

From Refusal to Reconciliation

Family Relationships After an Accusation Based on Recovered Memories

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Abstract: In following families who reported to the False Memory Foundation between 1992 and 2001 that a member had charged them with incest, a survey questionnaire (with a 42% return rate) was sent to some 4,400 families. These data demonstrate that 99% of these accusers were white, 93% were female, 77% were graduates, 86% were in psychotherapy, and 82% accused their father. Such accusations were rare events before 1985 but then grew exponentially in frequency, peaking in the 2-year period from 1991 to 1992, with 579 accusations. Thereafter, such accusations steadily declined so that in 1999 and 2000, only 36 accusations occurred. The accusers can be differentiated in the manner with which they reconciled with the situation: 56% refused all family contact, 36% returned but did not discuss the accusation, and 8% retracted completely. These data give evidence of a time-limited craze of therapy-induced incest accusations that has now dissipated.

Key Words: False memories, sex abuse, rehabilitation, psychotherapy, posttraumatic stress disorder.

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How does a family torn asunder by false accusations of incest ever come together again? That question—along with reports that families were now reuniting in growing numbers—prompted the False Memory Syndrome Foundation (FMSF) in March 2001 to undertake a survey of families that reported that they had been subjects of false accusations and recriminations. The FMSF, a 501(c)(3), was founded in

1992 in response to a flood of requests for help from parents who said that they were being accused by their adult offspring of childhood sexual abuse. These accusations were based on claims of recovered repressed memories. In addition to studying the problem, the foundation also helped families who believed that they had been falsely accused. Members of the foundation often asked how a family torn asunder could come together again. A survey might disclose how many families had actually reconciled, what process they followed in recovering, and what facilitated or inhibited their reconciliations. Such information would illuminate the nature of the strange psychiatric phenomenon of false memories, now entering its terminal phase (McHugh, 2003), and provide ways to encourage family rehabilitation.

Alienated families are not new, even if the phenomenon of incest accusations based on recovered memories is. The parable of the prodigal son indicates that family ruptures have been with us as long as there have been families. Until the false memory syndrome (FMS) epidemic, however, no sizable body of families afflicted by the same disruption was available for study. In one of its initial activities, the FMSF surveyed families that made contact to determine their characteristics and patterns (Wakefield and Underwager, 1992). Later, the Foundation studied how accusers could develop false memories of abuse (Lief and Fetkewicz, 1995). With the current survey, FMSF entered a new phase in moving to help families recover and reunite by investigating the large group of families available to it to discern what has worked and what may interfere with recovery.

The FMSF already had some experience with movement toward recovery. This information emerged mostly from anecdotal reports of reunification that some families sent to the foundation as early as 1993.¹ From these reports, we noted that recovery characteristically follows a process or

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¹The FMSF has archived thousands of letters from families after removing personal identifying information. These are available for perusal at the Center for Inquiry Libraries in Amherst, NY. In addition, anecdotal reports have been published in FMSF newsletters, available at www.FMSFonline.org.nrsid4470664.

path that can be separated into distinct stages. We identified three different accuser groups by the stage they had reached in recovery: the refusers, the returners, and the retractors. *Refusers* are the accusing offspring who refuse to agree that their memories and accusations were false and who reject contact with those who challenge their opinions. *Returners* come back to the family circle but fail to apologize, acknowledge error, or in any way withdraw their accusations. They may refer to the accusation so as to lay it to one side, but most often approach the central issue in the family with a deafening silence that keeps it out of bounds for discussion. Finally, *retractors* return to the family, acknowledge that the accusations are false, and seek to re-establish meaningful family relationships.

The survey, initiated in March 2001, used these proposed categories of accusers to develop our understanding of the reconciliation process. Did retractors, the ultimate reconcilers, always go through the returner phase? Was the process always unidirectional, or did returners ever change back into refusers or retractors into refusers? Was it crucial to reach the retractor phase for other forms of family life to proceed, or did the elephant in the living room aspect of the returner status interfere significantly with family harmony? What actions of the accused encouraged the accusers to move to returner or retractor status? We hoped to illuminate such matters and others by systematically surveying our families. In this article, we provide answers to some of these questions.

METHODS

Procedure

In March 2001, 4,400 survey questionnaires were mailed to past and present FMSF newsletter subscribers. We limited the survey mailing to subscriber families who reported they were dealing with an accusation by a family member 16 years or older. Scientists, psychologists, psychiatrists, clergy, students, and others who subscribed to the newsletter for educational or professional reasons did not receive the survey.

