Secrets and the Secretive Mode

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Abstract. While keeping secrets and revealing secrets are ubiquitous in the human condition, these phenomena can have special effects and significance in the development and in the treatment of individuals. In this paper the case reports of two people who were raised with a secret are presented. The secrets appear to have determined a particular way the individuals defined and maintained an image and sense of self. The therapeutic and developmental implications of these findings are then briefly raised.


Maintaining secrets and being secretive are important and pervasive behaviors. Such disparate organizations as college fraternities, the Freemasons, the mafia, the Ku Klux Klan, and others exemplify the sociological tendency toward the secretive mode (Desmonde, 1954). Several authors have noted the significance of the capacity to conceptualize and react to secrets in normal and pathological development. Blanck (1966) cites the importance of a capacity for secrecy in the developmental process of separation and individuation. Gross (1951) examines the content and functions of the secret following the dynamic point of view. Pustrom and Speers (1964) report that a factor common to three mothers of children with elective mutism “concerned conflicts about talking, primarily over revealing ‘family secrets’ ” (p. 293). Searles (1959) describes the devastating effect of a psychotic mother's impossible expectation...
that her child would know or guess her innermost secret thoughts. Margolis (1966) combines interpersonal and intrapsychic points of view to explore the interplay of secrecy and the sense of identity. Using his army experiences as data, Babineau (1972) describes the multiple functions of secrets for the psychological economy of intelligence workers. Dorothy Burlingham (1935) finds that a secret a child was obliged to keep in concert with the mother was a major obstacle in the child's analysis. Jacobs (1978) articulated a number of ways that secrets become interwoven with other dynamic forces during a patient's development and produce special technical problems in the course of psychoanalysis. In addition to calling attention to the secrets that surround birth, copulation, and death in virtually every family, Pincus and Dare (1978) also examined secrets and their effects in different developmental phases.

In this paper, we define secrets as conscious knowledge which the individual feels he cannot, or does not wish to, share with others. From information gleaned in the treatments of a child and a young adult (or perhaps better, late adolescent), we will trace the effects of chronic, shared but unacknowledged, family secrets on the developing personality.

**Clinical Material**

**Case 1**

Allen B. was 9½ years old when he was referred to the children's psychiatric hospital for an evaluation by the local school authorities in his hometown in a remote part of the state where he lived. Although his intelligence was estimated to be in the 120 to 140 range, Allen could not read beyond the preprimer level. While his fund of general knowledge was good and he was creative in art and an accomplished gadgeteer, he had failed the third grade. Special efforts to help him remedially had met with little success. Schoolmates had begun to deride him by calling him retarded and stupid. A local physician had also examined him and felt that emotional problems were interfering with both his academic and general growth and development.

Allen was a heavy-set youngster who appeared somewhat older

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than his 9½ years. He spoke with a slight speech impediment, but appeared intelligent and articulate though somewhat retiring and compliant. During the two-day diagnostic work-up, he quickly revealed that he had several complaints besides the one for which he had been referred by the school. He worried intensely about his family members when away from them for more than a couple of hours. For two years he had been eating excessively. He was chronically concerned about physical injury and reported repetitive dreams and fantasies about being poisoned, hit by a truck or car, or injured in some other way. It was also learned that he shunned physical activities, did not participate in sports, and was generally passive and slow in every undertaking.

Allen’s mother, who accompanied him for his examination, supplied much of the developmental history. She said that Allen was legally adopted shortly after his birth and raised in a small community in a rural section of the state. The family already had two daughters at the time of his adoption. Linda was 15 and Doris was 4 years old. The father abandoned the family when Allen was 1 year old and had not been seen by them since. The family knew only that he was in the navy.

