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Secrets: Concealment and Confiding in Helping

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Everything secret degenerates.[1]

Lord Acton

How does it happen that the deeper we go into ourselves as particular and unique, seeking for our own individual identity, the more we find the whole human species?[2]

Carl Rogers

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TO TELL OR NOT TO TELL

Early in life, I learned a basic truth that I have spent most of my adult years trying to understand more fully. This twofold truth says that keeping threatening personal information concealed from others can be damaging to your health and that confiding these secrets to people who care about you can have a healing effect.

My first encounter with secrets began with a surprise eye examination administered in the first grade. When the nurse gave me a yellow slip to take home to my parents, I knew what it meant: I was slated to become a "four eyes." This was a horrible fate from the perspective of a self-conscious young boy. I felt embarrassed, afraid, and somehow inadequate. I decided that the best way to manage these fears would be to hide the yellow sheet in my bookcase and say nothing to my parents.

At first, I felt scared every time I looked at my bookcase. I was definitely doing something wrong and was afraid of my parents' reaction. Still, the alternatives were even more forbidding, so I kept my secret.

After a few months, I would forget the yellow sheet for weeks at a time. Yet my problem wasn't really solved because back at school I struggled to read the blackboard. At my eye examination the next school year, the nurse asked why I hadn't gotten eyeglasses the previous year. The jig was up. I did get the glasses, and my parents didn't punish me, nor did my classmates ever tease me (at least not within my earshot). I learned that I could hurt myself by keeping secrets, and as a result I became more trusting of other people's responses.

As a young Catholic boy, I also negotiated secrets in the confessional. What to tell and what not to tell? I didn't, for example, tell Father Francis about my masturbating. Instead, I gave him the same litany each week: "I used bad language five times," "I tipped over someone's garbage can on Halloween," "I didn't obey my parents four times." The litany was carefully calculated to elicit an optimal penance—something like five Our Fathers and five Hail Marys. If I really got into trouble during the week, I usually confessed it, and on those days my penance skyrocketed to an entire rosary. Despite my less-than-always-truthful approach, confession usually felt good. I could share some of my secrets with a listener who didn't make harsh judgments about my everyday life.

I also remember some wonderful secrets as well: kissing Janet Page at age 6, stealing away with some older kids to have my first cigarette, hiding from my parents in a secret spot behind my sandbox, developing a secret code for communicating with my friend in math class, and soaping my second-grade teacher's windows. These experiences taught me that secrets can also strengthen one's sense of identity and add a sense of excitement to life, as the Swiss physician Paul Tournier noted when he said that every child is proud of having a secret.[3]

As an adult, I have continued to learn about secrets. During the past 10 years, I have explored secrets in many different professional contexts—with my psychotherapy clients, in my research on normal and traumatized people, in the classroom, and as a consultant working in different health care settings. I am not alone in my fascination with secrets; they have captivated the interest of humankind throughout history. The works of countless poets, playwrights, and philosophers have explored the psychological significance of secrets. The act of keeping distressing thoughts and feelings secret from others and the psychological consequences of doing so are also longstanding concerns of psychologists—from Freud's pursuit of the pathogenic secret to modern day family therapy's focus on family secrets.

Some great thinkers have expressed the view that humans aren't very good at keeping secrets. Benjamin Franklin remarked, "Three may keep a secret if two of them are dead" and Petronius, the Roman satirist, observed, "Sooner will men hold fire in their mouths than keep a secret."[4] Yet when we consider personal secrets, particularly those concerning information that is highly threatening to our self-esteem or well-being, the Latin saying that "small sorrows speak, great ones are silent" seems more accurate. These silent sorrows can include being molested as a child, a failed marriage, unexpressed grief, a serious illness, or any other great personal trauma. Most help-

ers have seen how major traumas, especially those with some social stigma attached to them, can lead to tightly held secrets. And they know that much of the work of helping involves being a companion to the person as he or she confronts these painful secrets.

In a series of classic psychology experiments, social psychologist Stanley Schachter found that when people are told they will soon be subjected to frightening experimental conditions, they prefer to wait with people who share a similar fate.[5] But when other researchers later added a condition in which subjects were told they were about to perform an embarrassing task, like sucking on rubber nipples or holding baby bottles, they found that their subjects tended to avoid people who were in the same circumstances.[6]

The person in distress, who must decide whether to reveal or conceal his or her difficulties, may experience both of the conflicting motivations identified in these experiments. There is often an ambivalent, approach-avoidance quality to our experience in these moments—one part of us would like to reveal our pain, to gain some acceptance of it, or to learn from others who have had similar experiences. Another part of us cautions against doing so and wonders, "Will they think less of me, maybe reject me, if they know this about me?"

At the core of this distress-disclosure dilemma is the desire to maintain one's esteem in the eyes of others. Our fear is that we might present people with an image of ourselves that we don't really want to project. Though we long to be known and cared for by another, self-protective urges caution us not to make ourselves more vulnerable than we can tolerate.[7] Our decision to conceal or reveal a particular secret reflects our feelings about the other person and the relationship, our trust in the other's discretion, the level of intimacy and empathy that already exists between us, and our personal proclivities.

The concern that others will evaluate us negatively and withdraw their support if we talk about our problems is not unfounded. There is a great deal of evidence that distress disclosure can lead to unfavorable reactions, rejection, and the loss of social support.[8] As psychologists Dan Coates and Tina Winston observe, "People who keep their negative feelings 'bottled up' and who turn out to be more sick . . . may have begun as individuals who talked about their troubles but painfully learned that no one wanted to hear about them."[9]

For example, when cancer patients reveal the fact of their disease, they often feel that friends and family members misunderstand them and explicitly or implicitly encourage them to avoid this difficult topic, with the rationale that focusing on it is a sign of poor adjustment.[10] The solution to the distress-disclosure dilemma,

according to Coates and Winston, is to surround ourselves with people who can continue to be supportive while allowing us to fully reveal our troubles.[11]

THE JOHARI WINDOW

The Johari Window is a helpful tool for thinking about our degree of openness in revealing ourselves. It was developed by Joseph Luft (Jo) and Harry Ingham (hari).[12] This simple and elegant graphic model identifies four different kinds of information about yourself. Think about the diagram as representing your total self as you relate to other people. The four panes of the window represent different aspects of your total self in relation to others and reveal several facets of what is happening at both the individual and interpersonal level. You can draw a window to describe specific relationships, or you can create one that illustrates how you generally relate to other people and yourself in terms of the secrets in your life.