Survey

Each family received a survey and a cover letter.² To illuminate all features tied to return and reconciliation, the questions in the survey ranged broadly. We were interested in identifying the characteristics of this population and the particular events and experiences that might relate both to the original accusations and to recovery. The survey questions included the following: basic demographic information of the accused and the accuser; therapy issues and the nature and characteristics of the accusations; details about and qualities of the family's relationship with the accuser at the time of the

accusation; and finally, questions addressing how the accused came to deal with the separation and accusation over time.

To maintain privacy, the identifying information (name, address) of the respondent was removed from returned surveys and replaced with a coded ID number.

Below are the specific definitions of the refuser, returner, and retractor characteristics the survey asked the respondents to use in identifying the accusers' contemporary status.

Would you classify your accusing family member at this time as a: Refuser_Returner_Retractor_ given the descriptions of the 3 different types of people who made false allegations?

"Refusers" refuse to have contact with anyone who challenges their opinion

"Returners" in contact with family but do not retract; usually do not talk about accusation

"Retractors" acknowledge that accusations were false and seek meaningful family relationships

The families were also asked whether a mental disorder afflicted the accuser. Those who responded affirmatively to the question were asked to describe or name the mental illness or reason for treatment of the accuser. On receipt of the survey by FMSF, two raters coded these descriptive responses into more specific subgroups: DSM-IV Axis I and Axis II. If unable to be fitted into these first two categories, they were placed into either "disturbances in living" or "unable to categorize."

Survey respondents were given an opportunity to add written comments or clarification of their responses and frequently did so.

We made only one attempt to follow up on families who did not return the surveys: we sent a reminder letter (along with another survey form) 3 months after the first mailing to those nonresponders who were still active subscribers to the FMSF newsletter. We tried nothing further to enhance our response rate, because the FMS Foundation has maintained an unobtrusive role with the families who make contact.³

RESULTS

Returns and Return Rates

A total of 1,847 surveys were returned, for an overall return rate of 42%. The return rate from families who were current subscribers to the FMSF newsletter was considerably higher, at 68%. Of the 1,847 returns, 113 could not be used.

²Copies of the survey are available at the FMS Foundation, 1955 Locust St., Philadelphia, PA 19103.

³When families stop subscribing to the newsletter, there is usually one of three explanations: families have suffered illness or death, they have experienced reconciliation or the wish to put this awful period of their lives behind them, or they have given up hope and do not want to think about the situation any more.

In sum, we were left with 1,734 (39.4%) completed surveys to study and analyze.

Categorization of Accusers

By using the selective criteria described, the informant families categorized 56% of accusers as refusers, 36% as returners, and 8% as retractors.

Characteristics of Accusers

Accusers were overwhelmingly white (99%), female (93%), and daughters (88%). Seventy-seven percent of the accusers were college graduates, and 32% additionally completed some form of postgraduate education. The occupations of 77% of the accusers fell into the professional and white-collar categories of employment as described in the Hollingshead scale (Hollingshead and Redlich, 1958).

The accusers were mostly adult women, with a mean age at the time of the accusation of 32 years, with a range from 16 to 61 years. Of interest is the fact that retractors were significantly younger at the time of the accusation (mean age = 28.98) than either refusers or returners, whose mean age was 32 years ($p < .001$, one-way analysis of variance).

The informants reported that 86% of the accusers were in therapy at the time of the accusation. Ten percent of the families said that they did not know, and only 4% said that the accusers were not in therapy at the time of the accusation. According to survey informants, 48% of accusers suffered from or were treated for a mental illness before the accusation. (The majority of them were considered Axis I conditions when separated independently by two of us. Interrater reliability was 80%.) There were no significant differences in reports of mental illness before accusations among retractors, returners, and refusers.

Characteristics of Accused

Fathers were most often the accused people (82.03%). Because 37% of accusers accused more than one person (some as many as six), we distinguished between the person primarily accused and the persons secondarily accused (Table 1).

Eighty-seven percent of the fathers had occupations in the professional and white collar categories as described in the Hollingshead scale. The mean year of birth of the person primarily accused was 1930, with a range from 1888 to 1971.

Accusations and Their Characteristics

Families were asked to indicate the year that they first learned about the accusations. These ranged from 1970 to 2001, with a mean of 1991. Of great interest is the pattern of accusations, which underwent exponential growth after 1985 to peak in the 2-year period of 1991 to 1992, with a total of 579 (34%) accusations in those years. The number of accusations steadily declined after 1992, and only 36 (.02%) families learned of accusations in the 2-year period 1999 through 2000 (Fig. 1).