In the course of giving the developmental history, Mrs. B. revealed the secret with which the family had lived since Allen’s birth. When Linda was 14 she was allegedly raped while visiting with friends in a large city. She conceived as a result of the assault and was sent to a community several hundred miles away from her home to have her baby. When Linda returned home with Allen, Mrs. B. legally adopted Allen and raised him as her own child. Linda continued to live in the parental home until she was 19, when she married and moved away from the community. The townspeople as well as Allen were told that Allen had been adopted directly from a large city hospital. She added that the deception had been rendered more difficult by Allen’s striking (and even startling) resemblance to other members of his maternal family.

After her husband left home, Mrs. B. took a position as manager of a drugstore and worked long hours to support herself and her family. This left Allen and Doris in Linda’s care, and when Linda left, Doris took over as Allen’s caretaker. Doris was then 9; Allen was 4. Mrs. B. reported that although they fought a great deal, Allen was very attached to Doris, and, since there were few children of Allen’s age in the neighborhood, she was his only companion. When Allen was 8, Mrs. B. became concerned that he and Doris were fighting too much and moved Allen from Doris’s to her bedroom.
It was the diagnostician's impression that, although Mrs. B. was somewhat masochistic and seductive in her relationship with Allen, she was also dedicated and tender. She devoted what free time she could to him, took him and Doris on trips whenever she could, and went to great lengths to procure the best medical care available for him.

Following the diagnostic study, treatment was recommended for Allen. Attempts to find a psychotherapist for him were fruitless, however, because mental health facilities in the part of the state where he lived were nonexistent. For this and other reasons, it was decided to hospitalize the child at the center where the diagnostic study had been done and to treat him there. Although Mrs. B. was upset by the separation, she realized the necessity for it and drove from her home to the hospital faithfully for her sessions.

Allen was devastated by the hospitalization. He felt he could never tolerate being away from his family since he worried about them so. He complained that he was being unjustly confined and that the doctors were his jailors and totally unsympathetic to his plight.

As his analysis began, Allen's protests about the hospitalization and the insensitivity of "the doctors" began to give way to concerns about confidentiality and games reflecting his more chronic preoccupations. From the first he told his analyst that he had been curious about his "adoption" and had searched his home for his "papers." (These were papers that Allen thought would describe his origins and how he came to live with Mrs. B.) In his sessions he used blocks to build sealed enclosures where people could live, "safe" from outside scrutiny and interference. In occupational therapy, he built a wooden safe in which he could store "the stuff" he wanted to keep secret.

He played a cowboy and Indian game in which a boy who had a secret message was trying to reach "Custard's [sic] last stand." No one would believe the little boy when he brought "Custard" the news. On occasion the theater of operations changed to Germany in 1944 where complicated war games took place in which American secret couriers were chased, intercepted, and tortured by Germans. Often he spoke directly about his worries that a firebug was loose in his hometown and was secretly setting fires. At other times he thought spontaneous combustion could possibly burn down his home. Extensive play around secrets and preoccupation with secret events permitted his analyst to interpret his concerns about secrets to him. The child responded with descriptions of his loneliness and
his longing for a male relationship. He told of an adult friend in his hometown who had helped him build a tree house in the woods and of how he missed this friend. He could state openly that he longed for a father like other boys and felt cheated at not having had one.

Allen continued to play “secret” games, recalled secret games he had played with Doris, and brought a secret code he had devised, which, when deciphered, spelled out “Home, Sweet Home.”

As the transference neurosis developed, Allen began to feel intensely possessive and competitive for his analyst’s time and concern. In this context he asked increasingly more pointed and discerning questions about his origins. These questions emerged first in the metaphorical language of his play and later in direct questions and statements of chagrin about the mystery and silence that cloaked issues regarding his past.

While this was occurring, Mrs. B. was reaching the conclusion that she should tell Allen the truth about his birth and relatedness in the family. A little more than a year after the beginning of the analysis, with Mrs. B.’s consent and in response to one of Allen’s direct questions, the analyst revealed the details of Allen’s conception, birth, and adoption to him. Assuming that Allen would want to talk to Mrs. B. further about these issues, the analyst also made provisions for Allen to visit his home for a weekend shortly after the revelation.