The Johari Window

	Known to self	Not known to self
Known to others	I Open	III Blind
Not known to others	II Hidden	IV Unknown

Quadrant I represents those behaviors and motivations that are known to you and others. This is your public self. Quadrant II is the hidden area of the self. This area includes all the personal information you are aware of but others aren't. If you are just meeting a new person, this quadrant is very large, and it shrinks as you share your feelings and other information about yourself over time. Quadrant III is a blind area, representing behaviors and motivations that you don't know about but that are apparent to others. For example, you may have a mannerism or a bad habit that you are not aware of but that is perfectly obvious to other people. (This quadrant is sometimes called the "bad breath" quadrant.) Quadrant IV, the unknown area, includes information that neither you nor other people are aware of. Our unconscious motives and feelings reside in this quadrant.

The Johari Window can also help us chart our personal growth and change. Luft and others argue that personal growth and psycho-

logical health are achieved as Quadrant I expands and the other three quadrants become correspondingly smaller. For example, when I help a client cope with her grief, I discover more about her feelings and her experiences, thus expanding her Quadrant I. In this process, Quadrant II also shrinks because fewer of her thoughts and feelings are concealed. As I continue to give her feedback, her blind area (Quadrant III) also shrinks as she learns new things about herself that others can see but she cannot. Once these are in her awareness, they can move into Quadrant I, expanding it even further. In our work together, the extent of personal information formerly unknown to her and unknown to others (Quadrant IV) also shrinks as she grows and learns new things about herself.

Try this experiment: Imagine that 100 points represent your total self. How much of this total self would you say is public—that is, known to others—and how much is private, or unknown to others? Distribute your 100 points in Quadrants I and II. Be sure your total adds up to 100. In this exercise, people typically assign about 60 points to the public area and 40 points to the private area. How do your figures compare with those?

Now look at the number you assigned to the private category. This category would include your secrets because your secrets are unknown to others. What percentage of your private self is currently represented by your secrets? Most people say that about 20% of their private selves is secret. Is your estimate of your secret self higher or lower than the average figure?

SELF-CONCEALMENT: WHAT YOU DON'T SAY CAN HURT YOU

Your estimate of how much of your private self you keep secret is an informal assessment of what I call self-concealment. Self-concealment is a familiar human experience. Most of us have uncomfortable feelings, thoughts, and information about ourselves that we avoid telling others. These secrets can range from mildly embarrassing to highly distressing.

Although we sometimes conceal positive information about ourselves, such as inheritances or awards, we most frequently conceal personal information that we perceive as negative. This kind of self-concealed negative personal information is consciously accessible to us, as distinguished from the "unconscious secrets" that result from repression or denial in the Johari Window's Quadrant IV. We actively keep these secrets from the awareness of others; sometimes we tell them to only one or two persons, and sometimes we don't share them with anyone at all.

My research, helping, and personal life experiences all confirm that some individuals tend to self-conceal more than others and that the most painful or traumatic experiences are often concealed (e.g., sexual abuse as a child, rape, strong negative thoughts about oneself, unhappiness in relationships, family secrets, grief, and medical conditions such as herpes or HIV infection.[13]

I have developed the scale on the next page to measure the different facets of self-concealment.[14] Before I describe self-concealment in more detail, answer the 10 items on this scale for yourself, using the rating scale provided. Add up your ratings. (Most people score about 26 on this scale.)

Self-Concealment Scale

1 Strongly disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly agree

1 2 3 4 5 I have an important secret that I haven't shared with anyone.

1 2 3 4 5 If I shared all my secrets with my friends, they'd like me less.

1 2 3 4 5 There are lots of things about me that I keep to myself.

1 2 3 4 5 Some of my secrets have really tormented me.

1 2 3 4 5 When something bad happens to me, I tend to keep it to myself.

1 2 3 4 5 I'm often afraid I'll reveal something I don't want to.

1 2 3 4 5 Telling a secret often backfires and I wish I hadn't told it.

1 2 3 4 5 I have a secret that is so private I would lie if anybody asked me about it.

1 2 3 4 5 My secrets are too embarrassing to share with others.

1 2 3 4 5 I have negative thoughts about myself that I never share with anyone.

One recent study found that high self-concealers tended to report more depression, anxiety, and physical symptoms than did low self-concealers.[15] These findings were striking but not surprising; the idea that hiding significant aspects of the self can result in psychological or physical illness is a very old one.

William James, the father of modern psychology, seemed to sense this connection when he described secrets as "pent-in abscesses":

> For him who confesses, shams are over and realities have begun; he has exteriorized his rottenness.... One would think that in more men the shell of secrecy would have had to open, the pent-in abscess to burst and gain relief, even though the ear that heard the confession were unworthy.[16]

Henri Ellenberger has traced the historical importance of the concept of the pathogenic secret in the development of dynamic psychotherapy.[17] The procedure of extracting concealed and intolerable experiences appears in the confessional practices of Catholics, the "Cure of Souls" tradition among Protestants, and the healing rituals of animal magnetism and hypnotism.[18] These were, Ellenberger argues, precursors to the application of this concept by Freud, for whom the pathogenic secret was at the root of mental illness.

Psychotherapist Carl Jung considered secrets a kind of "psychic poison" that estrange us from the larger community, but he also saw the role that keeping certain personal information private can play in growth and individuation:

> The first beginnings of all analytical treatment of the soul are to be found in its prototype, the confessional.... Once the human mind had succeeded in inventing the idea of sin, man had recourse to psychic concealment; or, in analytical parlance, repression arose. Anything concealed is a secret. The possession of secrets acts like a psychic poison that alienates their possessor from the community. In small doses, this poison may be an invaluable medicament, even an essential pre-condition of individual differentiation.[19]

Note here that Jung doesn't distinguish between self-concealed personal information, which is available to our awareness, and repressed information, which isn't.

Modern psychologists have also expressed this view. Erich Fromm considered the inability to disclose oneself as a core reason

for the alienation of the modern individual from self and others.[20] O. Hobart Mowrer believed that concealing one's misdeeds leads to neurosis and encouraged clients to disclose these behaviors to significant others.[21]

Sidney Jourard, who has conducted pioneering work on self-disclosure, explicitly relates self-concealment to stress and illness:

> Selye proposed the hypothesis that illness as we know it arises in consequence of stress. Now I think unhealthy *personality* has a similar root cause, one which is related to Selye's concept of stress. Every maladjusted person is a person who has not made himself known to another human being and in consequence does not know himself. Nor can he be himself. More than that, *he struggles actively to avoid becoming known by another human being.* He works at it ceaselessly, twenty-four hours daily, and it is work. In the effort to avoid becoming known, a person provides for himself a cancerous kind of stress which is subtle and unrecognized, but none the less effective in producing not only the assorted patterns of unhealthy personality which psychiatry talks about, but also the wide array of physical ills that have come to be recognized as the province of psychosomatic medicine.[22]

