Group analysis of those who deal with dying

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Abstract
To build up the trust of the participants in a group with dying patients, the therapist must make himself available as a transitional object due to the intense need for an object and the need for dependence expressed by the participants.
On the other hand, the need to empathise with such strong and painful sentiments can represent a challenge for the therapist, activating powerful counter-transference reactions, such as fear of being overwhelmed, anger and negation.
If the therapist knows how to deal with this delicate equilibrium, the group will be able to provide valuable aid for coming to terms with, and to integrate, the profound and ambivalent unconscious feelings evoked by daily contact with death.

Key words: group, therapist, dying patients, dependence, need, trust

"You cannot psychoanalyse someone who is dying"
(Rosiello, 1995)

Several years ago, when some colleagues in an oncology ward (for whom I had held a seminar on group analysis) asked me to provide them with a group experience to discuss their work problems, my first reaction was rather ambivalent. My interest and curiosity, in fact, was counteracted by the fear of having to deal with the subject behind their seemingly unaware request: the difficulty of dealing with terminal illness and death.
In our times it is no secret there is a negation of death and of dying. The whole of our society is closely bound to this process of negation that tends to contemplate death as something which cannot and must not be discussed.
Today, the subject of death suffers as perhaps none other, from a kind of "conventio ad excludendum" made up of silences and refusals, which prevent us from dealing with the problem of directly. Death and mourning are treated today with the same prudishness as sexual impulses were treated a century ago (Gorer, 1965).
Ancona's words (2000) in this regard are extremely relevant:
" Contemporary society, and in particular so-called lay society, does not like to hear death spoken and tends to exclude it in every way possible. Everyone is aware that funeral ceremonies have become more nebulous with the passing of time and that the death-event is hidden more and more or at the very least the ritual is shortened as much as possible. Mourning is no longer something to be displayed as in the past. Even on the religious front, funeral ceremonies are much shorter today than they once were. Prayers are more condensed. Everything is simpler. This meets with approval

by the faithful and not certainly their displeasure... There are, on the other hand, eloquent, indirect signs that point to this general unwillingness to come to terms with the death event, in ways which achieve the most success the more they succeed in exorcising death without even naming it, on the contrary even contradicting it."

The first task faced by professionals operating in environments where death not only refuses to be denied, but aggressively dominates the scene, is exactly that of coming to terms with this event.
As I already mentioned, these helping professionals were completely unaware of what to me appeared so obvious. They asked only to be able to have a series of meetings, in a place far away from the hospital and from the intense feelings of suffering associated with their particular type of work, which placed them continually face to face with death.
The sensations they referred to were of emptiness, general ill-being, depression, sense of helplessness, inability and frustration, which also had repercussions on their personal lives (scarcely represented given the enormous amount of time the subjects dedicated to their work in the hospital).
My proposal to create an analytic group to help them face up to the unconscious aspects of their problems was received with a mixture of pleasure and difficulty (namely for the length of time the prospective process would take).
The group was composed of five women and three men - four doctors, three nurses and one social worker, all were involved full-time in the activities of the ward.
The group lasted for about a year and was interrupted prior to expectation due to a series of events, entirely independent of our own wishes. However, the time had been sufficient for the group members to receive some benefits from the work and to reach a fair, even if not complete, awareness of the personal and collective dynamics involved.
As a result of its specific characteristics, the analytic group has shown itself to be a particularly important tool in the study and understanding of the psychological dynamics underlying confrontation with death.
A specific aspect of group analysis, which makes it a powerful and flexible analytical tool, is its potential for comparison with a real model, and not only the heuristic one of the human community, but is possible at various levels, from family to society as a whole (Zanasi 1996).
Participation to an analytic group, therefore, represents a unique experience. It allows one to observe the intricate web of conscious and unconscious relationships, laden with projective and fantastic aspects, which are woven in human groups, whatever their nature may be: work, study, social, occasional, affective, etc.
In the analytic group, the reality of human communication is reproduced in "total truth", allowing members a direct and complete experience of dynamics and the more hidden aspects that are often less accepted, that become more explicit in the relationships.