Allen reacted to the information in several ways. First, there was a veritable storm of grief and anger. He had known it all along! Why had they lied to him? How could he ever trust anyone again? He then alternately berated and sympathized with Linda. “Why had she gone to that city?” “She didn’t have to let ‘that guy’ get near her.” “Why hadn’t someone helped her?” Finally, in the weeks that followed discussion of the secret, Allen struggled in his analysis and in his “private life” with an identity crisis. While he maintained the gains he had made in school and in his daily ward life, his associations during his analytic hours and the reports of his fantasies while alone underscored his suffering. He wondered who he was; he thought that he was “born a mistake”; he wondered where he belonged and how he should act. In his play, he was a spaceship commander on an unknown planet. An enemy rocket entered his rear turbine and caused a fierce explosion. This game alternated with games where he used “hip talk,” drove motorcycles like Hell’s Angels, and raced dragsters. When older boys were aggressive with him on the ward, he occasionally felt that he was the ward “queer.”
At other times he wanted to attack them with bicycle chains, “beat the guts out of them,” or commit other forms of mayhem. At some times he wanted to dress like the black leather jacket set, while at other times he felt “as helpless as a little girl” and sent by God to spend the rest of his life in the jail he was in (the children’s hospital).

While we can undertake to explain or explore various aspects of this disconsolate boy’s psyche, it is to the secret and to his identity crisis that we will return after a description of the second case.

Case 2

George T. was 19 years old when he was referred for treatment by a friend of his father’s. The year before his referral he had left his Midwestern home to attend a small, academically excellent college on the west coast. Two weeks prior to his referral, his father was stunned to hear from the police of a large west coast city that his son was in jail on charges of pushing narcotics and counterfeiting. The father, a successful and competent lawyer, dropped everything to rush to his son’s aid. In part because of George’s youth, in part because the police recognized that he was little more than a messenger boy, and because of the father’s commitment to getting help for his son, the police dropped charges against him. The treasury department followed the recommendations of the police. The father brought his son back home and sought psychiatric treatment for him.

Before the first interview with George, Mr. T. requested an appointment. He was concerned about his son’s general psychological state and offered to go to any expense to uncover and solve the problem. He was an articulate and intelligent man. His work as a trial lawyer as well as his own intellectual interests had made him conversant with psychoanalytic thinking and he displayed a remarkable knowledge of both its theory and practical applications. He was concerned that the events leading to the near-disastrous encounter his son had had with the law were “the tip of the iceberg.” He was equally concerned about a detachment and distance that he sensed in his son and felt that for years they had only brushed rather than reached each other with their communications. He was afraid that he had contributed to George’s difficulties, but did not know what he had done. He revealed that George’s birth and development had been unremarkable until he was about 6 years old. The family had lived a gratifying and affectively rich life until George was 6 and his younger brother was 2
years old. Then tragedy struck the family in a gross and merciless way. During the course of a medical examination for a stubbornly persistent chest cold, it was discovered that Mrs. T. had chronic lymphomatous leukemia. After Mr. T. and his wife had helped each other recover from the staggering blow, they decided that they would not dwell on the illness but focus on the unity and strength of the family. With spartan courage they maintained this orientation for six years. Mrs. T. did fairly well those years, occasionally requiring antibiotics for infections and needing to be hospitalized briefly for transfusions a few times. Mr. T. reported that his sons gave no indication that they knew of their mother’s fatal illness. The end was, for her, mercifully swift. There was an acute, unexplained depression of her blood marrow with a concomitant bleeding episode; she was hospitalized at 9:00 in the morning and expired around noon. The children, now 12 and 8 years of age, were left in school for the remainder of the day. When they returned home, their father met them and told them that their mother was no more. Mr. T. said they sat huddled together for awhile in their grief, but he noted that while the 8-year-old brother wept and grieved, George was more concerned about how upset his father and brother were than he was about himself or his mother. Mr. T. said that he tried several times to reopen the issue with his son in an attempt to understand his reaction, but this was to no avail.

