FAMILY PROCESS

Family Secrecy in Family Therapy Practice: An Explorative Focus Group Study

EVA DESLYPERE*,†
PETER ROBER*,†

The aim of this focus group study was to explore the experiences of family therapists working with family secrecy. Our study highlights that family secrets present important and compelling challenges for family therapists. Furthermore, our study reveals that there seem to be some basic strategies family therapists use in dealing with these challenges in therapy sessions. One basic strategy is that family therapists try to guard their position of being a trustworthy therapist for each family member by avoiding becoming stuck in family secrecy. Furthermore, therapists explore ways to guide the family toward the disclosure of the secret in order to alleviate the toxicity of the secrecy. This highlights the importance of the systemic model and how influential this perspective is in family therapy practice. Some participants, however, have in addition a second strategy they sometimes use: talking with the family about secrecy without aiming to disclose the secret. In the discussion section of the article we reflect on the possibility that in the strategic choices family therapists make conceptual issues might be involved. Furthermore, we stress the importance of further research.

Keywords: Family Secrets; Selective Disclosure; Therapist Experience

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In this article, we want to report on an exploratory focus group study we did with family therapists. We were interested in (1) the question of when or where family therapists are confronted with family secrecy in their practices, and (2) how they then deal with it. These questions emerged as we noticed that family secrecy on the one hand is an important issue in the marital and family therapy literature, but on the other hand we did not find publications about how family therapists in practice deal with the challenge family secrecy poses in therapeutic practice.

FAMILY SECRECY IN THE LITERATURE

A Systemic Perspective on Family Secrets

Evan Imber-Black probably is the most important author in the field of MFT, when it comes to the issue of family secrecy. She comprehensively studied family secrecy, mainly based on her extensive clinical experience, resulting in some classic publications in which she presented a systemic perspective on family secrecy (e.g. Imber-Black, 1993, 1998).

*Institute for Family and Sexuality Studies, Faculty of Medicine, Department of Neurosciences, Leuven University, Leuven, Belgium.
†Context UPC KU Leuven, Leuven, Belgium.
Correspondence concerning this article should be addressed to Peter Rober, Institute for Family and Sexuality Studies, Faculty of Medicine, Department of Neurosciences, Leuven University, Leuven, Belgium. E-mail: peter.rober@med.kuleuven.be.

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Imber-Black highlights that in order to maintain a secret often families have to reorganize their lives together. Dyads, triads, and hidden alliances are formed, resulting in varying degrees of distance and closeness between family members (Imber-Black, 1998). Topics are avoided, information is distorted, and unspoken rules about off-limit subjects emerge, leading children to create myths, twisted beliefs, and wild fantasies about what actually has happened (Imber-Black, 1993; Rober, Walravens, & Versteynen, 2012). According to Imber-Black (1993), secrets are systemic phenomena, defining boundaries of who is "in" and who is "out". Therefore, questions like "who knows the secret?" and "who does not know the secret?" can reveal a lot about family dynamics. Moreover, the strategies used by families to maintain secrecy often cause confusion, anxiety, and loneliness, and may eventually lead to family dysfunction (Berger & Paul, 2008).

A wide range of issues concerning individual and family life may become veiled in secrecy: issues such as adoption, infertility, incest, abuse, addiction, suicide, physical as well as mental illness and death (e.g., Berger & Paul, 2008; Burghardt, 2015; Imber-Black, 1993). Family secrets are defined as the intentional concealment of information by one or more family members who are affected by it (Berger & Paul, 2008; Merrill & Afifi, 2015). Vangelisti and Caughlin (1997) state that secrets can be viewed as a form of information control in which certain information is under the control of someone who intentionally hides it from someone else.

Several authors emphasize the importance of differentiating between secrecy and privacy (Berger & Paul, 2008; Brown-Smith, 1998; Imber-Black, 1998). Karpel (1980) holds that the distinction lies in the relevance of the information concealed from those who are in the dark. According to Imber-Black (1998), "what is truly private doesn't impact our physical or emotional health" (p. 21) whereas secrets may have an impact on a person's well-being and life choices. However, both secrecy and privacy are culturally defined. This can make the distinction between secrecy and privacy sometimes difficult to make (Imber-Black, 1993, 1998). According to some authors, the definition of secrecy and privacy implies that privacy is healthy, whereas secrecy can be considered unhealthy (Imber-Black, 1998). Some secrets are viewed as "toxic" and "dangerous" (Imber-Black, 1998): They impact family relationships, create barriers and coalitions, reduce trust, and affect family communication (Paul & Berger, 2007; Vangelisti & Caughlin, 1997). Family members may experience stress-related physical problems, self-doubt, tension, and anxiety (Berger & Paul, 2008).