It is for these reasons that group analysis appears to be a valuable means of dealing with the dynamics ignited in situations characterised by deep personal commitment and the activation of strong emotive responses typical of those professions involved with illness, privation and human suffering (health workers in general, social workers, those who work with handicapped children and drug addicts, etc).
In such conditions, the possibility of being able to confront oneself with pain, illness, mourning, separation, assumes a vital importance since the more these elements are denied on a conscious level, as usually occurs, the more they condition the relationship, often in a destructive way.
The experience offered by the analytic group moreover, gives group members direct knowledge of conscious and unconscious relations in the process of personal and collective change in the social organisations and institutions where each individual, in his own role, lives, works, cooperates and competes.

The group

The prevailing dynamics in the group were the following:
· A deep, pervasive, desolate sadness and sense of emptiness, accompanied by a feeling of intense helplessness, linked to the mourning which group members had to repeatedly face in their work.
· Extreme difficulty to come to terms with themes connected to mourning, which could only be touched on by recourse to irony and jokes, which to an outside observer could seem downright monstrous and unacceptably cynical.
· Continual oscillation between the aspects of hyper-cathexis and cynicism
· The frequent presence of a vulgar, "bar-room" irony, often centred on themes of death (a phenomenon typical in fact of hospital environments), which had the flavour of denial and maniacal reparation of the profound sadness and anxiety inherent in close contact with death.
· A rapid development of the phase of enchantment with a subsequent swift passage to the phase of disenchantment.
· The discovery of mourning early on in the personal history of many group members.

This data induces us to make some considerations on the metapsychological aspects connected to it. In my opinion, the element of greatest interest concerns the presence of numerous significant losses in the personal history of group members. These losses appear to have had a profound influence on the subsequent psychological development of individual members.
The profound tension, the need for maniacal reparation (irony and jesting), the continual oscillation between hyper-cathexis and negation, (all processes which try to come to terms with the strong emotive exposure caused by daily confrontation with death and with lack of hope), were linked to the presence of "unfinished mourning", a presence, therefore, in group members' history of difficulty in accepting their

personal mourning, with a tendency to quickly close the door on the past without elaborating events of suffering and object loss.
In the case of unfinished mourning, the defence modalities, which are usually activated belong to the category of maladaptive mechanisms (in particular negation, maniacal reparation, anger, depression, rationalisation, projection, splitting and acting-out).
From a psychodynamic standpoint, maniacal defences emerge as a response to painful feelings caused by pining for lost love objects.
Such defences are used for the recovery and reinstatement of lost love objects, the refusal to recognise bad internal objects and the negation of dependence. An integrating aspect of the maniacal defensive attitude is often a desire to triumph over ones own parents in order to invert the child-parent role (Gabbard, 1995).
For the group, facing these aspects saw the emergence of a shared awareness that one of the important factors in their choice of that particular profession was linked to an attempt at "reparation" of the loss suffered in their private lives, (a fact common to many medical choices).
To commit oneself in the front line of the battle against death constituted, fantastically, a way to avoid dealing with ones personal sense of defeat and "expiation" for ones inability, in the past, to save loved ones from death.
Naturally from a psychodynamic standpoint, while the activation of these maladaptive and repetitive mechanisms represented, on the one hand, a vast expenditure of energy, whence the sense of emptiness and impotence towards one's work, on the other it did not allow one to complete work on one's own personal mourning, impeding the creation of a mental space for reflecting on death, ones own and that of others.
Despite all our efforts, in fact, sooner or later death pays us a visit reminding us that our own lives too are vulnerable.
In the group of helping professionals, negation of death entailed an enormous expenditure of energy, it was necessary to negate it both for their patients and their own sakes. The lay nature of our society has, moreover, left a void in the place formerly occupied by religious organisations. Religion and the Church have played an important role in consoling those in mourning and providing them with a structure in which grief can be expressed and accepted.
Philip Aries has shown how the idea of death has undergone an evolution in our culture since classical and mediaeval times. He considers the change in symbolic repertory used in portraying death in art and literature to be evidence of profound psychological, individual and social changes in our attitude towards death and loss.
Today we are assisting to a kind of "de-iconisation" process of death, which is not only negated as much as possible, but also suffers from a kind of inability to be represented on an imaginal level, as death is portrayed in the minds of most people only as a nothing, a long rest, or a way of exiting from the difficulties of life.
Much has been lost during this de-iconisation process, which, together with the progressive impoverishment of the ritualistic event, which allowed us a possible and