While Mr. T. presented this history, his affect and concern were genuine and intense. It was clear that while the family had done much to heal itself and reintegrate, the memory of their loss was poignant and alive.

George was a thin, tall, correctly dressed young man. Soft-spoken and exceedingly courteous, he expressed his desire to understand and put an end to his unproductive behavior. He gave his own version of his history openly and accurately and supplied the correct words for the affects that he experienced. His face even registered and communicated expressions of sadness, regret, and other affects. But something was missing. It was as if the concept of feelings was being conveyed without true memories of their flavor or aura.

In telling about his immediate past, George revealed that almost immediately after arriving on the west coast he had been drawn to the hippy community of a nearby large city. He did little more than register in the college, procure himself a room on campus, and leave for the large city. He was accepted into a circle of acquain-
stances relatively quickly and, like many other people in this circle, slept around at one pad or another, depending on where there was room. He maintained sufficient contact with the college authorities so that they would not be alarmed and call or write his father. When the semester ended and revealed that he had failed every course, he persuaded them to let him spend another semester in an effort to “make up,” pleading that he was having difficulty adjusting. He made no effort to improve his performance in the second semester, but became more deeply involved in his extracurricular activities. He had occasionally taken a hallucinogen with his street friends, and now he began to supply them with hallucinogens and other drugs. He procured these from fringe criminal elements that hovered around the periphery of his groups like predators around willing victims. It must be stressed that this was done without personal gain. He felt that acting as a supplier endeared him and made him an important member of his street group. He could acknowledge too that being in on secret deals gave him a feeling of importance and of belonging.

Toward the end of the year on the coast, an underworld contact asked him, as a favor, to deliver a briefcase containing drugs, money, and a small caliber revolver to a couple George barely knew. The man pleaded that there was hardly anyone around that he could really trust and that George was the only one on whom he could rely. George himself stated that this seduction was hardly necessary since he was so willing to participate in secret maneuvers. Moments after the delivery, the police burst into the couple’s apartment and took George and the couple to jail.

The description of his several weeks in jail was horrendous. Brutality and homosexual assault from other prisoners were only two of the almost constant agonizing fears with which he lived. When his father rescued him from jail, he experienced great relief, exhaustion, and a conviction that what he had just lived through could not be real.

George then turned to a description of his childhood and adolescence. His account of his mother’s illness and death revealed that despite the parents’ valiant attempt to keep the ambience of the home untainted by grief and despair, he was constantly aware that something was wrong. Too often after school when he ran into the house to exalt in a triumph or seek commiseration for a defeat, he found no resonance, for the door to his mother’s bedroom was closed since she was resting. Too often when he sought the flush of pride in his mother’s face, he detected only pallor and fatigue.
He felt that whatever he thought was wrong with his mother had to be treated as a secret. When he learned of his mother's death, he recalled no grief or anger but only feeling that someone had betrayed a secret that should not have emerged and that he was somehow responsible for protecting his father and brother from the affective consequences.

During his early and middle adolescence he fantasied that his mother was not really dead but away on a secret mission for the C.I.A. Sometimes he would fantasize that he too was a secret agent and would discover his mother working on the same mission.

Even as he began his treatment, George set up another secret situation. He had met and become enamored of a young lady who was beginning a career in addiction. He took it upon himself to reclaim her from perdition by being a lover, therapist, and avenger of the wrongs done her by her family. He felt that no one except he knew that she was on drugs and he cherished his relationship with her for almost two years. He ended it in pique when he discovered that she had revealed her addiction to a medical student who she felt could supply her with drugs at cut-rate prices.

