Article

group analysis

Groups for the dead

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This article[2] *describes a group for those bereaved following the death through suicide of a doctor. It describes why it was formed, how it links to Foulkes' matrix and, the conscious and unconscious processes which take place. This was the first gathering of a group of this kind in the United Kingdom.*

Key words: suicide, bereavement, matrix, medical doctors, shame and stigma

Introduction

The authors co-conduct a group for the dead, on behalf of the living. The 40 or so ghosts range from 25 to nearly 70 years old. All were doctors, who died through suicide or sudden accidental death. Some of them have been dead for many years, whilst others are so newly deceased that they have not yet passed through the formalities which always tend to follow a suicide; inquires, inquests, funerals and memorials. While suicide among doctors is higher than their age matched counterparts it is still a rare occurrence, and as such those left behind often feel isolated, stigmatized and alone. The dead members are represented in the group by their living relative, friends and colleagues.

The group: the dead and the living

Though not therapy per se, the group on behalf of the dead is a group to which no one wants to belong. Those struggling by the experience

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of having to survive the loss through suicide of a brother, sister, daughter, son, colleague, partner or friend, is co-conducted by a general practitioner (CG) and a group analyst (FG). Together we sit in a circle and the time limit for the session is strictly adhered to. Attendees are expected to come on time and stay for the whole time, although there is no requirement to return. Many do, and there is a core of about 20 bereaved members who attend every group. Some members are recently bereaved, while others lost loved ones many years ago—one attendee talked for the first time about the pain and shame of the suicide of her father, a surgeon who had died decades before.

Details are advertised on social media (*Facebook, twitter*), through sick doctor networks and via word of mouth. The group meets every two months. We try and meet all new members before the group begins to explain the group process, understand a little about their personal circumstances to ensure we are alert to any issues which might impact on the safety of the group.

Sadly, commonplace among the bereaved is the fear of being shamed and judged by others just because they or their deceased loved-ones are from the medical profession. Rachel Gibbons argues that doctors, general practitioners and psychiatrists in particular, are frequently held responsible in the aftermath of suicide for failing to prevent the death of their patients (2019). When attending other bereavement-support groups, this fault can be transmitted back to the medically-bereaved who are vicariously held responsible for any failures in care. The bereaved can also become the container for the shame of the medical profession in failing to keep their own kind alive. After all, doctors are meant to improve and extend the lives of their patients, not end theirs.

Perhaps rather fittingly and in acknowledgement of this complicated web, the group is held in rooms within grand medical establishments. These include the Royal Society of Medicine (RSM), a spectacular building located in Harley Street, the centre of the British private medicine, the Royal College of General Practitioners (RCGP), and the British Medical Association (BMA). All architecturally fine buildings housing a wealth of medical history.

The doctor's matrix

As co-conductors we make use of the concept of the group's matrix (Foulkes, 1964). It is where interactions between individuals and groups (living and dead) become inseparable, bringing the outside in

and creating, as Foulkes described, a field of mental happenings and transpersonal processes (1973).

The matrix has long since left the consulting room entering the wider sphere of communities, institutions and entire countries. Given doctors' shared education, historical, cultural, social and linguistic experiences, they have their own foundation matrix. Gerada (2019) has written about the doctor's matrix and how this acts to create group norms, among which are: doctors must not become unwell and do not show their vulnerabilities; they do not admit to being unwell; and they deny their problems. These norms, created by the dead and re-learnt by the living, ensure doctors do the work demanded of them and develop the defences needed to face suffering, disease and disability without breaking down.

The dead in the group: doctors and suicide

Across the world, whether in a publicly or privately funded health systems, regardless of age, level of seniority or stage of training, doctors have high rates of mental illness, especially depression, anxiety and post-traumatic stress disorder (Brooks et al., 2011). Doctors also have higher rates of suicide compared to the general population (Hawton et al., 2001). The suicide rate for doctors has been variably estimated at between two to five times the rate of the general population (Schernhammer and Colditz, 2004). This seems a paradox. After all, doctors are privileged. They have status, job security, flexibility and are well paid. From medical students to qualified doctors they are given the honour and responsibility of caring for others. But, the internalization of this often-overwhelming responsibility becomes incorporated into a psychological survival mechanism to defend against the fear of having come to the wrong conclusion and being found out of not being perfect and flawed.