In a series of studies, James Pennebaker and his colleagues examined what they call the confiding-illness relation or the inhibition-disease link. They found that not expressing thoughts and feelings about traumatic events (divorce of one's parents, death of a spouse, death of a parent, and sexual traumas) leads to long-term health effects.[23] Surveying his own and other findings, Pennebaker arrives at this extraordinary conclusion: "The act of *not* discussing or confiding the event with another may be more damaging than having experienced the event *per se.*"[24] Pennebaker explains these effects much as Jourard does, saying that they result from increased physiological and psychological work accompanying the concealment of the traumatic events.[25]

Another possible way self-concealment affects health is that by self-concealing we disconnect ourselves from whatever help might be offered by family, friends, and caregivers. If other people don't know that we are distressed about something, there is no possibility that they will offer us assistance. In this way, self-concealment obstructs helping by stopping it at its first stage: a potential helper's awareness of our distress. Because no help is offered, our distress increases, and our psychological and physical health worsen.

PEOPLE'S BIGGEST SECRETS

What is your biggest (i.e., most difficult, burdensome, or painful) secret? I once asked this question of over 300 human services workers and graduate counseling students participating in a questionnaire survey.[26] I also asked this largely (91%) female group to describe what keeping this secret was like for them. Because of the highly intimate nature of the questions asked, extreme care was taken to protect the confidentiality of respondents. All subjects were told not to put their names anywhere on the questionnaire.

Here is a small sample of the heart-rending disclosures given in response to these two questions:

> *The secret:* I had a little girl who was born severely brain damaged. I was young and just starting my career. For many months I tried caring for her but was "going under" fast. I eventually gave up all rights and responsibilities through the courts, and have felt guilty, sad, and terrible.
>
> *What it's been like:* I feel dishonest when others are describing similar situations and I can't talk about mine.

> *The secret:* I had sex with my younger brother when I was 17. I was drunk. I have never talked about it since, nor have I talked to him about it.
>
> *What it's been like:* It's terrible. This is the first time I have been able to even come close to talking about it. It has tormented me for years. There is so much guilt. I can't begin to describe it.

> *The secret:* I have this very strong feeling (always present, in retrospect) that I am not fulfilling my purpose in life, that when the record is written, I will not have been all that I could and should have been.
>
> *What it's been like:* Causes me to be dissatisfied with myself regardless of what others might consider my contribution to life to be.

> *The secret:* I'm not in love with my wife anymore. I care about her, and she's my dearest friend, but I'm very lonely for a passionate man/woman relationship.
>
> *What it's been like:* I'm crying on the inside, but I can't let it out. I feel very tight and can't experience happiness or enthusiasm for life.

The secret: I was young, naive, and trusted the clergy[man] where I worked part time as office church secretary. I was sexually abused and raped by him, yet the biggest hurt and pain was when no one would believe me because I was from a poor family and he was held in high esteem in the community.

What it's been like: Prior to sharing it with my spouse, it caused us much frustration and distress in our sexual relationship.

The secret: Homosexual experience when I was 26 or so. It lasted for 6 months or so and was a very rewarding relationship which filled needs I had at that time. I then moved back to heterosexual relationships and remarried.

What it's been like: At the time the relationship was going on I was very concerned that coworkers and friends would find out. A lot of guilt feelings since my family would have had a very difficult time understanding the relationship. Now that it is long past it's no problem, except that I sometimes would like to share it with my spouse, but know he'd never understand.

The secret: I have something to share, for which I require no response from you, except for you to listen. Maybe by your listening and my telling it, it will help me get rid of the guilt I carry. When I was 21 or 22 I allowed my father to fondle and caress me. I didn't let him have sexual intercourse; I feel that God stopped it before that.

What it's been like: I don't think of it much. I've buried it. It just reminds me of the humanness we all share (weak spots in our personalities).

The secret: Failure of marriage. I feel rejected, denigrated, demeaned. I feel that it must be my fault but can't put together the whys. It is a loss that fades slowly but will never go away entirely.

What it's been like: It imposes a feeling of sadness. I can compensate for it by making others feel happy; my job and clientele make this possible. I have lost any confidence that I might have any future meaningful relationship with another, and so I don't try. I don't want to. I feel lonely and try to assuage the feeling by working, reading, etc.

The secret: I had an affair. My son is not my husband's child.

What it's been like: A very trying experience for many years, but now it's faded in importance. Keeping the secret was easy because my parents would have been destroyed, particularly my father.

The secret: Concern that I was an inadequate parent to one of my children because I seem to have few feelings about that child. I don't like to have him around me.

What it's been like: Scary, mostly in terms of the damage I might have caused to his emotional health.

By coincidence, another person's secret complemented this parent's concerns:

The secret: I have never been sure that my parents loved me. At times I feel my father has cared for me. I never will know about my mother as she died 21 years ago. Can't remember ever hearing her say, "I love you" to me. I feel like a baby to be 40 years old and be so insecure about this.

What it's been like: It was very hard to even verbalize. Seems like by the time you are my age, a person should know whether they were loved or not. I think it was a cause of my insecure feelings. Parental love is our base. It's hard to love ourselves if we aren't sure about our parents. I feel this secret has influenced my personal relationships.

I was stunned by the fact that 20% of my subjects had not confided their biggest personal secrets to a single other human being! Some of their major reasons for not disclosing their biggest secrets were that they saw them as too personal or embarrassing, they feared others' reactions, they were afraid of hurting or burdening others, or they felt that it was nobody else's business.

But what happens when the secret is divulged? In another question, I asked about interactions in which a personal secret was revealed to another person. One woman said:

I told my best girlfriend that I had an abortion. Though she personally would never abort a pregnancy, she knew how devastatingly painful this experience was for me. She gave me total support. That was 7 years ago. We've gone through

> the deaths of both of our husbands since then. Our relationship has grown only stronger as the years have passed.

A positive effect on the relationship was described by more than 90% of the respondents; they used phrases like "our trust became stronger," "it brought us even closer," "it strengthened our relationship," "the best conversation I'd ever had with her," and "she knew my pain and still believed in me." One woman wrote, "I remember being amazed that she could know the worst thing about me and still want to have me for a friend."

