoric may amplify clinicians' and patients' rhetoric and attitudes and favor collusions related to separation, dependency, impotence or vulnerability. Attention to context when analyzing collusion is thus necessary, especially in the supervision of health care professionals.

How Context Favors Collusion

The following supervision, conducted by one of the authors, exemplifies how general characteristics of medicine and of setting favor collusions.

A 60-year-old woman with amyotrophic lateral sclerosis stayed in the palliative care unit for several months. The staff described her as a courageous patient facing increasing dependency. After a few minutes, the supervisor interrupted the eulogy and asked, "well, if everything is fine, why are you presenting the case?" At that moment, a social worker responded, "I didn't like her", a statement that prompted an avalanche of complaints from supervisees conveying that the patient completely monopolized them to the detriment of other patients. However, the clinicians repressed their aggressive feelings by reaction formation. The aggressive feelings finally found the following expression: when asked how the patient died, the team reported that they felt that a specialized setting was more adequate for her care, and they transferred her to a long-term neurology ward, where she died three days later.

Aggressive feelings, equated with aggressive deeds, provoked anxiety and were thus censored by the staff. The patient's constant demands of the staff may be interpreted as an expression of her anxiety provoked by the loss of control over her body (what is left is the control of others) but also

seemed to have had elements of passive aggressiveness. The example can be read from different perspectives. General characteristics of medicine may have favored this collusion due to its basic assumptions and working tasks (unlimited demands would be handled differently by the judiciary apparatus). Setting-specific characteristics concern the palliative care team's devotion to compassionate care and difficulty handling aggressive feelings toward patients (reaction formation as a shared and privileged defense).

Compassion discourses circulating in the medical institution have been described favoring collusions among the staff; such collusions may palliate feelings of not being a good enough carer, guilt and compulsion to repair (Dashtipour et al., 2020). Finally, medical settings, characterized by heavy treatments and technicity, may favor collusions of alexithymia, which help both patients and clinicians to avoid emotions generated by suffering (De Vries et al., 2012).

Regarding *society*, we will provide two examples illustrating how dominant discourses favor collusions. Discourse circulating in social media and the medical literature frames cancer as an opportunity to grow and become better, fitter and more resisting thanks to posttraumatic growth (Bell, 2012). In contrast, the reality of cancer survivorship is characterized by long-term physical and psychosocial harm. (Danesi et al., 2020). Posttraumatic growth discourses might provide hope and appease some patients, but they are also perceived as injunctions to fight and to improve, which may provoke feelings of inadequacy and guilt (Stiefel & Bourquin, 2018). Such discourses favor collusions between patients and clinicians over issues related to loss or feeling lessened. The same holds for the recovery discourse in psychiatry (Jørgensen et al., 2020).

The second example illustrates how cultural characteristics can favor collusions. Japanese male psychiatrists attribute depression to hard work in men and to psychological difficulties in women (Kitanaka, 2011). The unresolved issue can be considered to concern failure to respond to the exigency of the world. In a culture marked by shame and gender differences (Benedict, 1946), this collusion allows male patients and male psychiatrists to avoid the shameful and painful topic of psychological difficulties, since hard work is quite valorized.

Delineating Context-induced Collusions

We end this part of the manuscript by providing two examples distinguishing collusions from similar phenomena.

Schruijer understands collusion as an institutional omerta (Schruijer, 2013). She reported a conspiracy of silence in an academic institution among members of a jury evaluating theses. Decisions to accept a thesis were influenced by the fact that the institution was rated and remunerated by the number of successfully conducted theses. The same phenomenon has been described in the early management literature and referred to as the Abilene paradox (Harvey, 1974). Here, the unconscious dynamic is missing since the colluders are aware of what is going on but do not dare to protest. However, what might be considered a collusive unresolved issue is the unwillingness to initiate a conflict due to separation anxiety or other fears. In other words, even if collusions may be consciously experienced, the unconscious aspects driving the collusive process may remain unknown to the colluders.

In child protection, collusion has been reported to be favored by the managerial pressure for clinical productivity, leading to the underdetection of child abuse (Revell & Burton, 2016). If one assumes that social workers more easily succumb to denial, since being distracted (and at the same time relieved not to have to look closer at the horrible situations of child abuse) by managerial pressure, one could argue that they are more inclined to engage in symmetrical collusions with family members who participate in the denial. They could thus share a common defense, with certain professionals working in this field known to be affected by their own abuse (Revell & Burton, 2016). Identifying collusion would require a deeper analysis of these situations since the nonidentification of child abuse may have many different causes.

Overcoming Collusion: Supervision

The main means to prevent, identify and work through collusion is the therapist's own psychotherapy. Ferenczi already reported a case ("A note on criminality") for which he suspected that he shared the same unconscious problem with a patient and that this explained his tolerance of the patient's deviant behavior (Dupont, 1995, p. 194). Identifying collusion requires attention not only to the patient's verbal expressions but also to the interactional dynamics. This is especially difficult for inexperienced clinicians who tend to consider symbolic expression to be the most important dimension of the therapeutic process and focus on verbal exchange.