Stigma and shame among the dead

Stigma is defined as a sign of disgrace and sets a person apart from their peers. Mental illness is itself stigmatizing, more so amongst doctors. All too often mental illness is seen as a failure and weakness, and conflicts with the still prevalent culture that the doctor can, and should, cope with all the ills of life and work—'physician, heal thyself'.

Stigma is both external, evident in the public's view of mental illness (although increasingly less so the United Kingdom), but a less

easily acknowledged problem is that of internalized stigma found among doctors who are unwell (Henderson et al., 2012). This is hardly surprising as doctors as a group are altruistic, responsible and conscientious—anything less is deemed by peers as unacceptable. These traits, while necessary for a career in medicine, reinforce the illusion of invincibility when left unchecked.

Shame, as with stigma, is a universally painful, personal emotion. It is caused by the belief that one is, or judged to be inferior, unworthy of affection or respect because of one's actions, thoughts, circumstances or experiences. Those who are ashamed often hide their true feelings from others. The psychologist Peter Fonagy suggests that unbearable shame is generated through the incongruity of having one's humanity negated (2002, 12–13). This is especially following circumstances when '*one is legitimately expected to be cherished'*. Doctors expect to be cherished by their patients and it is the shame of not fulfilling this expectation which can push doctors over the edge to suicide. It is not uncommon for a mentally ill doctor to present very late in their illness, in crises at work or following a drink-drive offence or following a failed suicide attempt. For doctors with addiction, death either deliberate or accidental might be the first time anyone is aware of their problem.

Stigma and shame amongst the living

Bereavement is a lonely experience and grief following a suicide is complex, especially so when a doctor kills themselves. Those bereaved following the death of a health professional more often than not work within the same health system as their dead friend/colleague/relative and this complicates an already difficult grieving process. All parties (the dead and the survivors) might have a personal as well as a professional relationship with local services and this makes it difficult to untangle where responsibility might lie if clinicians are also personal friends or close colleagues.

For all, when death occurs, there is always the familiar constellation of feelings: denial, angry protest, searching, despair, and recovery leading (hopefully) to the establishment of new attachments. However, when death is due to suicide this is complicated by the additional dimensions of stigma and shame, as these emotions have now been transmitted from the dead to the living. The bereaved experience a wall of silence, an absence of caring or interest, or conversely an unwelcome array of unhelpful and awkward advice given by

well-meaning friends or colleagues (Feigelman et al., 2009). These authors write about how those left behind confront acts of informal social disapproval, and the suicide-survivor family member may be suspected of being partly responsible and consequently may be subjected to informal isolation and shunning. A subtle form of stigmatization. Suicide, more so than death through other causes, therefore leaves the bereaved with feelings of shame and self-denigration, blame and self-recrimination; they are left with nowhere to go with their grief. Shame hides in dark places and, if not spoken about, is concealed or denied and feelings fester, and grows. Rustomjee (2009) writes about the solitude and agony of unbearable shame and Mollon (2002) of shame lurking unseen. For those bereaved following suicide, the shame is magnified, and this prolongs the process of grieving. This is confirmed by a study comparing measures of stigma, grief process and suicidal ideation in families following the death of a child either through suicide or other causes (for example, natural causes, accident, murder). Over all, 462 (86%) of the sample were family members bereaved through suicide. The results showed that those who lost a child through suicide reported moderately higher levels of rejection and shunning by significant others than was reported by the survivors of a child's natural death (Feigelman et al., 2009).

The group

Vignettes

The first session. The conductors sat nervously awaiting members to arrive. As they did, tea and coffee were served, and attendees busied themselves with entering the wi-fi code and checking their phones. All waited anxiously in an anteroom, as if in a doctor's surgery, trying to avoid contact with each other. Sadness permeated the room. At the allocated time, the group started. Sitting was unbearable and tears started before words. The only available option was to 'just to keep on breathing' the title of a book written by Gary Marson in 2016 where he writes a day-by-day account of his experience following the suicide of his GP wife. Once the dialogue started, connections began to be made. Two families shared the same (unusual) surname; two of the deceased had the same first name; two died on the same day; and a further two had chosen to kill themselves in the same manner. The group members began to be united through death.