The positive effects of these exchanges on relationships seem to have positive effects on health as well, especially when stress levels are high for the discloser. Several studies have looked at the health protective functions of having a confidant following a stressful life event. The findings are striking. Women who had severe life events and who lacked a confidant (defined as a person with whom the woman had a close, intimate, and confiding but not necessarily sexual relationship) were roughly 10 times more likely to be depressed than women having such a relationship.[27] Women reporting the lack of an intimate confidant had more psychological symptoms than those who did report such a relationship.[28]

Based on my research, my clinical experiences, and my personal life, I have come to the simple conclusion that we all need to have at least one significant other we can confide all our troubling thoughts and feelings to. I also believe that we need to disclose all these distressing thoughts to at least this one confidant. If we don't, our self-concealing behavior tends to influence our attitudes toward ourselves, and we conclude that there is some part of ourselves that is in fact unlovable, or else we would reveal it. The only way out of this vicious cycle is through disclosure to a caring and empathic confidant. T. S. Eliot expressed this idea eloquently:

> If a man has one person, just one in his life,
> To whom he is willing to confess everything—
> And that includes, mind you not only things criminal,
> Not only turpitude, meanness and cowardice,
> But also situations which are simply ridiculous,
> When he has played the fool (as who has not?)—
> Then he loves that person, and his love will save him.[29]

SECRETS OF PEOPLE FACING LIFE-THREATENING ILLNESS

My professional interest in secrets developed from my clinical work, particularly my work with people facing terminal illnesses. Working

with people whose deaths are imminent ushers us into a world where efforts to encourage honesty and genuineness are often frustrated. Secrets are held by many patients, their families, and their helpers as well. People are often "protected from the truth," and difficult feelings are kept hidden.[30] Some secrets are vigorously concealed by their holders; others are loosely held and readily revealed to a receptive listener. The secrets range from information concerning diagnoses and prognoses to confidences shared in tender moments, from disturbing family secrets shared with the proviso "Promise not to tell" to unspoken anger, shame, guilt, and hope.

For example, from a self-concealment perspective, AIDS is nothing less than a nightmare, an ordeal made worse by the secrecy that so often accompanies it. At each stage of this disease and its treatment, tough decisions concerning whether to conceal or to reveal difficult personal information add to the suffering of persons with AIDS, their caregivers, and their professional helpers. These decisions begin with the dilemma of whether or not to be tested for the virus, multiply with a positive test result, and continue throughout treatment: "Whom can I tell about this?" "What will my employer, coworkers, friends, family, or lover think?" If the person is gay and has concealed this fact from family and friends, disclosing this disease is made even more difficult: "Whom should I tell about my treatments? . . . my feelings? . . . my grief?"

Concealment in this kind of circumstance is not irrational. Tremendous stigmatization and discrimination are directed toward people with AIDS, and the disclosure of personal information must be carefully managed.[31] This situationally induced self-concealment makes coping with the disease even harder. Its pressure compounds the physical and psychological stress of the disease, its treatments, and the multiple losses so often experienced by persons with AIDS and their primary caregivers.

The helping professional or volunteer who cares for people with AIDS can also be thrown into a self-concealment pressure box: "Whom should I tell that I'm doing this?" "Whom can I turn to for support?" Many caregivers tell me that friends and family members either ask or demand that they not work with persons with AIDS. Ironically, at a time when these dedicated and committed helpers need support the most, it often disappears.

Faced with life-threatening illness and loss, family members sometimes make a bad situation worse by adding the burden of secrecy. Usually well intentioned, they seek to prevent pain, but their actions often increase it. I once worked with a Chinese American family in which the patriarchal grandfather prohibited the family from telling his enfeebled 94-year-old wife that her daughter had

died. Younger members of the family refused to attend the family's Chinese New Years party—a very strong statement in their culture—because they were not allowed to acknowledge her death. In their words, "To deny her death was to deny her."

Family members can also conceal medical information from the patient. A nurse once described the following scene: She and the rest of the medical team were at the door of a patient's room. Inside the room, the patient looked up from bed and said, "What's this?" pointing to the large tumor that now protruded from his abdomen. At this same moment, the patient's wife stood behind him, waving her arms, commanding the caregivers not to talk with her husband about the tumor.

In situations like these, it often seems as though there is an elephant in the room, but no one can talk about it. Everyone knows what the truth or issue is, but no one feels comfortable directly addressing it. Caregivers in these situations must become experts at secret management—the keeping or uncovering of secrets. They must, as philosopher Sissela Bok puts it, "navigate in and between the worlds of personal and shared experience, coping with the moral questions about what is fair or unfair, truthful or deceptive, helpful or harmful."[32]

These choices are never easy for the caregiver, but sometimes we know that we have made the right one:

> A dying patient's wife said, "Don't talk to him about dying. He's a private person—doesn't talk much and doesn't want to talk about death." I went into the room without the wife, and he seemed so in need of talking, I asked, "What would you like to share in the time you have left?" He held my hand and poured out his heart for 2 hours and talked of fears of dying.

Deep disclosures can bring healing and closure to one's life:

> One of my patients opened up and told his family through me about a whole lifetime of experiences which he had never shared before. I had wondered when I first saw him how I could possibly help him—he was followed for months by other nurses, and there had been no changes and no real problems to solve. Shortly after he shared his secret stories he died, his work done. I felt overwhelmed with gratitude that I could be the helper for this final work of his.

A colleague of mine once related a similar story. An elderly dying woman was visibly agitated, and he stopped to talk with her. After

several minutes of solid attention, she began to tell him a secret from her childhood. She had stolen her parents' silver setting and had never told them. This secret had haunted her throughout her life. My friend stayed with her for a bit longer, and she seemed much relieved. Late that night she appeared at the nurses' station and gave the nurse her Bible and her false teeth, saying, "I won't need these anymore." She went back to her room and died in her sleep.

In this deathbed scene, a daughter's ambivalence toward her dying mother is explained by her lifelong secret:

> We cared for a 65-year-old mother who was dying. A very pleasant, jovial daughter who was caring for her seemed so unsure of what she wanted to do for her mom. Her feelings swung from one day wanting to do a great job (which never quite happened) to the next day seeming disinterested. It was easy to wonder what kind of daughter was she. The last few hours of her mom's life she disclosed that she had been sexually abused as a child by her mom's boyfriends, and how her mother had just looked the other way. I wondered how often I had come to conclusions about people and situations. I realized how little we really know about some of the people we care for, and I felt guilty because I sometimes judge them even when I try not to.

HELPER SECRETS

The demanding and emotionally complicated nature of caregiving can trigger self-doubts and arouse strong emotions that may be embarrassing or even mortifying. All helpers probably have some troubling thoughts and feelings related to their work that are difficult to share with others. When these troubling thoughts and feelings are kept inside and not confided, they can become invisible, internal stressors, which I call helper secrets.[33]

It often feels inappropriate to admit one's limitations, vulnerabilities, ignorance, and problems, particularly in one's work. As professional or volunteer caregivers, we expect ourselves to be knowledgeable, strong, successful, and in control. When problems do arise, most caregivers feel that they are at fault and hide them from others; they assume that everybody else is coping effectively and that they alone are failing. The result is what social psychologists call the *fallacy of uniqueness* or *pluralistic ignorance* (i.e., the individual falsely assumes that he or she is the only one feeling this way).[34] Although individuals with a greater propensity for self-concealment would be more likely to hide these experiences, all helpers do this to some degree.