shared approach to death, today leaves the non-religious person (but even the believer, given the secularisation process of Christianity) naked in the face of death.
Modern society's impossibility to represent death is most evident in those places and situations where the management of death and the dying take place, the mechanisms of negation and displacement become numerous, as could also be observed in the daily activities of group members. It is generally believed that many hospitals have been built in vicinity to cemeteries, whether this is true or not, it reflects popular belief in the eighteenth and nineteenth centuries that hospitals were places for dying.
The development of modern medicine has changed this situation. Hospitals are now seen as places interposed between the patient and death. A dehumanised death by the standards of the nineteenth century, where the patient is often lost in the reanimation machinery and can become, for medical staff, a simple substrata on which to practice routine and meaningless medical care.
The hospital is no longer the final lap of a path leading little by little to the inevitable conclusion, accepted by everyone.
Today we react to death as if it were an affront or an error and we often consider the healer responsible who becomes the container of our magic desires for immortality as well as our frustration.
The loss of a patient, therefore, not only wounds the physician's narcissism (rekindling those fantasies of incomplete grief, scarcely and inefficiently kept at bay by the above-mentioned reparation mechanisms), but also his self-esteem can be further lowered by anger and criticism by the patient's family.
In the first phase of shock, before their grief is internalised, the surviving family members project feelings of rage arising from ambivalence towards the lost object, and against a third party represented by the physician.
They therefore provoke a sense of guilt in the physician (who shares an unconscious, primitive and irrational desire to negate death with the surviving members). He defends himself from these emotions by assuring himself that he has done everything humanly possible and by making obsessive time-consuming efforts to showing he didn't make any mistakes.
To understand these emotive reactions it is necessary to reflect on the psychodynamic aspects underlying the confrontation with dying.
If on the one hand, fear and compassion seem to dominate the scene, modulating themselves into the two extremes of hyper-cathexis and emotive anaesthesia, one aspect, deeply unconscious, but no less powerful, is represented by anger towards the dying.
This anger is, as ready mentioned, an unconscious anger, which, particularly in the case of healers, is linked to the "medical checkmate" which death determines, not only entailing a sense of failure, helplessness and inability but also the feeling of having been wounded and tricked by the person who, despite all our efforts, in dying has betrayed us.

These sentiments were referred to by Kuebler-Ross, for example, in relation to the feelings of nurses taking care of terminally-ill patients, who reacted to the death of their patients by openly displaying anger towards them.
This unconscious anger should not be underestimated and requires explication, as Ancona (ibid.) points out, above all to avoid typical reactive behaviour in those medical workers assisting the terminally ill.
"… there is no doubt for example that the anger-laden difficulties shown by doctors and patients' relatives every time death is mentioned arise from this latent hostility towards terminally ill patients, or rather from its negation. Here we find the reason why every single time death is spoken of or confronted, it kindles in whomever is unprepared an unconscious impulse of hate with which, even though thoroughly hidden, it is necessary to come to terms…"
If these aspects are not acknowledged, in fact, unconscious destructive desires and behavioural defence mechanisms of negation come about, which can have a strong, negative impact on the patients' therapy, leading to errors in diagnosis, therapeutic persistence, not to say an "unwillingness to let his dying patient go, making it impossible for the latter to take his final leave from his human bonds, which is what he most desires" (Greenwald and Nevitt, 1982).
The presence of this mechanism in the group was considerable. Perhaps as a result of belonging to a team of the uttermost technical excellence, they were succumbed daily to these magical expectations and to the subsequent anger caused by disappointment.
It was very important that the members of the group recognised right from the start how each of them was continually competing with the others for the role of White Knight, whose armour could not show any cracks in the daily battle.
For the first time, as a group, they had been able to communicate and share mourning, disappointment and anger without the fear of appearing too vulnerable or helpless.
After an intense, but brief phase of Enchantment, in which ways of communication were of the clearly defensive type, characterised by irony, negation, cynicism, the Group passed on to the phase of Disenchantment.
This phase, characterised by long silences and, at times, emotive explosions, was experienced by the group as a moment in which they could - in the words of one of the members - "cry freely for all those for whom we had not been able to do so".
In this phase, the group represented a "religious" structure in the sense of "uniting" emotions and sentiments of suffering, frustration and helplessness into a common and shared network. In this sense, it seems to me that the group had an important role, mutatis mutandis, that religion and the church played in consoling those in mourning and providing them with a structure in which mourning can be expressed and accepted.
Naturally, this does not mean that the group only represents a place where members can offload their own suffering. It is also where they can create sufficient and adequate "mental space" in which emotions find their place.

