THE COLLUSION OF ANONYMITY: SOME COMMENTS WITH A CASE VIGNETTE [1]

Dr. KimonGanev, Dinamika Mental Health Centre, Sofia

1 T he paper is based on a presentation at the Annual Conference of the Bulgarian Balint Society held in March 2018.

Rezumat: *Articolul aduce în discuţie factorii ce contribuie la formarea conspiraţiei anonimităţii (termen creat de însuşi Michael Balint) – acea situaţie în care pacientul este consultat de mai mulţi medici, dar niciunul nu îşi asumă responsabilitatea unor decizii şi tratamente importante. O prezentare de caz poate fi de ajutor la ilustrarea unor puncte esenţiale, explorând care este scopul conspiraţiei anonimităţii şi care ar fi atitudinea constructivă faţă de aceasta.*

Abstract: *This paper discusses the factors contributing to the establishment of the collusion of anonymity – a situation where the patient sees a number of doctors, but nobody takes responsibility about the important treatments and decisions.*
A case vignette helps illustrating some of the main points in exploring what purpose is served by the collusion of anonymity and what could be a constructive attitude towards it.

Buletinul Asociaţiei Balint, vol. xX., nr. 79, septembrie 2018

The collusion of anonymity is a term coined by Michael Balint (1964)[1] that refers to a situation in which several doctors are involved in the treatment of a patient, but no one takes full responsibility. It looks like that a simple solution would be to encourage the doctors to assume responsibility.

Before insisting on adopting such a stance, we will focus our comments around two issues.

The first is **what are the forces that determine the development of the collusion of anonymity?**

The second one would be **what kinds of responsibility are we expected to assume?**

This paperpresents the participation in the collusion of anonymity from my perspective as a psychiatrist involved in the treatment of a patient with anxiety symptoms.

A case vignette:

V.V., a woman of 66, in retirement for 3 years (she was a high-level accountant), widow from 20 years, lives with her only daughter. About 6 months ago, she came to see me (a psychiatrist) for anxiety symptoms: a feeling of inner tension, basic insecurity, headaches, restlessness, tingling and numbing of the hands. These complaints were especially pronounced in the morning and in the evening (occasionally, in such instances she calls her daughter for reassurance).
Currently she is taking very low doses of an antidepressant, which she started after extended discussions with me (she feared severe side effects and that she would become addicted to the drug).
She visits also other doctors: a gastroenterologist for intestinal troubles, a cardiologist for elevated blood pressure (which, in fact, is not elevated), and anophthalmologist for recurrent conjunctivitis. During the last year, she also considered the possibility of consulting a neurologist and an

orthopedist for a pain and a burning sensation in the lower leg. From time to time, she visits her GP for a consultation or a referral. In the last year, V.V. has received a number of examinations and treatments: she has undergone a colonoscopy; she uses intermittently antibiotic eye drops; for periods (especially in wintertime) she takes an antihypertensive drug; she regularly takes herbs with a laxative effect; she started treatment with an antidepressant. During this period, she also made some important life choices:

she suspended the decision to live separately from her daughter;

she considered her emotional state too frail and therefore discontinued working (which was a source of satisfaction for her – she has been working after retirement);

she stopped travelling and hiking (that she loved doing before) because it caused her a lot of anxiety.

This case shows some typical features. There are several physicians engaged in the case, each one dealing with a separate problem. None of the physicians is taking responsibility for the overall case. Various treatments and examinations were conducted, but they do not bring about a more stable solution to the problems, neither a deeper understanding of the patient. The doctors keep their fields separate and suggest interventions for specific problems.

Some of their suggestions are contradictory – e.g. the cardiologist recommended avoiding stressful situations, while I (the psychiatrist) believed important for the patient not to stop her working involvement. Meanwhile important changes in the life of the patient occurred with nobody (neither the doctors nor the patient) acknowledging responsibility for them.

We assume that the evolution of the situation is not determined by chance or by the insufficiency in the skills and knowledge of the participating physicians. Rather there are serious reasons for it to be the way it is. We can approach these reasons via the way we think about the diagnosis of the case.

Classica l and expanded diagnosis

A classical diagnosis: V.V., a 66-year-old woman presents with marked anxiety and hypochondriac symptoms lasting for a couple of months with a possible trigger a recent colonoscopy (with a negative finding).

Possible treatment: Medication for the anxiety; Counseling focusing on defusing the extreme perceptions of bodily threats and trying to develop further areas of autonomous functioning and rewarding activities.

An expanded diagnosis: V.V., a 66-year-old woman presents with exacerbated in the last couple of months anxiety and hypochondriac symptoms, that add to a period of several years, characterized by illness, suffering, somatic and emotional complaints. This period was probably the result of the changes inthe life of the patient: retirement and the anticipated separation with her daughter who planned to live separately with her friend. Likely themes / issues to be considered in the treatment of the patient are **dependence and responsibility; loss and loneliness; meaning of survival**

1 T he literature listed at the end of the paper comprises a few of the numerous references relating to the basic concepts on which this presentation is grounded.

and death.

Even if the expanded diagnosis gives a larger understanding of the patient's problem, it does not readily imply better and more effective interventions. It leads us into a vaguely charted territory of feeling ill, having a **dis-ease** (not feeling at ease).