For about a year and a half, George was faithful in presenting himself for his hours. He spoke freely and apparently made every effort to communicate all that he thought. Outside of his relationship with his girlfriend, he stayed away from any contacts with the drug culture. He had enrolled in college when he returned home and was doing passable work. His relationships with his family were calm and appropriate but not intimate. But despite his regularity and apparent commitment, little was happening in his treatment. In reviewing his therapeutic hours George's therapist was impressed by a quality that reminded him of some of Albee's plays; that quality of forever waiting for something to be revealed or happen that will change the stagnant, inevitable repetition of the characters' lives. The therapist reacted to this either by continually leaning forward in his chair as the patient spoke, trying to pick up subtle cues that would make the sessions meaningful, or by slumping back in his chair as if weighted down by crushing boredom. George had engaged the therapist in re-creating a situation he had previously experienced in childhood. While they were going through the motions of relating meaningfully, something was missing and neither patient nor therapist was to speak of it. This defense transference naturally was discussed a number of times.

As this issue was being raised in treatment, George had a deeply moving experience. Having decided to get a part-time job, George
became an orderly in a local hospital. He worked mostly in the evenings and one night when work was slow he found himself sitting in a lounge area just outside a patient's room and letting his thoughts wander aimlessly. Suddenly the conviction (or memory) that this was the hospital where his mother had died exploded into awareness. He was overwhelmed with grief, awe, and anxiety. He wanted his mother, and he felt for a brief moment that he could not survive his longing for her. As he told of this, he sobbed with despair and grief and realized that he was not mourning the mother who had died but the one who was behind the closed door when he returned from school. He wept for the mother that had vanished behind the pallor and fatigue of illness—and for the mother with whom intimacy had been put out of reach by their mutual commitment to a conspiracy of silence.

The very next hour George was his old self again. Although he returned to his experience in the hospital corridor and his affect of the hour before, he discussed them with poised inquiry rather than as one remembering an intense experience. In the next several weeks George acknowledged that although he had told the truth as he knew it, his therapy had had the quality of playacting. He was acting as he thought a psychologically sophisticated young man in treatment would act. In contrast to this “act,” he felt that what he had experienced in the hospital corridor and the hour following it in the treatment hour had been real. Those moments, however, had been accompanied by an intolerable sensation that only the affect was real, and for the rest he did not know who or what he was or what he was doing. He did not know what would happen to him in the next moment or what would become of him as a person. When he experienced the throat-clutching intensity of the affect that accompanied the memory of his mother, he also experienced a frightening identity crisis.

**DISCUSSION**

There are many paths of inquiry that we could follow in reviewing the clinical material. For heuristic reasons, we should like in this paper to confine our comments to some dynamic and structural considerations. The situation of pseudosecrecy that the two cases described above exemplify may seem at first glance to be so specific and unusual that generalizations are unwarranted. Further consideration may demonstrate this specificity to be more apparent than real. We would submit that a similar situation obtains in many cases of incest, infidelity, or when one or the other parent
is addicted to alcohol or drugs (Jacobs, 1978). This is but to name a few of the more dramatic issues that, by unspoken consensus, are treated as family secrets.

In both cases, the children knew that there were important conditions in the home that were affecting them deeply and that they felt were being treated as secrets. We do not mean to imply that George knew the nature or significance of his mother’s illness, but he did know that something was wrong with her, and he was grievously hurt by its manifestations. In the same way, Allen may not have known the details of his conception and birth, but he knew that a shameful mystery surrounded his origins. It is difficult to believe that parents could long keep secrets such as these from their developing children. Even though they knew that there was a secret, both children had concluded (probably from clues that they had received from their parents) that it would be more painful to question or to discover the secret than to participate in the silence.