In this sense, it is very useful, in my opinion, to interpret the group process as an initiation process.
The group process is in fact articulated in a series of stages, which signal change, the overcoming of conflict, transition to new cognitive levels.
In the language of psychological analysis, this subsequent progress of the group represents the path towards individuation.
The group can be likened to a true and proper initiation rite in which, through a series of trials such as confrontation with the threat to its own identity, the danger of fusion, guilt, regression and, to state it in the language of myth, so dear to Jung, confrontation with the uroboros, the slaying of Tiamat, the descent into the Underworld, the emergence of the hero - one arrives at symbolic thought and the maturation of the personality.
What counts at this level is not so much interpretation or insight, but participation in the rite, the adoption of an ancient role and outside of time, the interpretation of a supra-personal theme (Zanasi, 1998), where one is no longer "thrown into the world", prey to an insensate death, but part of the collective journey of humanity.
In this perspective, in the light of Jung's finalistic conception, even the irony and maniac tendencies can be read, not only as expressions of a maladaptive defence mechanism against suffering, but as signs of a transformation process.
As already stated, in the initial group phases there was a tendency to use heavy irony, sometimes a grand guignol style, to discuss the topics of illness and death group members faced daily. The external observer was often bewildered by the discordance between the suffering manifest in the themes expressed and the sudden tendency towards cynicism, play on words, double meanings, allusions, laughter, etc.
In my opinion, such behaviour can be considered as the emergence of Trickster aspects, brought on by contact with the collective Shade represented by Death.
The Shade, in the meaning given to it in analytic psychology represents a baser part of the personality, expressed by archetypal images of myths, sagas and the great religious and philosophical constructions. Just as the individual Shade is a constant component of personality, also the collective figure of the Shade is continually reproduced. Death, with its worldwide representations as the Great Reaper, Skeleton, Black Demon, certainly represents an archetypal expression of the collective Shade, full of absolute arrogance and not tempered by any human relationship.
In the group, the ability to talk about death, interpreted as the absolute evil, was made possible only by resorting to less horrific and aggressive, but more human images, represented by less frightening thematic derivations, the most frequent of which was represented by Trickster, whence joking, irony, the grand guignol.
The Trickster is a fantastic theme, an archaic fantasy, a figure found in myths, in stories, in the literary works of human beings, from the ancient times to the present day. The Trickster figure re-emerges constantly with the same thematic characteristics, becoming part of history throughout the various ages. In numerous literary representations and in oral tradition Trickster is a laughable figure, who plays a crooked hand and whose actions are on the borderline of jesting and wickedness.

The figure of Trickster appears also in very ancient themes, shaping itself in a continuum which passes from an almost naïve jesting (Maccus, Giufà, Calandrino) to the maliciousness of the devil.
The Trickster is a "psycologema" or an archetypal psychic structure, which represents evolution, the remains of original Shadow, of primordial evil. No longer characterised by cruelty, brutality and demoniac insensibility, but he presents attractive, playful and temperate behaviour.
The process of civilisation commences within the Trickster cycle. The Trickster loses the characteristics of total unawareness (which is typical of primordial collective figures) and his behaviour passes from stupid and insensate wickedness to something more civilised and sophisticated, as joking for example.
The group is the bridge that allows a passage to this more civilised and accessible part of the archetype, which ceases to be a blind and insensate force and takes on value and human perspective.
This seems to have happened in the group: the passing through the Trickster phase enabled members to temper and render "thinkable" what had been up to then unthinkable. Only after the Trickster phase, and thanks to this phase, could the group's depression disperse during the passage to the phases of Disenchantment.
To conduct a group so full of painful features naturally requires special efforts by the therapist, as indicated by my initial perplexity.
In particular, in order to build up the trust of the participants in groups like these, the therapist must make himself available as a transitional object due to the intense need for an object and the need for dependence expressed by the participants.
On the other hand, the need to empathise with such strong and painful sentiments can represent a challenge for the therapist, activating powerful counter-transference reactions, such as fear of being overwhelmed, anger and negation.
If the therapist knows how to deal with this delicate equilibrium, the group will be able to provide valuable aid for coming to terms with, and to integrate, the profound and ambivalent unconscious feelings evoked by daily contact with death.

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