In a schematic way we can conceive all symptoms presented to the doctors pertaining to two categories: either as being reducible to a specific disease (which is likely to have a specific treatment), or communicating *a disease*, *amalaise* (not being at ease, a feeling of being ill), which is rooted in the personality of the patient. In this second instance, we do not have clear-cut guidelines as to what would be helpful and what would be harmful to the patient. Therefore, we face a suffering where there are symptoms, but they are refractory to the usual approaches towards them. One can hypothesize that these symptoms are derivatives of the way the personality of the patient has been constituted. Therefore, we can assume that the basis for these problems has been set very early in the development of the patient. Therefore, it is likely that in working with these patients we would face very early modes of functioning and relating to the other.

The appare nt para dox in the 'dis-ea se' ca se

The patient has symptoms. He suffers and seeks relief. The physician and the patient identify the symptoms as the target of the cure. However, the symptoms do have a deeply rooted function. We could elaborate much more in depth about what is the origin and what is the role of these symptoms. For the purposes of this paper, I propose to think them as helping to maintain an integrated self-representation that is otherwise experienced as frail, weak, or prone to fragmentation.

Each attempt to eliminate the symptoms is unconsciously perceived as a major threat for the self. Therefore, there is a strong resistance to the therapeutic interventions – and this despite the desire of the patient to be cured. Neither the somatic nor the psychotherapeutic treatments eliminate the symptoms (or they are replaced by new complaints).

The suffering of the patient - that is in the core of his being ill – is beyond description. We cannot name it. The closest approximation to it are the symptoms. Therefore, we talk with the patient about symptoms. Quite often, it is a tedious and unproductive conversation.

We have spent a lot of time talking about the symptoms with V.V. Even describing them as a phenomenon and placing their development in a period is not an easy task.

The account of V.V. is vague; it requires a lot of focusing to get even a rough picture of the complaints. For her, making differentiations and talking in nuances about her inner life is difficult. The attempts to explore the circumstances surrounding the symptoms are likely unfruitful. I am often experiencing a heavy feeling of helplessness and sense of failure. I suspect that the symptoms of V.V. are rooted in similar experiences.

A hypothesis is that such emotional states that we both

share (her as a patient and me as her psychiatrist) are a kind of communication permitting us to get somewhat closer to the core of her suffering.

The co llusion of anonymity and the partici pants in it

Here we will present a brief outline of some of the challenges to the participants in the treatment of the patient. The 'collusion of anonymity' can be viewed largely as a response to these challenges. It serves as a complex defense mechanism to protect us from the threats experienced, when facing them.

The doctor is more or less helpless in front of the symptoms of the 'dis-ease'. At the same time, he is expected to be capable to relieve the patient from his suffering. He often has the experience that his efforts and competence are devalued – and therefore feels irritation and anger. His ambition to cure the patient endures a major setback. Not rarely – especially after some of the treatments have failed – he starts perceiving the patient as an enemy. Moreover, the patient visits all types of healers, which may be perceived by the doctor as a narcissistic hurt.

The patient – as elaborated above – experiences the treatment as a threat to the integrity of his self. He often feels rejected by the doctor, who is more and more impatient regarding his complaints. The patient does not receive enough attention and anger ensues. A series of unsuccessful examinations and consultations adds to a general feeling of disillusionment and discontent.

The consultant (the specialist) is bound to face very high expectations (from the referring doctor, from the patient, and often from the family) in a very limited time. The fear of not being able to meet them produces considerable distress.

The uncertainty of the situation is further amplified by the often-vague referral. Sometimes such consultations result in a conflict (overt or covert) between the referring physician and the consultant.

Considering the situation in such a way, it becomes more comprehensible why assuming responsibility is not welcomed by anybody. Hence, the responsibility remains dispersed between the different participants. Therefore, nobody will be really carrying the burden of untoward consequences.

The po ssible route

The first step is to abandon the strategy to eradicate the symptoms and to adopt a stance of trying to understand them as a result from the clash between the problem (life dissatisfaction, impaired self-representation) and the healing powers of the person. Therefore, in a sense – the symptoms are an ally to the treatment. They are not to be destroyed, because they tell us important things about the suffering of the patient and they help him or her preserve a sense of self-integrity.

One can describe the healing effect not in the terms of a cure, but rather in the terms of accompanying the person in the meanders of his struggle with his predicament. Put in other words – the important thing is not what exact interventions the doctor is implementing, but rather his attitude while implementing them. We can suspect that the healing effect comes out of the encounter between doctor and patient (between their personalities).

An important step of the therapist is to recognize how he contributes and participates in the situation. The doctor is there as the one who tries to understand. The trap is to

assume the role of the one who knows. A clue to being in
such a consultation is the skill to listen: listening to what
comes from the patient and at the same time relinquishing
part of the usual activity of the doctor; paying attention to
the observation and to the spontaneous expression of the
patient. This skill is crucially enhanced by the capacity of
the doctor to bear uncertainty and not reaching for premature
decisions.

I have less and less answers to my patient V.V. To my surprise,
she does continue coming for consultations where we
talk about her symptoms and a little bit more than before
- about her life. Where are we heading now?
I do not know.

References

• Balint M. The doctor, his patient and the illness (2-nd ed.) Pitman publishing ltd, 1964.
• Beck D, Frank Y. Le malade psychosomatique rebelle à la thérapeutique et son médecin. Bale, Suisse, 1979.
• Debray R, Dejours C, FédidaP. Psychopathologie de l'expérience de corps. Dunod, Paris, 2002.
• Dunbar F. M ind and Body: Psychosomatic Medicine. New York, Random House, 1955.
• Haynal A, Garrone G. L'entretien médecin-malade. Bale, Suisse, 1979.
• M arty P. Les difficultés narcissiques del'observateur devant le problème psychosomatique. Revue française de psychanalyse, 1952.