Focus on the Complexity of the Process of Disclosure

While the systemic conceptualization of *family secret* highlights the importance of family structural aspects and family secrecy as (possibly) toxic, in recent years a new perspective emerged in which the focus is on the process of disclosure or nondisclosure, rather than on the secrecy itself. The issue of family secrecy is addressed with concepts such as "selective disclosure," "gradual disclosure," "partial disclosure," and "modulated disclosure" (e.g. Dalgaard & Montgomery, 2015; Leask, Elford, Bor, Miller, & Johnson, 1997; Rober & Rosenblatt, 2013; Rober et al., 2012; Van Parys et al., 2016; Wyverkens, Van Parys, & Buysse, 2015). This perspective highlights that disclosure should be viewed not as a 'once in a lifetime' event but as an ongoing dialogical process in time (Indekeu et al., 2013; Rober et al., 2012), in which there are tensions and hesitations of the family members around openness and silence. Research shows, for instance, that parents generally act in the best interest of their children when they try to provide them with an acceptable and age-appropriate narrative that answers as much as possible the questions they might have (e.g., Van Parys et al., 2016). Hesitations to speak openly often are grounded in attempts to protect loved ones as well as oneself (Rober & Rosenblatt, 2015). Without

denying the importance of the systemic perspective and the danger of the toxicity of secrecy in families, this perspective can be characterized as a dialogical perspective. It emphasizes the importance, not necessarily of the full disclosure of the secret, but rather of the creation of a space to talk safely about sensitive issues that have been left unspoken until then (Rober & Rosenblatt, 2015).

While research on family secrecy has been interesting and revealing, the main focus has been almost exclusively on the family, and on the effects secrets have on family dynamics (e.g., Imber-Black, 1998). Other aspects of family secrecy, for instance how family secrecy complicates the work of helping professionals, have hardly been studied. This is remarkable as family secrecy seems to play an important role in so many important family issues (like adoption, medical procreation, trauma, grief, . . .) in which professional helpers are involved. The only research we found on family secrecy and the professional helper concerns the ethical dilemmas secrets pose to professional helpers. Fall and Lyons (2003), for example, have explored the ethical issues concerning a family therapist's responsibility for in-session disclosure and maintaining postsession safety of the family members.

So with the exception of the ethical dilemmas that challenge professional helpers, as far as we know, no research has been done on the perspective of the helper. As family therapists, we wanted to learn more about the challenges family secrets pose to family therapists in practice. While we know from our own clinical experience, and from supervising other therapists, that these challenges can be very pervasive, as far as we know, no systematic research has been done on the issue. Therefore, we did an explorative study in order to map the experiences of therapists when they are confronted with secrets.

OUR STUDY

The aim of the present study was to explore the experiences of family therapists working with family secrets. We had two main research questions: (1) How do family therapists encounter family secrecy in their practices? and (2) When they are confronted with family secrecy, how do they deal with it during a therapy session?

Methods

Participants

The participants were licensed family therapists (who also were psychologists, psychiatrists, social workers, or pedagogues, as this is a requirement to be licensed as a therapist in Belgium) with experience in working with family secrets. Recruitment was conducted via training centers, seminars, and group practices in the Flemish part of Belgium. Eighteen women and four men, from all corners of Flanders, agreed to participate in one of six focus groups (each focus group constituting of two–seven participants). The group of family therapists was quite heterogeneous. Most of the participants worked as family therapists in psychiatric hospitals, in outpatient clinics, or in private practice. One worked in a school, another one in an adoption agency, another in child protection, and still another one in a department for unplanned pregnancies and abortion in a general hospital. The average age of the therapists was 42 years, within an age range of 28–66 years.

Procedure

Focus groups were used as the data collection method. This method yields a rich and varied set of data on participants' experiences, beliefs, attitudes, and feelings (Barbour, 2007), resulting in a depth of dialogue not often found in individual interviews (Smithson, 2000). However, the method also has limitations (Flick, 2006). Focus groups data are

generated through conversation among participants. In that way, the resulting data present a rather crude portrait of combined local perspectives. Therefore, it is difficult or even impossible to know what the participants' individual perspectives are (Markova, Linell, Grossen, & Orvig, 2007). Smithson (2000) writes that opinions stated in the groups should be treated not as 'belonging' to individuals within the group, or as opinions held by the whole group, but as discourses which emerge in this context. A focus group leads to rich data of a discursive nature, but it is not possible to link what is said to individual voices of participants. That is the reason why we only very generally present the differences in the group (e.g., some participants . . ., most of the participants . . ., and so on) and we cannot reliably present the data in a way that allows us to evaluate in more detail how many participants held this or that opinion.

All focus groups were recorded using an audio-recorder, enabling verbatim transcriptions afterward. Once the audio recordings were transcribed, the audio files were deleted. The focus groups had a duration of 60–90 minutes and were semistructured. The first author was the moderator of the focus groups. The second author was only present in the first focus group, where both he and the first author acted as moderators.

The focus group started with the question "How do you encounter family secrets in your practice?", followed by the question "How do you deal with family secrets during a therapy session?".