Teaching and Supervision

Most literature on supervision and collusion describes collusion between supervisees seeking guidance from idealized parenteral figures and supervisors looking for narcissistic gratification (Milne et al., 2009). Regarding the identification of clinician–patient collusions, a cue is a shift in the supervisee's narrative from reporting the experiences of the relationship to actually reliving the patient's experience

(Grinberg, 1979). Another sign is so-called parallel processes where the supervisor–supervisee dynamic mirrors the supervisee–patient dynamic (see example below). Of course, any enactments, deviation from good clinical practice or partial or split representations of the patient are also signs of possible collusion.

A parallel process allowing us to identify collusion over intimacy is illustrated by the following supervision conducted by one of the authors. *The supervisor felt discouraged, helpless and pressured to make sense of the situation presented by a junior psychologist. The reported case was about a middle-aged woman who adopted a very dominant and controlling attitude from the onset of therapy. The psychologist felt unable to explore basic anamnestic elements, such as the relationship with her husband, fearing touching on a possibly sensitive topic. However, she learned that the patient was raised in Hungary as the single child of a mother she described as "cold" (the father died shortly after she was born). The only meaningful relationship during her childhood was a friendship that ended at the age of ten when the girl moved away. This friend died a few years later of leukemia. The supervisee reported that the patient was successful at work but disliked because of her dominant behavior. Feeling paralyzed, the supervisor spontaneously stated, "I feel unable to think. It is a tough situation, and if I had a choice, I would, instead of talking, rather "do" something with this patient—drink a cup of tea or go for a walk. At this moment, perhaps "warmed up" by the hot tea or the walk, the supervisee reported of the patient's recent trip to Hungary where she met her childhood friend's mother, who gave her something that belonged to her daughter; they have remained in contact by e-mail since. The supervisee had left out this intimate and meaningful episode, contrasting with the "stiff" relationship she had with the patient. The oppressing atmosphere of the supervision disappeared, and an animated discussion followed. Feelings of sadness regarding the patient's history emerged, as well a desire to further explore the trip to Hungary. Upon leaving, the supervisee said, in a low voice, that she knows how it feels to grow up "like that".*

We consider that recognizing personal issues in the supervisory process is usually beneficial for the supervisee and the therapeutic process. However, the old Vienna-Budapest-Berlin debate about handling personal issues in supervision has left its mark, and supervisors are often wary of addressing countertransference reactions (Soreanu, 2019). Indeed, without touching on personal issues, collusions can be addressed by questioning how the psychological functioning of the patient affects the therapeutic relationship (and the therapist) or by imaging countertransference experiences that could be provoked by such a relational dynamic (Grinberg, 1979). Addressing collusive countertransference depends on the context of supervision; if hierarchical or professional relationships exist between the supervisors and supervisees, exploration must be cautiously considered. These observations remind us of the high exigency toward clinical supervisors. Supervisors ought to support but also confront and stimulate supervisees. While psychotherapists learn and teach how to treat patients, much less attention is given to how one becomes a supervisor and formal teaching is lacking in most settings.

Balint work and related approaches are also valid to identify and work through collusions in the medical, social and psychiatric setting (Mills & Smith, 2015). Other methods, such as "examining the group shadow", which focuses on stereotyped perceptions of other groups, are proposed by consultants who work for nonclinical organizations (Gemmill & Elmes, 1993).

Regarding context, training in critical reflexivity may be beneficial to identify context-related factors favoring collusions. Moreover, interventions to prevent collusions on an institutional level may take the form of modifications of the setting. An example is the therapeutic community technique (Main, 1975), which aims to distribute responsibility also to patients and thereby diminishes polarized clinician–patient perceptions (e.g., expert vs. ignorant).

Terminological and Conceptual Aspects

By reviewing the literature, we observed that various terms are used to designate situations of collusion (e.g., reversed projective identification or extrojection by the therapist) and that specific types of collusions are described without specifically referring to collusion (e.g., supertransference or parallel processes in supervision).

To be distinguished from collusion are enmeshment, enabling, vicarious gratification and enactment. Enmeshment is due to weak ego boundaries, leading to resonance in all protagonists (e.g., family members) when one of them psychically wavers (Wikler, 1980). Enablers comply with the demands of others, which they disapprove (Rotunda et al., 2004). Unlike in collusion, one does not need the unconscious to explain enmeshment and enabling. Vicarious gratification (Johnson & Szurek, 1952; Wangh, 1962) can be a manifestation of collusion if the protagonists share the same unresolved issue, which is not always the case. The same holds true for enactment (Chused, 1991), which can be collusive (Devereux, 2006) but can also be solely related to the patient's projective identification (Grinberg, 1979).

Conclusions

Collusion emerges as a concept that allows different universes to communicate and cooperate. Collusion brings together patients and clinicians; the intrapsychic, the interpersonal and the context; the clinician's private and professional life; psychoanalysis, system theory and social psychology; psychiatry and medicine; and psychology and the social sciences. We hope to convince the readers of the relevance of collusion for clinics and supervision in medicine, psychiatry and psychotherapy, and related fields, such as social work and education.

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