The group talked of their dread in meeting each other that day but of the release of being able to connect with people with similar

experiences. Painful narratives, yet no-one was shocked. Inured almost certainly to feeling anything anymore, deadened by their experiences which were now amplified by the group were too painful to hear and the group became silent until a new thread emerged and attempts to connect re-appeared. Connection centred on collective feelings of anger: anger at the system for contributing to the death of their loved ones. Complaints, inspection, revalidation, rotas, and more were the cause.

P, the mother of a young doctor who had killed herself with an overdose talked bitterly of *how the system [NHS] had let her daughter down*. Anger took hold and resonated with the experience of the group as a whole. As in other groups, members shared in their anger. In this group they spoke about how they felt the 'system' had contributed to the suicide and especially how complaints, even trivial ones, had left the doctor who had died feeling shattered.

The dialogue then turned to how wary they were of talking about their loss to friends and colleagues, unsure of the reaction of those they might be telling. They tended to steer clear of the mention of suicide to avoid creating undue distress, trying perhaps to protect its co-conductors. One member discussed how he encountered such hostility in the telling of how his daughter died that he now never mentions her, almost as if he has to kill off the memory of her ever having lived.

The group were anxious about how we, the co-conductors, would react? Would we be able to hear the traumatizing experiences in the group and not run away from the pain? At the end of the group an empty chair was noticed and spoken about as a symbol of all the missing people, the dead in this group and the pain of those left behind, having to carry on breathing in the face of unbearable pain. The relief of knowing that there would be another group was palpable and allowed us all to take another breath.

Group 5. The group's fifth meeting was in a new venue. This time a room in the doctors' trade union headquarters—British Medical House—a more imposing building. It seems fitting to have a group in such a venue—the doctor's matrix, represented by the portraits and plaques of famous doctors, presidents and other doyens of the past, connecting the long since dead with the recently bereaved. These men look down on the dead and the living below, creating unconscious connections in the transitional space of the group. The act of being in this space creating a link across time.

The venue was also one of more recent historic importance. Death was penetrating the group from outside in. In 2005, within yards of our group room, a suicide bomber killed 13 people who were travelling with him on a London bus as part of an orchestrated terrorist attack in the capital. Doctors from the BMA who were attending a meeting rushed out to help find their colleagues amongst the dead and injured.

As each member arrived, those who had met before greeted each other as long-lost friends. The group had three new attendees, and they were welcomed: a husband and wife, grief etched on her face, whose 29-year-old daughter, had died two years before; and a brother, whose sister had died a short while before. In both cases, the relative had jumped into the sea from an infamous location for suicide. Neither body was recovered. For their surviving loved ones, finding themselves in the same group was profound. After a welcome, the group set about taking an interest in one another and especially in the new members. They helped them to see that they were all in the same place, grieving the loss of a loved one, and that it was safe for the new members to talk about their experience.

J, a new member, told of his relief on hearing of the group and that it was a space where he could say how he felt. He started talking, as many had done before, about his regret that if he had acted differently, he could have (magically) changed the moment his sister had decided to take her own life. There was much soul-searching and guilt that he had not seen it happening.

> What if I had taken S's phone calls and conversations seriously?
>
> What if I had listened to what S was saying?
>
> What if I had gone to see S and not gone to work that day?
>
> Why didn't the system, the NHS see what was going on with S?

The group talked of the relief of allowing light to be shone on suicide; how they were able to gain support from others in the group and get comfort from not being alone. They shared their experiences of not being able to talk about suicide to others, feeling like it was their shameful dirty secret.

The youngest member of the group, who had lost his elder brother, began to talk about how shame was at the heart of his grief. This was followed by heads nodding and each began to share how difficult it was to tell others as if the shame, that internal feeling of disgrace, has been passed to them from the dead.

P, the father of a young man who had died three years ago wept quietly. For the first time he talked of how shame had prevented him from accepting that his son might have died deliberately, that his death was suicide rather than accidental (he had died after falling from a third story window).

S, a doctor herself, whose sister had killed herself, talked of the shame that she did not know how depressed her sister had been, and of not being able to help prevent her death. She said, '*her death makes no sense or logic'.*

They discussed how the group had become a place where they could grieve without being pitied. One group member said that in the group he felt he was able to get off the 'pity train', which felt so suffocating and which allowed him no identity other than bereaved. B talked of the importance of knowing that she could bring her grief to a place where compassion fatigue did not exist, where there was only genuine concern for others in the same boat.