Qualitative data analysis

Thematic analysis (Braun & Clarke, 2006) was used to analyze the transcripts of the focus groups. The transcripts were divided into meaning units that were coded using MAXQDA software. The coding resulted in different codes in a hierarchical code system. As more focus groups were coded, the code system expanded and became more differentiated. The codes of all the meaning units were revised several times, as part of the constant comparison between the data and the code system. The code system did not expand significantly after analysis of the fourth focus group. This led us to conclude that saturation was achieved. Nonetheless, a fifth and sixth focus group were conducted and analyzed to test the saturation of the coding system. The coding of these two additional transcripts did not generate significant changes of the code system.

To enhance the reliability of the coding, the second author functioned as external auditor. A consensus method was used to reach agreement across the two coding systems (Hill, Thompson, & Williams, 1997). This resulted in a code system consisting of 56 codes, organized in six hierarchical levels.

RESULTS

The participants of the focus groups were asked the following questions: "How do you encounter family secrets in your practice?" and "How do you deal with family secrets during a therapy session?" These are the results for each of the questions.

Research Question 1, "How Do Family Therapists Encounter Family Secrets in Their Practice?"

Our analysis revealed two main codes and three subcodes related to our first research question. Figure 1 represents the interrelations between the codes and subcodes.

We will explain these findings now in more detail, referring to the numbers of the codes. In most focus groups the discussion started with reflections on what a family secret is (e.g., what the difference is between a taboo and a secret). The most frequent remark in this context was that there are many different kinds of family secrets. One participant, for

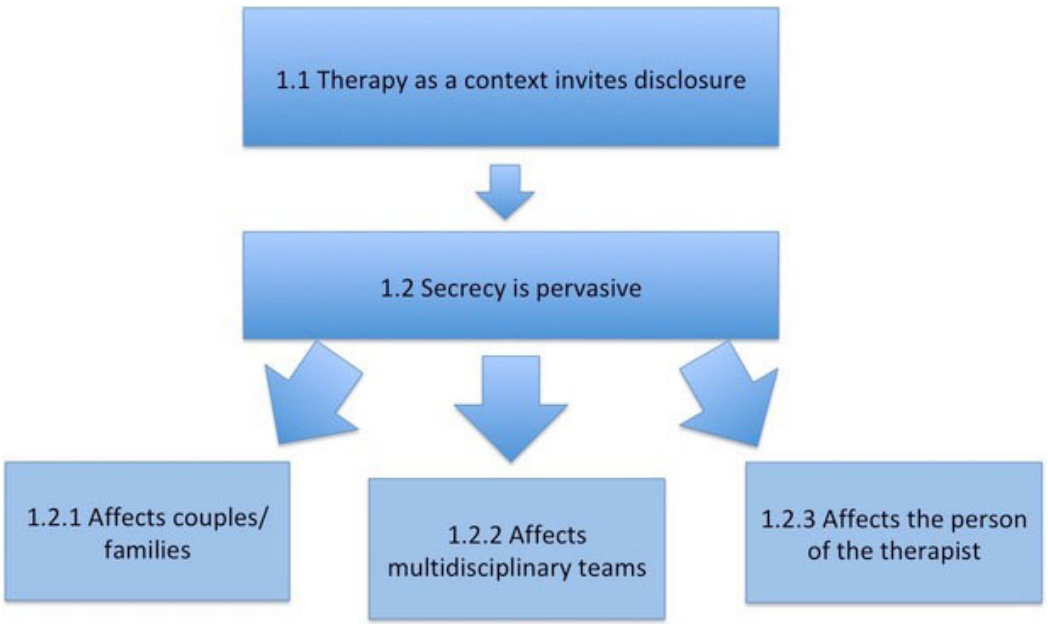

FIGURE 1. How Family Therapists Encounter Family Secrets. [Color figure can be viewed at wileyonlinelibrary.com]

instance, said: "There are family secrets which are known to all family members, but they never talk about it. Sometimes, only some family members know about the secret, and the others don't. Sometimes, only one family member has a secret and he/she does not want to share it with the others, yet. Eventually, after some years maybe the secret will be shared, or maybe not."

Some of the participants in our focus groups said that in almost every family therapy at some point secrecy might emerge as an important issue. "Probably all families have secrets," one participant remarked. This pervasiveness of family secrecy may be due to the observation of several participants that for some clients the context of therapy can be inviting to consider disclosing family secrets (code 1.1 "therapy as a context invites disclosure"). Feeling safe and secure with a therapist they trust can make clients feel invited to share sensitive stories they have kept secret until then. A participant in the focus group spoke of clients telling her: "I'm in therapy, I'll just tell you everything." Another participant recalled that a client said: "It's like going to confession. I tell you everything and then I'm rid of it. I'm free."

Of course, being in individual therapy or in family therapy makes a big difference here. Participants who work with individuals as well as with families recounted how secrets often are shared with the therapist in an individual session, rather than in a family session. Sharing secrets in a family therapy session, with other family members present, is less likely. But still, it happens, often at specific moments. For instance at the end of the session, when all family members have left the room, and one lingers behind and shares with the therapist in a kind of hush hush way sensitive information. One participant, for instance, told about a woman who whispered to the therapist, while the husband had already left, "This might be important for you to know, my husband is waiting for me to get pregnant but he does not know that for the last 6 months I have been taking contraceptives."