As a consultant to health care teams and organizations, I discovered many years ago that when caregivers revealed these kinds of personal thoughts and feelings, they always felt that theirs was a unique experience. Yet my cumulative experiences taught me that these helper secrets also have a universal quality—the specifics change, but the larger themes they reflect are repeated over and over, both within and across helping organizations.

My subsequent research on helper secrets confirmed this view. I have studied many thousands of helper secrets that I have collected from nurses, clergy, physicians, social workers, home health aides, volunteers, and other caregivers. In my formal studies of helper secrets, I have used content analysis procedures to identify the major themes and issues repeatedly reflected in these disclosures.

As you encounter the helper secrets that follow, keep in mind that these are, in fact, secrets—they are uncomfortable and embarrassing personal information. Only some serious soul searching and the assurance of anonymity permitted their disclosure. So, these self-revelations must be approached with compassion and respect; they reflect the inner struggles of caregivers as they strive to be competent and caring helpers.

"I've Distanced Myself From Patients and Families"

In a study of helper secrets I conducted involving nearly 500 nurses, more than one out of five responses contained descriptions of participants' wanting to or having actually emotionally or physically distanced themselves from patients, patients' families, staff, or their own family members.[35] This distancing took many forms: "becoming emotionally distant," "ignoring patients' needs," "avoiding visiting the difficult patient," "holding a part of myself back," and "feeling cold and unsympathetic" are just a few examples. This theme is also pervasive in the helper secrets of other caregiver groups.

Can you think of a way in which you have emotionally or physically distanced yourself as a caregiver? How did this make you feel about yourself? Chapter 3 offered a close look at how avoidance leads to lowered self-esteem and gave some examples of avoidance in caregiving. These experiences might be placed at the low-involvement end of the continuum of emotional involvement, as discussed in chapter 2. The difficulty for the helper in attempting to achieve emotional or physical distance is that these efforts actually raise, rather than lower, stress levels because they lead to feelings of self-doubt, guilt, shame, and personal and professional inadequacy. They aug-

ment distress and in doing so make this an untenable long-term stance.[36] This stress–avoidance–guilt sequence is reflected in the following disclosures:

> I have "distanced" myself deliberately from some patients and families as a form of self-protection when I've felt emotionally overloaded—even though I felt they needed emotional support themselves.
>
> I feel guilty that my caregiving has become more emotionally distant. Seems I'm protecting myself. I don't want to give so much of my energy to others' lives or my work.
>
> I feel cold and unsympathetic when a coworker tells me the same old problem.
>
> I often say I'll be right back when I have no intention of coming back.
>
> I have always tended to avoid saying good-bye to my patients. I sometimes make myself do it but am glad if they slip into a coma before I make the time to tell them how I feel about them.
>
> Sometimes the last thing I want to do is care about the person. I just want them to get away, at the same time I realize I care. I don't know which feeling to respond to. I just need to get away.
>
> Right now I feel as though I don't want to commit myself to a new patient. I'm not sure I want to take time away from my family, which is very emotionally satisfying at this time. I feel guilty about this.
>
> I became friends with one of my patients, and we often had lunch together and talked on the telephone. Then her doctor told me that she was terminal. I went on vacation, and when I came back I never called her or returned her calls. That was over a year ago, and I wonder now whether she is dead. Her doctor does not know because she changed to a doctor who is with a different hospital. A week ago, I called her number—no answer. Is she dead? I feel guilty.

"I Feel Inadequate"

Concern about one's competence and effectiveness as a caregiver is another frequently occurring theme in helpers' secrets:

> My inadequacy is my most personal secret, and it is very frustrating to be constantly in the company of so many talented, capable people.
>
> I wish I had more confidence in myself. I feel everyone is smarter and more knowledgeable than me.
>
> I often feel inadequate to say those wise and empathetic things that can be so comforting. I wish I could say those special words/phrases that are "just right."
>
> I'm always scared I won't have the technical skills to handle the patients' needs. This makes me really feel like an incompetent, bad nurse. Everyone sees me as capable, but I am afraid. I seem to do OK when faced with new situations, but I panic inside. I'm afraid of being seen as incompetent by patients—that's where it hurts most.

The prevalence of this kind of helper secret is not surprising. Feelings of inadequacy and incompetence are frequent themes in the secrets of nonhelper populations as well.[37] These kind of concerns and self-doubts seem to be invisible stressors affecting all helper populations. In one study, for example, psychotherapists reported that doubts about the efficacy of their helping were their number one stressor.[38] Also, feelings of inadequacy and strong self-doubt are understandable given the many challenges facing today's caregiver. The relentless demands of ever-changing technologies, treatments, and psychosocial complexities can create the "terror of error" experiences described in chapter 2.

"I'm an Impostor"

Feelings of inadequacy and self-doubt are common and often take the form of feeling like an impostor—someone who is posing as a competent caregiver but who really lacks the expertise to do the job. There is a strong fear of being exposed as a fake and a fraud:

> I feel I've really fooled the world. That I'm in this position and people think well of me. I've fooled them! I'm not that great.
>
> Even though I have been a nurse for many years and am now a nurse administrator, I'm sure I couldn't pass state boards today.
>
> Deep down inside I feel that I am fooling everyone—I'm not as bright or competent as people think I am. What if I fail? What should I do?

I feel that I'm a fake. Someone else would be more effective. I frequently feel like I'm flying by the seat of my pants.

I feel like I am an impostor—at work everyone looks up to me for the "latest" or "how to do it best" information. So far I have been able to wing it or come up with an acceptable answer, but I live a lot with the fear of making a big mistake in front of everyone.

I am really uncomfortable—I've been put in charge of developing a hospice program; I don't think I know enough about it; I feel like a fake trying to pull off a bubble about to burst. On top of that, if the bubble did burst, and I was exposed as a fake, I would deserve to be ridiculed, laughed at, scorned, fired, burned at the stake.

I'm afraid that if anyone found how much I don't know they'd head for the door.

"I'm Angry!"

Unspoken anger, frustration, and impatience—with patients, family members, coworkers, and administration—is a frequently occurring theme in the helper secrets I have gathered:

There are times when I'd like to shake some of the people I work with until they scream and cry. I hate detachment as a coping mechanism. I can't reach them and I don't feel like they can *hear* me.... So how on earth can we deal deeply with patients, family, and each other?