While the ability to keep a secret from parents may be important for the purposes of separation and individuation (Blanck, 1966; Gross, 1951), the wish to communicate the secret to achieve intimacy and cement the loving relationship is also great (Babineau, 1972; Gross, 1951; Rosenbaum and Mayer, 1963; Sulzberger, 1953). Indeed, it would seem that titrating the amount one reveals of his secret inner self to another person is one vehicle for achieving and managing varying degrees of intimacy. Margolis (1966) has described in some detail the contribution that the capacity and opportunity for secrecy make to identity formation, and has explored with relatively broader strokes the potential for pathology inherent in the vicissitudes of developing this capacity. In the cases of the youngsters we have presented, the secret could not be repressed because its manifestations were constantly in the air. Nor could it be communicated and used as a bond for intimacy because they felt that the parents had signaled their wish for silence. Finally, it could not be interpreted into the ego as knowledge about how to view or how to adapt to the world because it was experienced as unique and idiosyncratic to their family. To attempt to resolve this apparently insurmountable dilemma, our young patients did several things. First of all, they identified with the attitudes, modes of communicating and not communicating, and the withholding of information that they attributed to their parents. Secondly, they became chronically preoccupied with secrets and secrecy. Finally, they imposed inhibitions on free and spontaneous verbal and affective expression. The resulting personality organization included a secretive mode of relating to the world, one that
was so deeply ingrained as a way of life that it could be called an ego distortion.

Gitelson (1958) following Brenman (1952) said, "'Ego distortions' are highly organized clinical phenomena whose etiology is not assignable to any one of the major psychic institutions. Each case represents a way of life, a method of adaptation which has been compelled by particular deviations in the internal and external environment which have been impressed upon the whole development of the personality" (p. 246). Gitelson further stated that these ego distortions are fixed clinical pictures that resemble the normal ego patterns seen during developmental and adaptational crisis. He added that the ego was immature but strong.

While Allen's secretive mode of relating was not as rigid or as fixed as George's, both boys were preoccupied with secrecy as a way of life. Although the content of George's secret had become indifferent, he seemed literally to go in search of secrets that he could cherish in order to justify his secretive mode of relating to the world. We would submit that both George and Allen suffered an identity crisis, not as a result of having the content of a secret revealed, but as a result of a severe challenge to a secretive mode of relating that had come to contribute to self-nonself discrimination and to formation and maintenance of their self images.

In Allen's situation, the influence of the analysis, the mother's change of heart about keeping the deception alive, and his puberty and his growing wish for intimacy with his analyst all served to disturb the adaptive balance he had achieved in his secretive world.

In George's case, the threatening situation of being jailed, the pressure of therapy, and the intense memories of past anguish that burst into consciousness in that hospital corridor momentarily at least shattered the characteristic posture of secrecy that he had assumed. George's state was also more complicated in that it appeared that part of the secret had been repressed. We believe the affects which accompanied his awareness of his mother's illness and his responses to her unavailability were not within the range of his conscious scrutiny. His mode of "playing it cool" and never letting spontaneous expression "get out of hand" were conscious.

In these patients, the secretive mode then served not only as a preferential mode of relating but also as a personality quality which had become an important part of their sense of self. When this secretive mode of relating became impossible, it was as if a new person were functioning in their place. The secretive mode of relating had become more important for their psychic economy than the content of the secret.
Passing now to the technical aspects, we can see several problems in the treatment of persons such as Allen and George. Our training and implicit attitudes, especially as they are interpreted by young therapists, place a high premium on the revelation of secrets in the therapeutic endeavor. There is evidence that in some of these situations the revelation of whatever secret the patient is harboring is less important than his secretive way of life. Once this is recognized, one must wonder if the therapist’s revelation to the patient of this mode of life will be enough. The privacy and confidentiality of the analytic or therapeutic situation lend themselves to being used as still another secret, and even as the problem is being discussed it is also being indulged. We may have to consider the possibility that the analyst or therapist may be seduced into attending to the content of secrets in order to indulge the patient’s wish to re-create a conspiracy of secrecy with him. Florsheim (1967) addresses an aspect of this issue in his report of the analysis of a paranoid patient. We believe this to be a cogent issue to be contemplated in the treatment of all secretive patients. The secret is an important human phenomenon, and perhaps our two young patients gave us glimpses of a significance which, when understood more completely, will lead to more thorough understanding of forces which affect development.

References