In the context of couple and family therapy, participants told us, secrets may be disclosed when one or more members are absent in a therapy session (e.g., a family member

being ill). For instance, one participant talked about a case in which the parents, in a session when the daughter was not present, confided to the therapist "in fact she is adopted, but she doesn't know." Also, during an occasional individual session with a spouse or family member, as well as in phone calls and emails, clients may try to share secrets with the therapist, without the other family members knowing. If clients secretively share information with the family therapist, and ask him/her "not to tell anybody," it puts the therapist in a bind, as the therapist aims to have an open and honest relationship with all family members. Some participants explained that such a request made them feel like they became an accessary to the secrecy in the family.

Our data furthermore illustrate that a secret sometimes emerges in an implicit way in therapy, as if it seeps through in the interactions of the family (1.2.1 "affects couples/families"). Often the therapist first senses that something important is not said in the family. One participant said: "What are the shadows of the secret the family presents to me?" Typically, according to our participants, the therapist then slows down the pace, in order to get a better sense of what is going on in the family. Sometimes later, the secret may gradually surface more openly in the interactions of the family.

When the therapist senses that something important might be unspoken in the family, this may also be the moment that he/she feels something of the emotional grounds of the secrecy. Secrets in families are often grounded in fear or shame, according to our participants. Furthermore, the participants also mentioned the protection of self and/or others as a ground for secrecy. As one participant said: "What lies beneath the secret can be a heavier burden than the secret itself.... Otherwise secrets would not exist." Moreover, some participants said, secrets can also connect family members or strengthen relationships. On the other hand, participants also recounted that they had often seen how secrecy affected family relationships in a negative way: tension, rupture, and pressure to keep silent often are consequences of secrecy in families, according to our participants.

Most participants told us that they experienced their therapeutic team as an important source of support in their work with family secrets (1.2.2 "affects multidisciplinary teams"). Not only did the team help them to reflect on their positioning as a therapist, but the team was also a place where therapists could share the burden family secrecy placed upon them.

However, some participants mentioned that while they as a therapist want to take more time to explore what is going on in the family, other team members, who may perceive secrets as "unhealthy" or "toxic", might urge the therapist to take action, in order to "uncover and open the secret". This may increase the pressure on the therapist to confront the secrecy in the family and to push the family toward disclosure. Interestingly, some participants recounted that—in order to avoid the pressure of their team—at times they have decided not to inform their team about a family secret they were confronted with in one of their sessions. The consequence of this decision is that the therapist becomes isolated in the team, and may feel like an accessary to the secrecy in the family. For example, a therapist in the focus group recalled that she did not tell her team about a client's wish to keep his hereditary disease a secret from his family. This made her keep a secret in her team. In that way the family secret had contaminated the team as a safe place to talk about some of the challenges therapists face in their daily practice.

Not only teams, but also the person of the therapist can be affected by family secrets (1.2.3 "affects the person of the therapist"). The therapists in the focus groups recounted that they sometimes were challenged with difficult dilemmas when being confronted with secrets in the session. The participants explained that when the secret is disclosed to them, without the other family members knowing, they feel stuck. They described that in those situations this makes them question if they can still function as a family therapist, as they want to be a safe and trustworthy therapist for every family member. Several

participants indicated that they prefer not to know the secret if they "aren't allowed to talk openly about it in the therapy session". One participant described how a mother told her that her husband was not the biological father of her children and that neither of her sons knew. The mother asked her to act as if she did not know. The participant recounted how she was afraid to slip up and spill the secret in the family session. Moreover, she also was preoccupied with the question whether or not to disclose the secret to her team, as she was afraid that her colleagues would put pressure on her to disclose the secret in the session.

Feeling stuck because of a family secret can also feel like "an ethical dilemma": Is keeping sensitive information secret fair toward the ones who don't know? The participants who spoke about this "ethical dilemma" recounted that they were torn between staying loyal to the secret keeper on the one hand, and their ethical duty to other family members on the other. One participant gave the example of a father not wanting his family to know about his genetic disease, thus forcing the therapist to choose between this father's right to his own privacy around his health, and the family members' right to have access to information about their health.

Apart from posing different kinds of dilemmas, our participants furthermore recounted that family secrets may also evoke different kinds of complex personal experiences in therapists. Especially when secrets are shared with the therapist with the understanding that he/she would not disclose it to the other family members. For example: Several participants recounted instances when they felt stuck by the secrecy in the family. This left them confused, angry, paralyzed, or powerless. One participant, for instance, related about a session with two parents in which they told her that that their daughter was adopted, but that this could not be discussed with the daughter. The therapist recounted: "Then I felt powerless.... Damned, I shouldn't have talked to these parents, without their daughter being present." Another participant, who was told by a husband that he needed other women besides his wife, but that this should remain a secret, said in the focus group: "I needed two hours after the client had left, wondering 'Jesus, what do I have to do now?'" Others said working with secrets created a feeling of uncertainty and doubt about their capacities as a therapist.