There are times when I feel like screaming or kicking or hitting something—like I'm about to lose control—but I usually just make tight fists, breathe, and then return to the situation looking and hopefully acting calm, in control, and like a nurse.

A couple of weeks ago, I was feeling really burned out and I had a newborn who wouldn't eat, and when I gavaged (tube-fed) him, he spit all the formula back up, and I gritted my teeth and became so angry at the baby, it really scared me because I felt like I could have hit him for not eating. I waited 15 minutes and then tried to feed him again, feeling much better, but I felt guilty for a *long* time.

Sometimes when an AIDS patient is very difficult, demanding, and obnoxious, I would like to tell them they deserve what they got.

> Sometimes I feel like I'd really like to tell a few certain arrogant doctors to stop feeding their egos through their ill patients and that their patients aren't the only sick patients in the hospital.
>
> I hated the husband of a patient because he wanted her to die and did not want to care for her or be with her. I couldn't be totally effective because of my antipathy. He was selfish and I didn't help him through the crisis as I should have.

This last disclosure reminds me of conflicts I experienced while working with a particular family. Jane was a 50-year-old woman with metastatic breast cancer. As she became more seriously ill, I met with both her and her husband. She didn't want to be told how long the oncologist thought she might live; although she was aware that her condition was terminal, she preferred not to have a "death sentence" hanging over her, and she expressed this desire clearly to me and to her husband, Ray.

On a rare day when Ray accompanied her to the oncologist, he remained alone in the office and insisted that the oncologist give him an estimate of how long Jane would probably live. After extracting this prognosis from the reluctant physician, Ray immediately went out in the hallway and delivered this information to his wife, something akin to passing her an emotional hand grenade. Later, Ray also pointed to a drawer where he kept a revolver and said to Jane that if he were in her situation, he knew what he would do. He also refused to comply with Jane's request that her deathbed be moved to the room looking out at the flower garden she so dearly loved.

Knowing the agony he caused Jane, I hated Ray, and I often thought that if the world had an ounce of fairness in it he would be in that deathbed, not Jane. I somehow persevered and helped with Jane's dying, but I could not bring myself to have any further contact with Ray after her death. I didn't help him with his grief and felt guilty about it for a long time.

"What About Me?"

One-way giving is built into caregiving. Of course, there *are* moments of reciprocity—a deeply felt thank-you, an award, unsolicited caring from a coworker—but these events do not change the fundamental reality that in caregiving the focus is on your patients or clients, and

there is no guarantee that you will receive anything more in return for your services than a paycheck, the intrinsic satisfaction of helping others, or both.

A small but significant group of helper secrets contain direct expressions of a desire to receive—as well as to give—caring and appreciation from patients and their families, coworkers, and the administration. Although these secrets represent only a small percent of the total number of secrets, they poignantly highlight an important stressor in caregiving:

> Sometimes I wish I weren't a nurse—because I don't want to give anymore and don't want to have to keep constantly learning. I resent it. I want to be taken care of—me.
>
> Sometimes I get angry and disgusted with myself for being afraid to discuss my feelings or communicate intimately and effectively about things in my life that really bother me. I always give in and never insist on being heard and cared about. I never think my feelings are as important as other people's.
>
> I sometimes get to the point where I can't pick up a baby and hold him/her because I can't "give" any more. I'm the one that needs to be held and rocked!

This next secret contains the themes of distancing, feeling like an impostor, and one-way giving:

> I feel like such a fraud. All my life people have considered me so strong, and I'm not. I badly need to have someone to talk to about things that happen in this work, and it never seems to occur to anyone that I need support too. The thing that weighs heavily on me is that I make deep personal contact with about one patient in five, and I feel so guilty about the other four.

A desperate need for more nurturance and self-care is reflected in this ominous secret:

> Sometimes I wish that I would come down with a semi-serious illness so that *I* could be taken care of for a while.

These secrets usually include an inner voice that is asking, "What about me?" and critical feelings toward oneself for not being

to create a sense of inner turmoil that is then concealed. Most helpers would probably feel relatively comfortable confiding in someone about the excessive demands they face, but they still might hide some of the deeper experiences related to those demands: the pain they feel when the "domino effect" occurs, "hating to fail," "feeling manipulated and drained," and "resentful." As noted in chapter 2, these kinds of demoralizing experiences can be key contributors to burnout.

"I Wish He'd Die"

Life isn't tidy, and death doesn't always come at exactly the right moment. Caregivers working with the terminally ill often confront situations in which their deep caring and compassion lead them to wish for the death of a patient. I remember that I felt this way about my grandmother, who had severe Alzheimer's disease.

Patients whose pain cannot be controlled or who, suffering greatly, ask with their eyes or with their words for assistance with their dying can trigger many difficult feelings in caregivers. An extremely common secret of caregivers working with the terminally ill is the unspoken wish that a patient would die to end that patient's agonizing suffering:

> Sometimes I pray that God takes this patient because he's suffering so much. I hope he dies soon. I feel guilty.
>
> I've wanted to help a terminally ill patient to die before things got worse. That is to say, I've wanted to give or encourage them to take too much pain medication so that they would die peacefully without further pain or suffering.
>
> I wish I could pull the plug on someone I know will have a poor quality of life.
>
> A patient wants to commit suicide so she will not suffer too much and will not continue to be a burden to her family. I find I have very ambiguous feelings about what to say to her. How can I say she should continue to suffer? How can I possibly understand how she feels? She only has a short while to live anyway, and it will be very painful.
>
> He was in constant pain, unable to move, unable to control bodily functions. I straightened his bed and I held the pillow. I wanted to cover his face. I didn't. He died 4 painful days later.

One caregiver disclosed an actual assisted death:

> The patient I grew to love deeply in a short time—I euthanized her, before the very end—she requested it, but I didn't have any experience in doing a proper job and screwed up terrible. She awoke and said to me, "We goofed up, didn't we?" I had to tell her yes and acknowledge the added pain and discomfort I caused her. The second time I gave it a try, it worked.

Discussions of the pros and cons of assisted euthanasia are increasing in the United States and Europe. Dame Cicely Saunders of St. Christopher's Hospice offers these thoughts on the implications of offering assisted euthanasia as an option:

> We would present people with an intolerable dilemma when they need support to take courage and trust us never to think they are a burden. Those most experienced in meeting the difficult medical, nursing, and above all, personal and social problems that are now referred to hospice teams are the very people who see the most compelling arguments against euthanasia, understood as the deliberate shortening of life. We know something of the potentials in treatment—and are learning all the time—and we believe in personal growth, even to the end of life, however diminished it may look.[40]

Saunders's comments remind me of the aphorism that you only get to see the light from your star when it gets dark. The darkness of night is terrifying. The stars come out slowly. If we don't find the courage to journey into the darkness with our patients, we may be abandoning them to a starless night.