Shame and the group

Shame, as discussed before, is a powerful, painful, primitive and personal emotion. It is at the centre of the doctor's matrix and also at the heart of the 'group for the dead'. Doctors are exposed to shaming throughout their daily work. The shame of failing to meet organizational targets, of not conforming to an idealized image of the 'perfect' doctor and making errors and the shame of becoming mentally unwell. Many of those who killed themselves were subjected to shameful events, complaints, mental illness and errors. It was the shame which most likely (as we shall never know) led to a distortion of their sense of identity, of the person they thought they were, a competent, trustworthy, caring doctor. Instead a new persona emerges, as flawed and inadequate. These emotions are carried into the group by the living members.

Sara Scott (2011) talks of the role shame plays in the development of analytic groups. She describes a process, referred to as 'the shaming other', which is a communication process unconsciously adopted in the group as a means of trying to avoid facing shame. When shame is integrated within the group and becomes conscious, the communication pattern changes, both strengthening the connections between group members and their attachment to the group.

As the bereavement group has become more cohesive and members trust each other more, the dialogue has moved from a focus on the 'the system', complaints, the NHS, regulator, inspection and other external events into internal issues—their anger, resentment, and disappointment in their loved one. The bereavement group allows for their shame to be made visible; it allows the taboo of suicide to become manifest and explored, no longer hidden from sight.

Scott talks about shame in the group, saying,

> In my view, for any group to establish itself, the unconscious shame that exists within it needs to be made conscious, otherwise it prevents group members from establishing links with one another. (Scott, 2011)

Others have suggested that analytic group psychotherapy may be well-suited for the treatment of shame-related conditions: Alonso and Rutan (1988) see shame as both stimulated and resolved by the presence of others, and Tantam (1990) that it is the treatment of choice. Our group has allowed for belonging and demands honesty and the exposure of vulnerability. Wright believes that the sense of belonging that groups offer is key to the resolution of shame, because it militates against the terror of abandonment (Wright, 1994) while 'belonging implies a sense of ease due to being accepted and acknowledged as part of a group' (Millard, 2002). This is something that the group analyst, Gillian Rathbone concludes in her article on use of groups for the resolution of shame. She argues that the social nature of the original trauma (for doctors in our group, the shame of suicide) and the particular configuration of the analytic group means it is

> the ideal arena for a reparative 'good enough' experience of attunement and thus for resolution of shame-based psychopathology.

She concludes that this

> may be considered an additional therapeutic factor alongside socialization, mirroring, activation of the collective unconscious and exchange. (Rathbone, 2012)

In our group, as the individuals (including the conductors), became more attached to each other, the talk of shame intensified. Importantly, this allowed for a shared sense of powerlessness rather than one of problem solving and 'fixing'.

From mourning and melancholia to hope and redemption; the transformative process

What is spoken at each group varies but is invariably along the themes of loss, mourning and recovery. The group allows for 'healthy' mourning, authenticity and a space where the wall of silence can be broken; where denial and inconsolable preoccupation with the lost loved one can be transformed from monologue to dialogue and then discourse (Schlapobersky, 2000). Sitting in a group can ease the passage from grief to recovery. The mix of ages and stages of mourning is enormously powerful as each member is able to give advice drawn from genuine experience, not from platitudes or knowledge acquired from books or lectures. New members, with their bereavement often raw (only days old), are supported by the group and given the time and space to ask for answers which only those in this group can give: '*when does the grief begin to get better*?'; '*What should I say to others*?'; '*when will I stop hurting so much?*'

Grief also becomes transformed into creative action and it is telling how many of the bereaved use their experiences to support others and their generosity and creativity is humbling. One was leaving his highly paid banking job to help others get over the shame of mental illness; another was starting a charity to support doctors; and the parents of a junior doctor had set up a social media group to help junior doctors who might be in crisis. Others were working hard to change how complaints are handled and raising awareness of mental illness. Group members reach out to each other and to others who ask, offering support and advice. Giving to others helps in the healing process.