According to some participants, working with family secrets feels like a heavy burden, making their work as therapists complex. It seemed that this burden was especially heavy for the therapist if the secrets of the family resembled secrets they held themselves in their personal life, or if children were involved and if the content of the secret was life threatening (e.g., abuse, suicide) or of an existential nature (e.g., not knowing you're adopted). Especially in these three cases, participants were likely to be preoccupied by the secret in the family long after the session was finished. Some even said that the secret "haunted" them.

Research Question 2, "How Do Family Therapists Deal With Family Secrets During a Therapy Session?"

Our analysis suggests that there are three distinct ways in which family therapists deal with family secrecy: Therapists try to avoid losing their position as a trustworthy therapist for each and every family member by becoming entangled by the secrecy of one (or more) secret keeper(s) (2.1). When they are confronted with family secrecy in the session (2.2), therapists seem to experience that they have the choice to keep silent and bear the secret with the secret keepers (2.2.1) or to "take action" in order to deal with the secret (2.2.2). Figure 2 represents the interrelations between the different strategies.

We will explain these findings now in more detail. The participants in the focus groups explained that they used several strategies to try to avoid losing their position as family therapists by being sucked into the secrecy (2.1 "trying to avoid becoming stuck by

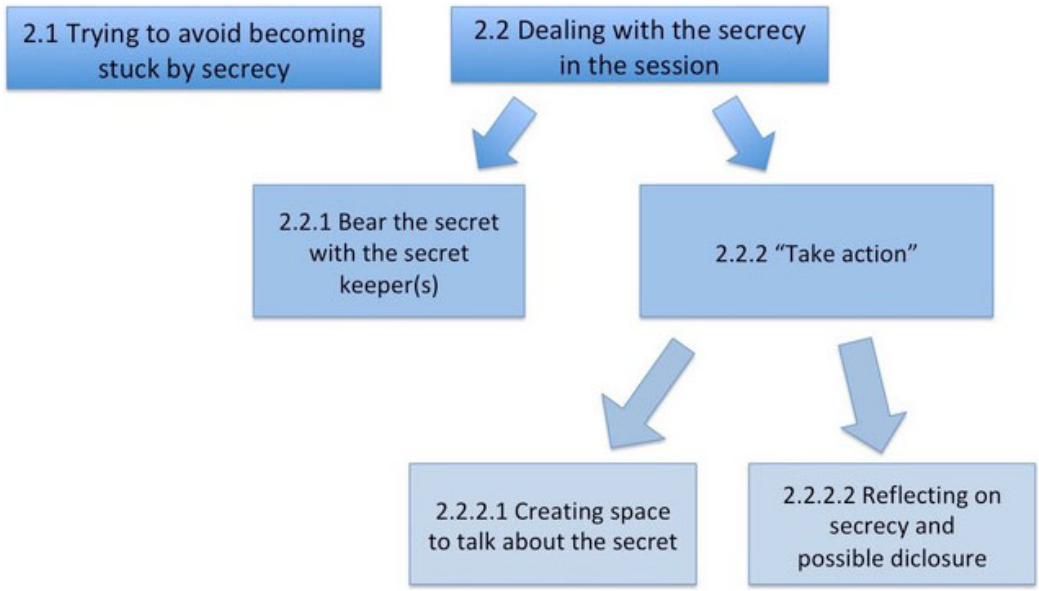

FIGURE 2. Strategies for Dealing With Family Secrecy. [Color figure can be viewed at wileyonlinelibrary.com]

secrecy"). First of all, some of the participants mentioned that they tell clients, at the beginning of the therapy or at the start of an occasional individual session, not to share things with them that they did not want to discuss in the family session. This includes information shared with the therapist in e-mails and phone calls in between therapy sessions. Other participants as a rule did not do individual sessions and only did family sessions in order to avoid being dragged into the family's secrecy. Nevertheless, the participants admitted that such strategies did not always work, and that they did not always succeed in avoiding becoming stuck by secrecy.

Besides trying to avoid becoming stuck by the secret and preserving their position as a trustworthy family therapist for each and every family member, our participants have strategies to deal with the secrecy itself (2.2 "dealing with the secrecy in the session"). One of these strategies, they told us, is that they might decide to keep the secret a secret: to bear the secret with the secret keeper(s), not to share the information with the other family members, and not to question what he/she senses about the secrecy (2.2.1). There seemed to be a consensus in all focus groups that not every secret needs to be disclosed. Secrets such as a husband not knowing that his wife has had a one night stand, children not knowing that their father has had an affair, parents not knowing that their teenager has been smoking pot, were examples our participants gave of secrets of which they thought that disclosure would not be necessary. These are examples of situations in which "... it's better if a secret stays a secret", as one participant stated. The decision to keep the secret a secret depends in part on the secret itself. Therapists reflect on questions like: Is there some urgency? Is there immediate danger? and so on. One participant for instance said: "There is a difference between a secret about the abuse of a child that may still be going on, and a secret about collaboration with the Nazis during the occupation in the second World War."