TABLE 1. Individuals accused as percent of total accused

| | Primarily accused (N = 1731) | Secondarily accused (N = 985) |
|--------------|---------------------------------|----------------------------------|
| Father | 82.03% | 54.49% |
| Mother | 9.65% | 21.35% |
| Grandparents | 2.48% | 8.17% |
| Brother | 1.91% | 5.63% |
| Other | 1.33% | 5.67% |
| Uncle | 1.50% | 2.65% |
| Stepfather | 0.87% | 0.81% |
| Cousin | 0.12% | 0.37% |
| Sister | 0.12% | 0.85% |

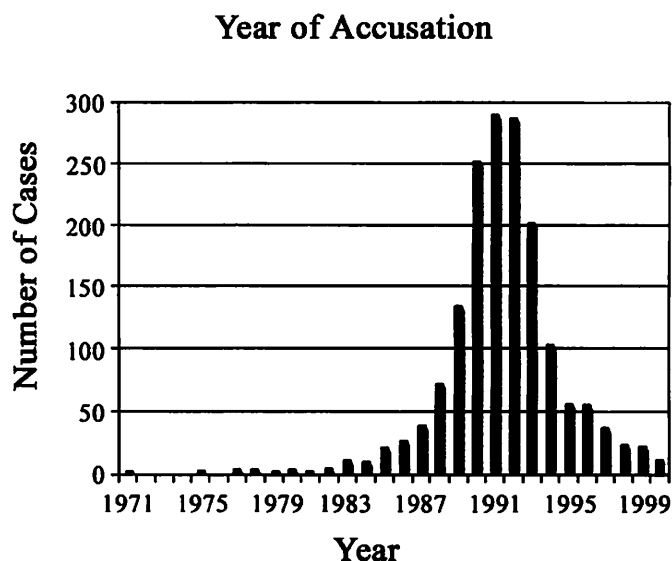


FIGURE 1. Number of cases according to the year each family learned of the accusation against them by a member.

In 92% of the cases, the accusations involved repressed memories, and in 19% of the cases, the accusations included claims of satanic ritual abuse.

The informants reported that the accusers claimed the alleged abuse began when the accusers were very young children, with a mean age of 4 years and a range from 0 to 18 years. The mean age of the accuser when the alleged abuse ended was 13 years, with a range of 1 to 50 years. However, many informant families were unable to define either when the alleged abuse began (37%) or ended (46%), because the details of the accusations against them were too vague.

Twenty-four percent of the accused were subjected to a confrontation by their accusers during a therapy session. Confrontations occurred significantly less often in families of refusers ($\chi^2 [2] = 25.819; p < .001$). On the other hand, refusers

tended to have made their accusations public—as in legal representations or media announcements—more frequently than returners or retractors ($\chi^2 [2] = 15.193; p < .001$).

Family Response to the Accusation and Its Relationship With Recovery

The accusation of incest was disruptive to many aspects of family life, but the majority (60%) of other family members, such as siblings of the accusers or extended family members, did not support (as by agreement or by concurring testimony) the accuser after the accusation. However, there was significantly more support for the accuser from family members of refusers than for the retractors or returners ($\chi^2 [2] = 7.342; p < .025$).

Some families (21%) reported that someone acted as a mediator (e.g., family member, clergy, professional, and so forth) to facilitate reconciliation. This occurred more frequently among retractor families ($\chi^2 [2] = 18.571; p < .001$). When respondents were asked whether the family was unanimous in wanting reconciliation with the accuser, retractor families were more unified in desiring reconciliation with the accuser than either refuser or returner families ($\chi^2 [2] = 46.663; p < .001$).

Families of retractors often did not seek help outside the family (56%), and those who did (44%) sought help most frequently from mental health professionals. Less common sources of assistance sought by families included clergy, family, and friends.

The mean duration of the accuser's separation from the family was as follows: for retractors, 5 years (range, 0 to 14 years); and for returners, 6 years (range, 0 to 23 years). (One retractor and 30 returners never completely cut themselves off but maintained some communications with their families.) Most families reported that returners did not discuss any aspect of the accusations (79%). Most retractors (63%) returned to the family and began some interactions before retracting the accusations—that is, they were returners for a time before they became retractors.

Retractor families were asked to comment on measures that they believed were helpful in reuniting their families. Ninety percent of those families identified one or several of the following sources of help:

- Help from outside family.
- Change in accuser's situation such as births, deaths, moves, and so forth.
- Contact by family and friends with the accuser.
- United stand by family.
- Family keeping door open and showing love.
- Confrontation and challenge by family.
- Influence on the accuser of books, information, and media.

DISCUSSION

Methods Discussion

For our survey, we have drawn on a population known to us and likely to be willing to cooperate with this enterprise. These people joined the FMSF because they sought support, guidance, and a sense of fellowship in the face of unexpected and inexplicable threats to their personal integrity and the coherence of their families. Most of these people were interested in reuniting as a family with the accuser. We expected and received considerable cooperation from them given their initial motivations for subscribing to the newsletter.