REAL VERSUS IDEALIZED IMAGES OF SELF AS HELPER

Avoidance, self-concealment, unrealistic expectations of self, the tendency toward self-blame, and the fallacy of uniqueness all foster the development of helper secrets. Another key, related element is the discrepancy between the caregiver's real and idealized images of self as helper.

As caring and altruistically motivated helpers, we ask ourselves, "I am a caring and giving person. That's why I got into this work in the first place. How can I ignore patients' needs? Why do I distance

myself and wish that patients would die? Why do I feel so angry toward the people I'm caring for?" We ask, "Is there something wrong with me?" and then our self-esteem begins to plummet. This negative self-talk becomes an internal stressor that can make even the brightest of helping flames flicker, if not burn out completely.

When our self-expectations are not realized, we tend to experience guilt and anxiety, then resentment, anger, and burnout.[41] This discrepancy between our idealized images of ourselves as helpers and our day-to-day experiences creates inner turmoil and promotes the development of helper secrets.

Where do these idealized images of self as helper come from? Claude Steiner suggests that the idealized self-images of nurses can be traced to the "script" they are assigned by society: "Take care of others first" and "Don't ask for what you want."[42] These injunctions conflict with many of the strong feelings that are reflected in helpers' secrets, thus explaining why the latter are concealed and not openly confided.

Another source of problematic idealized self-images for female caregivers in particular is the training in being overly responsible that they receive in our society. Women are taught from an early age to be responsible for managing relationships and making them work; this training can make women caregivers more vulnerable to overextending themselves and to blaming themselves when their helping fails. But this overresponsibility is not a sign of sickness and should not be pathologized and given labels like codependent caregiving; rather, as Jo Ann Krestan and Claudia Bepko put it, it is a positive impulse gone awry and simply needs to be balanced with a sense of responsibility to self.[43]

We all had parents, teachers, and other helper role models in our lives who shaped our idealized image of self as helper. But I think we can also gain some insight into these idealized images—these schemas or mental blueprints we have for helping and helpers—by carefully looking at some of the helping heroes we have been exposed to. Mother Teresa, Albert Schweitzer, and Florence Nightingale are just a few of the most famous and influential helpers who may have inspired us. The model they all reflect is that of the selfless caregiver working tirelessly in the most adverse of circumstances.

We also need to look to our popular culture. As a child, my favorite fictional characters were the Lone Ranger, Batman, and Superman. Vicariously participating in the adventures of these valiant helpers always made me feel good because, in retrospect, I think it affirmed my altruistic self.

As helpers, these fictional characters had several striking features in common: First, their true identities were hidden from others.

Second, a traumatic loss preceded each of their careers as a helper: Superman lost his entire family and was orphaned; the Lone Ranger was a Texas Ranger attacked and left for dead by bandits (his brother was killed in the attack), who was rescued and revived by Tonto; as a young boy, Batman witnessed the brutal murder of both of his parents. We sensed a profound connection between these painful events and our heroes' passionate commitment to doing good. Third, their helping was, it seemed, purely altruistic. These were people who selflessly did good for others. They rode, flew, or drove off before anyone could even thank them, let alone ask about their own needs: Who was that masked helper? Fourth, each seemed, in the end, invulnerable. Although there were some close calls with kryptonite, we knew that when we looked up in the sky, Superman would always be there. Fifth, these superhelpers all had unhappy personal lives—they were wounded healers.[44] Bruce Wayne had an unending string of failed relationships—Julie Madison, Vicki Vale, and the Batwoman. Clark Kent desperately sought real intimacy with Lois Lane but was brutally beaten by a bully when he shed his super powers to attain it. Finally, they *never* failed. They always came through, no matter what the odds against them were.

During the endless hours I watched these helping icons, I vicariously felt that good feeling that comes from helping others—the do good–feel good effect. Unfortunately, I also learned that helpers can't be fully authentic, don't seek help in dealing with their traumatic pasts, never accept any appreciation for the good work they do, have miserable personal lives, and always succeed. Now, when I sometimes fail or feel vulnerable or have a need for appreciation or greater authenticity as a helper, I feel uneasy because these experiences don't match with my mental blueprint of the "great helper."

A key antidote to this insidious source of stress is to develop a more balanced, less perfectionistic, and more realistic ideal image of yourself as helper, and to do this without sacrificing your vision.

THE HELPER SECRETS EXERCISE

The best way to relieve the stressful effects of helper secrets is to disclose those troubling thoughts and feelings to a trustworthy confidant. Before I explain why this is helpful and how best to do it, let me emphatically state what *not* to do with your helper secrets: Do not indiscriminately share them. Nothing could be more hurtful to yourself. Both research and our informed intuition suggest that the choice of confidants and the context for this self-disclosure are critical considerations. You have to find a trustworthy confidant who is

able to respond openly and nondefensively to your inner experience. Friends, family, and other members of your social support network can provide one arena for these disclosures. But perhaps helper secrets are best shared with a colleague who does the same kind of work (i.e., someone who can have "instant empathy" with these difficult feelings).

Revealing difficult inner experiences is not something you want to leave to chance and to the conversational patterns of everyday life, where interruptions, quick advice, veiled judgments, and other unhelpful responses are common. When I have given workshops or led retreats, I have found that the following highly structured exercise can be an excellent vehicle for caregivers to disclose their helper secrets and get a caring, helpful response from others.

I ask the caregivers to write their helper secrets on identical index cards or sheets of paper.[45] I ask them to exclude any personally identifying information in their secret descriptions. The secrets are then gathered and randomly redistributed in the group. (If someone gets his or her own secret, that will still work because the rest of the group won't know this.) Of course, if members of the group know one anothers' handwriting, extra precautions, like having a person outside the group type or transcribe the secrets, should be taken to preserve anonymity.

The secrets are then read aloud, and I ask the other participants to share experiences similar to those expressed in the secret being read—what psychologist Gerald Goodman calls "me-too self-disclosures."[46] These me-too self-disclosures are directed toward the person who is reading the secret, and that person simply listens to the responses of others as a kind of surrogate receiver for the actual secret holder. Here is a sample of the kind of dialogue that can occur in these sessions:

> *Secret:* There was a young mother of three I cared for dying from ovarian cancer. We were giving her a big dose of IV morphine every 1 to 2 hours. After one of the doses I gave her, she quickly stopped breathing. One of the family members asked me if I killed her with that last dose.
>
> *Response:* I was really close to a family and followed the patient for 3 years, it was a baby, from birth, and gave him his last dose of morphine, and that's exactly what the mother said to me—"You've killed my baby." But to this day she still has contact with me and calls me. But it's still . . . it's right here *(tears in her eyes as she touches her heart).*

In nearly a decade of doing this exercise, I have found that the listening group members can almost always find some part of the experience conveyed in the secret that they can identify with and be self-disclosing in response to. Sometimes the entire room is filled with nodding heads, but everyone is a bit reluctant to respond verbally because the secret shared is reminiscent of the participants' own secrets. Other times, nearly everyone makes an empathic self-disclosure. For the deeper revelations, it might take quite a while—certainly more than a few minutes—until someone gets in touch with a similar experience, so you might need to give more time.