Other participants emphasized that keeping secrets implies loneliness and that secrets can be a heavy burden for the secret keeper. One participant said that in cases where she decides to keep the secret with the secret keeper, she always reminds her client

"Remember that a secret can be hard to bear, especially if you have to do it alone." She then tries to find out if the client would not share the secret with someone outside of the family she trusts, like a friend or a teacher.

The participants did not only have empathy for the secret keepers, and the burden of loneliness a secret implies. They were even more empathic toward children, because of the effect of secrecy on the development of children. "They are sensitive," one participant said, ". . . and their fantasies about what is not said are sometimes worse than the secrets themselves." Furthermore, our participants were also cautious about the effect the eventual disclosure of the secret might have on children. They explained that they wanted to avoid impulsive disclosures and that they often asked themselves: How can I help the parents to find a way to disclose the secret in a sensitive and age appropriate way? One participant told a story about a session in which a mother told her children the truth about who their father was: "When such a secret is shared, what it does to the children. . . . Everything is turned upside down for them. . . . It's all a mess." "It is like an earthquake," another participant in the same focus group replied.

In most cases, our participants told us, when a therapist is confronted with a family secret in the session an immediate reaction is "I have to do something with the secret." They feel that they have to—in their words—*"take action"* (2.2.2). According to most participants, "taking action" means creating space to talk about the secrecy (2.2.2.1). Our participants recounted that this is not easy to do, and one of the ways in which they try to create space to disclose the secret is by telling the family members about the tensions they sensed in the family. A participant in one of the focus groups said: "When I suspect there is a secret in the family, I try to slow down and get some idea of what is happening in the session. . . . I sometimes start to ask questions concerning the context of the secret. I speak about the secret without speaking about the secret. Often they will start to tell me something . . . I also tell them: 'You don't have to tell me now, the time will come when it is necessary to tell me." Another participant in another focus group said that if she senses that there might be important issues unspoken in the session, she asks the family members: "What do you think? Do you have bombs in the basement of your house? Sometimes it is better to identify the bombs in the basement and talk about them before you start to renovate your house. You never know if these bombs are going to explode and destroy your house."

Usually the disclosure of the secret is a gradual process that may take some time. One participant shared a clinical case of hers in which a young woman had been raped by a friend of her husband two years before. She had never told her husband. After a long therapeutic process in which the woman's mother and her brother were also involved she told her husband about the rape.

It seems that sometimes the disclosure in itself can create surprising new possibilities in the therapeutic process, such as abolishing the loneliness the secrecy brought about, reconnecting with loved ones, and so on. Sometimes the disclosure may mean a therapeutic breakthrough in an impasse that paralyzed the system for years. A participant described how disclosing the secret of a father's suicide and the shame surrounding it created space in the family to talk about the son's psychiatric problems and eventually resulted in finding appropriate care for him.

Trying to make space to talk about the secret is not easy. Our participants talked for instance about the difficulties they experienced in trying to keep a balance between speaking about the sensitive content of the secret and avoiding a crisis. One participant, for instance, remembered asking herself the question "Would exploring this subject benefit the family or would it do more harm?". Our participants also try to weigh the children's and parents' best interests when creating space to talk. A therapist in one of the focus groups recounted the case of a family where a father asked his daughter to leave the

therapy room because he wanted to speak to the therapist about his suspicions of his daughter having autism. The therapist was then confronted with the challenge of exploring with the father how he could tell his story in such a way that the daughter would also benefit.

Most participants emphasized that when therapists *take action* it is important to attune to the pace of the different family members. "You can't bulldozer your way in," a therapist said, "because people have good reasons for keeping secrets" (see 1.2.1). If the therapist would go too fast or force things this might lead to the breaking of the safe therapeutic bond and eventually to the clients not coming back. So the therapist has to be patient and proceed carefully and respectfully. Some participants mentioned that in order to be respectful they try not to decide for the family members whether or not a secret should be disclosed. One participant gave the example of how she told clients "tell me only what you feel I need to know or what is important at this point," thus undermining the assumption some clients have that "everything needs to be told in therapy" (see code 1.1) and introducing the idea that it might be ok to keep some things unsaid.

While for most participants "taking action" meant trying to create space to disclose the secret, some participants recounted that in some cases, rather than aiming at disclosing the secret, they preferred to reflect with the family on the secrecy itself (2.2.2.2). According to some participants, questions such as: "Help me understand your good reasons to keep this a secret", "What would happen if you went home and told your secret?", "If you would share your secret with someone, who would it be?", "How would your best friend react if you would disclose your secret to her?" and so on are very useful. Without aiming at the disclosure of the secret, such questions can help clients reflect on their secrets and decide when to tell what, to whom, and in what way. In fact, one participant said, this is about "exploring with the client what he or she really wants to do with the secret". One of the participants, for instance, recounted the case of a young mother of three children who was given a diagnosis of terminal cancer. "You have 2 years to live," the doctors had told the mother. In an individual session with mother the therapist had explored the mother's thoughts about telling the children that she would die in 2 years. The discussion ended in the mother's decision to wait 1 year before disclosing the diagnosis to the children, as in a year the children would have grown an additional year and it would be less difficult for them to understand. "Also," the mother had said, "I want to be there completely for them", implying that from the moment the prognosis of her illness would be disclosed to the children, in a sense she would stop being their mother as the children would be there for her and take care of her.