At one group the facilitators decided to take a cake to the group. A lovely rich fruit cake. As each new group member arrived, they were given a piece of cake and encouraged to eat it and to savour it. As the group moved from mourning and melancholia to hope and redemption, one wonders whether in taking, breaking and giving pieces of cake was in fact recreating Holy Communion, albeit a secular one? The cake, the body of dead relatives, broken not on the cross, but during their work. Despite their grief, we leave knowing that it is possible to live again.

Summary

The community of the bereaved are in the process of finding a way to make their collective voices heard, in and outside the group. As their capacity for concern for others in the group becomes audible then the

parallel process of caring for what goes on outside the group is amplified. The pain in the group mirrors and resonates with the pain in their community. However, in coming together, hope is emerging from sorrow. The conductors also, far from being passive participants are learning themselves what it means to bear witness to suffering and resurrection. What is emerging is the group, whilst led by group therapists is evidence of Foulkes' dictum that the therapeutic process in the group, is of the group, for the group, including the conductor.

We suggest that the format of this group, part therapy, part support, part belonging is worthy of greater exploration.

Dedicated to lost doctors.

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Notes

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2. Some details have been altered to maintain confidentiality.

References

Alonso ARJ and Rutan JS (1988) The experience of shame and the restoration of self-respect in group psychotherapy. *International Journal of Group Psychotherapy* 38(1): 3–14.

Brooks SK, Chalder T and Gerada C (2011) Doctors vulnerable to psychological distress and addictions: treatment from the Practitioner Health Programme. *Journal of Mental Health* 20(2): 157–164.

Feigelman W, Gorman B and Jordan J (2009) Stigmatization and suicide bereavement. *Death Studies* 33(7): 591–608.

Fonagy P, Gergely G, Jurist EL and Target M (2002) *Affect regulation, Mentalization, and the Development of the Self*. New York: Other Press.

Foulkes SH (1964) *Therapeutic Group Analysis*. London: Karnac.

Foulkes SH (1973) *The Group as a Matrix of the Individual's Mental Life*. London: Karnac.

Gerada C (2019) The making of a doctor; the matrix and self. *Group Analysis* 52(2):1–12.

Gibbons R, Brand F, Carbonnier A, Croft A, Lascelles K, Wolfart G and Hawton K (2019) Effects of patient suicide on psychiatrists: survey of experiences and support required. *British Journal Psychiatry Bulletin* 26: 1–6.

Hawton K, Clements A, Sakarovitch C, Simkin S and Deeks JJ (2001) Suicide in doctors: a study of risk according to gender, seniority and specialty in medical practitioners in England and Wales, 1979–1995. *Journal of Epidemiology and Community Health* 55: 296–300.

Henderson M, Brooks SK, del Busso L, Chalder T, Harvey SB, Hotopf M, Madan I and Hatch S (2012) Shame! Self-stigmatisation as an obstacle to sick doctors

returning to work: a qualitative study. *BMJ Open* 2: e001776. doi: 10.1136/bmjopen-2012–001776.
Marson G (2016) *Just Carry On Breathing: A Year Surviving Suicide and Widowhood*. London: Dark River Press.
Millard P (2002) *Belonging, Intimacy and Agency in Group Analytic Psychotherapy*. Unpublished MSc Dissertation. University of London.
Mollon P (2002) *Shame and Jealousy: The Hidden Turmoils* (Psychoanalytic Ideas). London: Karnac.
Rathbone G (2012) The analytic group as an arena for the resolution of shame. *Group Analysis* 45(2): 139–153.
Rustomjee S (2009) The solitude and agony of unbearable shame. Group Analysis 42(2): 143–155.
Schernhammer E and Colditz G (2004) Suicide Rates Among Physicians: A Quantitative and Gender Assessment (Meta-Analysis). *American Journal Psychiatry* 161(12): 2295–2302.
Schlapobersky J (2000) The Language of the Group. In: *The Psyche of the Social World, Developments in Group Analytic Theory*. Jessica Kinglsey. London.
Scott S (2011) Uncovering shame in Groups: An Exploration of Unconscious Shame Manifest as a Disturbance in Communications within the Early Stages of an Analytic Group. *The International Journal of Group-Analytic Psychotherapy*, 44(1): 83–96.
Tantam D (1990) Shame and Groups. Group Analysis 23(1): 31–43.
Wright F (1994) Men, Shame and Psychotherapy. *Group* 18: 212–21.

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