After all the secrets are read and responded to, there is usually a tremendous sense of relief in the room that comes from knowing that one is not alone in having these thoughts and feelings. Many people have said that what had been a well-kept secret became something that they could freely discuss with others. Even though their secrets remain anonymous, they experience the feeling that a formerly secret part of themselves is now known to others (i.e., Quadrant II of the Johari Window has gotten smaller), and the responses they have received make them feel differently about these formerly secret parts. I believe that this profound change in stance toward one's inner world is a key element in helping and psychological healing.

You don't need to participate in a helper secrets exercise to experience this kind of shift. You might not even need to communicate these difficult experiences to anyone else. The simple act of writing about our secrets can have a positive effect on our stress levels.[47] This is one reason I encourage caregivers to keep a diary of their helping experiences.

What you can't fully achieve through writing alone is that sense of "being in the same boat" with other caregivers—the deeper knowing that others have some of the same difficulties with the stressful situations you encounter. You might know this at a cognitive level—for example, as a result of reading this book—but real knowledge at a deeper level can only occur when you actually hear and respond internally to the disclosures of others like yourself.

The best antidote to helper secrets is to talk about our stress and to learn to see it as a common part of our work. When these difficult feelings are shared and worked through, they can be normalized, the natural bias toward self-blame can be corrected, and your energies can be directed toward developing better coping and problem-solving skills and strategies.[48]

In your work, you naturally value and promote honesty, openness, and revelation; your courage and skill, applied in a timely and strategic manner, allow painful experiences to be safely confronted and the burdens of patients and families to be lifted. Yet in this role

of midwife to open communication you may sometimes forget that your longevity as a helper also requires maintaining an open and friendly stance toward *yourself* and the inevitably difficult experiences you have as a caregiver.

Helper secrets alert us to our inner crises as helpers. The Chinese pictograph for crisis is composed of two characters, one signifying danger, the other opportunity. Helper secrets have a similar twofold nature. Though frequently highly painful, they contain information vital to your survival as a helper; they point to difficult areas of experience that demand greater attention. When they are concealed, helper secrets can corrode you from within; when revealed to empathic others, they can strengthen your support network and enhance your personal and professional growth.

CONCLUSION

In *The Great Turning,* Craig Schindler and Gary Lapid point out that the single-celled organism differentiates between "me" and "not me" and adjusts the flow of information across its boundaries accordingly:

> A primitive single-celled organism can be observed to move toward that which nourishes it and away from noxious stimuli that threaten it. In a nourishing environment, the organism becomes more porous and the flow across its cellular membrane is enhanced. In toxic or less supportive environments, the organism reduces its porosity and the flow across the cell wall is diminished. The single-celled entity therefore spends a great deal of its life moving toward "friendly" environments and away from "unfriendly" ones.[49]

Creating friendly environments that facilitate a caring sense of connection and encourage the free flow and exchange of information crucial to the health of all living systems is a challenge that pervades all our work as caregivers.

One experience on my own helping journey taught me a great deal about the healing connections that can rapidly develop when a friendly environment is offered to people in emotional pain. Let me describe this situation as if we were there: We are at a rustic retreat site in California. Sunlight is streaming through tall cathedral-like windows, warming the chilly meeting room. I look out at the expectant faces of the retreat participants. The diversity of the group is striking. The more than 70 cancer patients and family members

attending this We Can Weekend program span different ages, races, and nationalities.[50] But, as we will soon discover, the differences among group members will be dwarfed by their common experience of cancer.

It is the first morning of our retreat. We have just completed some ice breaker exercises that helped us introduce ourselves. Now red pieces of paper are distributed, and I am asking participants to write their secret fears on one side and their secret hopes on the other side. Quiet fills the room. I begin to worry about what will happen. Perhaps this is too threatening for the group. This exercise is my addition to the We Can Weekend curriculum, and I fear I might regret it. Only hours ago these people were complete strangers, and now I'm asking them to disclose some of their deepest feelings. When everyone is finished writing, the papers are exchanged randomly several times to ensure anonymity, and we slowly begin reading our fears:

Being totally dependent on others.

That I will not be there when needed most.

I'll die a painful death.

Giving up.

Having to say good-bye.

My dad dying.

That I might get cancer when I grow up.

The loss of my closest, most understanding friend and supporter.

That I will die without coming to peace with my life.

Many participants are trembling as they read their secret fears. Others begin to cry. Their hands and arms are extended to virtual strangers. Tears stream down my face, and a look of awe is on the face of a colleague. A kind of emotional contagion spreads through the room: A fear touches one person, then someone else. To an outside observer, it might seem that we have jumped into the Helper's Pit together. But for us, it feels more like we are scaling the walls of the pit together, reaching out to hold on to one another as we climb.

After a pause, they turn the papers over and begin to read their hopes:

That I will be able to see my grandchildren.

To be able to keep laughing at this.

My brother gets well soon and we can be a family together again.

That my wife is successful in combating and overcoming her cancer. That she and I will remain together until the end of our lives.

That I can give the emotional support that is needed throughout this ordeal.

That I beat this.

Communication, openness, forgiveness, patience, and that there is hope.

That my mom will not suffer.

I hope for courage—and lots of it.

The change in mood in the room is palpable. The connection between us—that almost sacred sense of we-ness—is something I will always remember. When things get tough, it is a real source of strength for me.

An extraordinary level of trust and openness prevailed during the remainder of the weekend. A group of strangers had become intimate and supportive friends, and many of these relationships continued long after the retreat.

It is often forgotten that in the Greek myth of Pandora's Box, after the Furies escape, one entity remains: Hope. Perhaps the key to our success was that we kept the lid open long enough for Hope to emerge. We might have closed the lid too soon, or never opened it, or tried to beckon Hope without her terrifying companions. The lesson here—which applies to both personal and helper secrets and which is the focus of the remaining chapters in this book—is that hope can emerge triumphant, replacing denial, avoidance, and fear, when it is sustained by caring, empathy, and support.

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Chapter 4. Secrets: Concealment and Confiding in Helping

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Chapter 5. The Helping Relationship

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