On the other hand, this second strategy of exploring the possible disclosure of the secret using hypothetical questioning sometimes—although it is not the first intention of the therapist—may lead to some level of disclosure of the secret. One participant stressed that she sometimes openly discusses with the clients "do you want to keep it a secret, or do you want to disclose it in time?" Then there is an open conversation about the secret, the emotions involved (shame? fear? guilt?) and the silent burden for the other family members if the secret would be kept. Such a dialogue with the client then can lead to reflections on possible disclosure: what will I tell, and what will I leave unspoken (for now).

DISCUSSION

To date, the main focus of research on family secrecy has been on family functioning, highlighting that family secrets are a systemic phenomenon, with toxic impacts on the family members who are kept in the dark (e.g., Imber-Black, 1993). In this present study, we wanted to explore how family secrecy functions in family therapy practice.

The first thing that struck us was that when therapists start to talk about family secrecy questions pop up about what a family secret is (what is the difference between a secret and a taboo; what is the difference between secrecy and privacy, and so on). Furthermore, remarks were made about the different kinds of family secrets. Although in the past several definitions have been formulated (e.g., Imber-Black, 1993, 1998), this raises questions about the need for a clearer conceptualization of family secrecy, and also about the need to develop a classification or typology of family secrecy. But more than this, the practicing family therapists' conceptual questions that arose in the focus groups highlight the complexity of family therapy practice, in which concepts do not offer much to hold on to as they often fail to capture the chaotic interactions that emerge in the here-and-now of the session. And it is this complexity the practicing therapist has to make sense of and deal with in the moment, without much time for reflection.

Our data furthermore seem to indicate that it was a good idea to study family secrecy in the context of family therapy practice as the data suggest that secrecy not only affects the functioning of families, but that it also presents serious challenges for family therapists. For instance, our data show that therapy is a context in which family members can feel invited to share things they have not talked about before. Also, it seems that family therapists who are confronted with family secrets in the session have to face difficult questions about their positioning in the session, in order to try to avoid becoming an accessary to the secrecy and being stuck. The position of the family therapist becomes endangered when he/she is presented with information that cannot be openly discussed with the other family members. Participants reported that especially in such cases family secrets can evoke strong experiences of powerlessness, uncertainty, and even anger in therapy sessions. Therapists then are faced with the challenge of managing these emotions without endangering the complex therapeutic alliance that is typical for the multiactor setting that a family therapy session is (Rober, 2017). Often, family therapists find support in their team to share the burden of dealing with secrecy in the session. However, sometimes the secrecy of families infects the team of the therapist, as the therapist—out of fear of being pushed to move with the family toward disclosure—feels the need to keep the family secret unspoken in his/her team.

One of the ways family therapists deal with the challenge of family secrecy in the session is to try to avoid becoming stuck by the family secrecy. This is crucial as the therapist wants to preserve his/her position as a trustworthy therapist for each family member, and becoming an accessary to the secret would seriously endanger this position. While in the different focus groups there seemed to be a consensus that this avoiding strategy was important, most participants readily agreed that this is not easy, and they admitted to not always succeeding in avoiding getting stuck by family secrecy.

When family therapists are confronted with secrecy in the session, there seems to be a choice between trying to bear the secret with the secret keeper(s) and what they call "taking action". For the majority of participants in our group "taking action" consists of trying to create space to talk about what was kept unsaid in the family, in order to move toward the disclosure of the secret. One way to do this is for the therapist to share with the family members his/her sense that there is something important that is left unspoken in the family and linking this felt sense with some of his/her observations of the interactions in the family. This strategy is meant as an invitation to disclose, and sometimes it creates space for the family to talk about the sensitive issues that had been kept secret until then. Our data furthermore suggest that for family therapists trying to open space to talk about the secret is a hazardous project. Attuning to the pace of the family members is crucial. Moving too fast often results in clients closing up and recanting their story, or in the breaking off of the therapy.

Some participants had a more complex view of "taking action". For them moving toward disclosure was only one of two possible strategies. Another possible strategy for them to consider was the exploration of secrecy without aiming at the actual disclosure of the secret. One way to do this is to try to explore the good reasons clients have for keeping secrets (e.g. Rober et al., 2012). This can be done by saying clearly to clients, "you don't have to tell your secret, but I wonder . . ." and then asking questions like "Can you help me to understand what are your good reasons not to tell . . .", "what would happen if you disclosed your secret to this or that person?" Other possible questions are of a hypothetical kind, for example "If you would tell your secret to one family member, who would it be?", "If you would tell not the whole secret, but a part of it, what would that be?", and so on. This strategy resembles the concept of *decision dialogue* (Sheinberg & Fraenkel, 2001). Developed in the context of a multimodal treatment program for survivors of incest, in a decision dialogue the therapist reflects with a family member what to share with others, how, when, and with whom.

Probably, the two strategies of 'taking action' are linked to different conceptualizations of family secrecy. The creation of a space to talk about the sensitive information that was not shared before (first strategy of 'taking action') may fit better with the traditional systemic view on secrecy (e.g. Imber-Black, 1998) where the therapist's aim is to assist the family to move toward disclosure. The second way to "take action", namely to reflect with the family on the secrecy and the choices one can make in the selective disclosure of sensitive information, seems to fit better with a more dialogical perspective as it builds on the concept of selective disclosure (Rober et al., 2012). By exploring the silences, the hesitations and the good reasons, therapists can create a space to talk about the dilemmas family members might face in contemplating the disclosure, or the partial disclosure of the sensitive information that was kept unspoken (e.g., Dalgaard & Montgomery, 2015; Wyverkens et al., 2015). In this dialogical space, the therapist can help the family members reflect on the essential questions that are involved in the process of selective disclosure: when to tell what, to whom (e.g., Rober et al., 2012; Wyverkens et al., 2015). The participants who—in addition to the possibility of assisting the family toward disclosure—reflected on the process of selective disclosure acknowledged that not every secret needs to be opened, and some secrets may be life-giving, rather than toxic (Rober & Rosenblatt, 2015).

It seems that, added to the systemic model of secrecy, the concept of selective disclosure (e.g., Dalgaard & Montgomery, 2015; Rober et al., 2012; Wyverkens et al., 2015) may provide the therapist extra room to maneuver in dealing with family secrecy in the session. The concept offers the choice between moving toward disclosure and exploring the secrecy (2.2.2.1), on the one hand, and reflecting with the family on choices about what to share with whom, when, and how (2.2.2.2.), on the other. An interesting question would be how therapists decide for one strategy or for the other. However, in our data there do not seem to be a lot of elements that can help us with formulating hypotheses about this issue. Probably, it is wiser to investigate this question further in future research. There is also another decision family therapists make in their dealing with family secrecy in the session, namely the choice between "bearing the secret" (2.2.1) or "taking action" (2.2.2.): how therapists in practice decide to use the first strategy or the second. There are some indications that this choice may depend on the nature of the secret: whether it is—in their words— "a big secret" or "a small secret". Although there is some similarity, it seems that the distinction made by our participants between "big secrets" and "small secrets" is not identical with the distinction between "secrecy" and "privacy" that is often made in the literature (e.g., Imber-Black, 1993). For our participants "big secrets" are secrets that are life threatening (e.g., rape, suicide, . . .), illegal (e.g., involving illegal drugs), or having an impact on a person's identity (e.g., knowing who is your biological father). The participants

indicated that "big secrets" often required from them to be more direct and confrontational, and in some cases also to take protective action (for instance: contacting child protection services). Secrets were considered to be "small" if there was no immediate risk to a person's safety or health, for example, skipping school or a son not telling his parents that he has a girlfriend. With "smaller secrets", therapists are more relaxed and it makes them feel they have more time and space to explore the secret. In addition, it seems that therapists are less inclined to take protective action over such smaller secrets, both in and out of the session. But also concerning this question, about the therapist's decision to bear the secret with the secret keeper or to 'take action', rather than formulating wild hypotheses, at this stage it is probably wiser to further research the issue. Both questions will be the subject of research we are currently planning using a tape-assisted recall research method (e.g. Rober, Elliott, Buysse, Loots, & De Corte, 2008). This method can provide insight into the thought processes of therapists when making such choices in family therapy practice.

Finally, we want to mention some important limitations of our exploratory study. As our study consisted only of 22 participants, questions can be posed about the possible lack of diversity in the group (and possibly in the families these therapists work with). What is certain is that there is a lot of homogeneity in the group of participating family therapists concerning their cultural background. All participants of our focus groups were Flemish family therapists. It is hard to imagine that the cultural heritage of growing up in a country that is traditionally Catholic would not influence the way these therapists deal with secrecy. When a participant characterizes the therapeutic context as "it's like going to confession", this reveals the influence of a Catholic culture. So while we can be sure that the cultural background of our participants has colored their way of dealing with secrecy, we cannot make any definite statements about the way this contaminates our findings, as we did not do research on how therapists from other cultures would deal with secrecy. In order to map the influence of culture it would be necessary to do an intercultural research. So in terms of suggestions for further research it might be a good idea to replicate this study in a country with another religious cultural heritage.

CONCLUSION

In this exploratory study, using focus groups with participants who were all practicing family therapists, we tried to come to a better understanding of how family therapists encounter family secrecy in their practice and how they try to deal with it during a therapy session.

The most important conclusion of this study is that dealing with family secrets is a challenge in family therapy practice, and that therapists have different ways to deal with this challenge.

It is also suggested that the way family therapists deal with this challenge may be connected with conceptual issues. All therapists seem to be familiar with the systemic perspective that secrecy may be toxic, and that it makes sense to assist a family to move toward disclosure. There are indications that the concept of selective disclosure allows some therapists some additional room to maneuver in dealing with secrets. However, this is an exploratory study, and maybe the most important outcome of this study is that it gives us ideas about the future studies that need to be done.

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