The survey instrument was a simple questionnaire that required little judgment beyond identifying the present state of the accusation and placing the accuser into one of the three stages (refuser, returner, retractor) of the recovery process.

By separating these three stages, we are certainly overlooking many phases of internal doubts and debates that an accuser follows when living and dealing with such a harsh and personally disruptive belief as this one. However, they have the advantages of simplicity, have a step-like character, and are easily operationalized to provide us with a picture of the recovery process. In fact, these simple distinctions did identify significant differences in the characteristics of the accusers that will be useful to further planning.

We decided to send out questionnaires to every family that subscribed to the foundation's newsletter, thus extending our reach back to 1994. We appreciated that this decision would lower the response rate to our survey, given that many of the original subscribers to FMSF newsletter would, for many reasons, have lost interest in this enterprise. However, such a broad reach would bring us into contact with all our correspondents, including those from the early years of the foundation, and thus give us a longer time span in which to follow recovery from false memory as it occurred in some of the families.

We have no way of confirming the validity of the replies we have received. However, we can comment on the consistency of the demographics in these replies with our previous studies and on their internal coherence with anecdotal experience as reported in the FMSF newsletter.

Demographic Results

Ninety-nine percent of both the accusers and the accused in the FMSF survey sample were white, with family wage earners in professional and managerial positions. These demographics, as mentioned, repeat the findings in our previous FMSF surveys. The accuser demographics do not resemble people who have been sexually abused (Sedlack and Broadhurst, 1996) but are remarkably like the populations who seek psychotherapy (Olfson and Pincus, 1994). In fact, 86% of the accusers were undergoing psychotherapy at the

time of accusation, and 92% reported recovery of repressed memories as the source of these accusations.

Certainly the accusation of abuse and the cutting off of family relations are radical and angry actions, so we naturally wondered whether some form of hostility existed among the members of the families before the accusation of sexual abuse that initiated the breakup. On the basis of our survey, we cannot speak to the existence of any particular source of hostility toward the family in the accusers or say for certain that there was not hostility in families. However, anecdotal information leads us to believe that there was little. Retractors do tell us that there were occasional problems in the families, but those families were loving and specifically not hostile. Note, for example, this quotation on the FMSF web site from a retractor: "The sad fact is that the parents you 'remember' in therapy are the lies and the parents you remember before therapy are, in fact, the loving parents you've loved all your life." Indeed, this description of the experience of the therapy—which is usually instrumental in generating the beliefs of abuse—is just what handbooks for this therapy prescribe. Here, for example, is what *The Courage to Heal* prescribes: "If you maintain the fantasy that your childhood was 'happy' then you have to grieve for the childhood that you thought you had...you must give up the idea that your parents had your best interest at heart" (Bass and Davis, 1988, p. 119).

Implications of the Frequency of These Accusations Over Time

Our results on the timing of the accusations indicate that the FMS occurred in a particular period of history in the United States and that these accusations and false memories are rapidly receding. Such a sudden rise and fall seems to indicate that some change in practice or some change in the culture, or both, has taken place, because the alleged events of abuse were supposed to have occurred over several decades many years ago, and that would not have changed. In fact, our data have all the appearance of a kind of epidemic, with the sudden explosion of these accusations in the late 1980s and early 1990s and now their subsidence. Either an epidemic of child abuse and repressed memories occurred in the 1960s (in a population quite distinct from that of usual child molesters), or a craze in therapy occurred in the 1980s that afflicted many vulnerable and, perhaps, suggestible people, only to be challenged, stigmatized, and ultimately rejected when the damage was recognized.

Surely the latter proposal is the more likely. The FMS epidemic most resembles a craze such as has been described in other medical and social situations by Penrose (1952). The first stage is characterized by the perception of a threat by a few people who try to spread awareness to the public. In the next phase, the spread of the perceived threat explodes, and many people join in the concern. As time goes on, an increasing number of people become skeptical about the

threat and consider it exaggerated. As resistance spreads, there may be social controversy. Finally, the concern diminishes until it is maintained only by marginal groups. In the case of FMS, the accusations may be waning because this craze has reached a downward phase. Perhaps people have become immune because of all the information about the controversy surrounding false memories that has been in the media.

Apportioning responsibility between patient susceptibility and therapist error is not simple. Some evidence is emerging that people who recover false memories may be different from others. Thus, McNally et al. (2000) conducted studies on personality traits of people who report repressed and recovered memories of child sexual abuse. In measures of fantasy proneness (absorption) and dissociation, women reporting recovered memories of child sexual abuse scored higher than those reporting continuous memories of child sexual abuse and those reporting no history of child sexual abuse. Subjects with repressed and recovered memory scored higher than the other groups in measures of distress.

Retractors report that they were psychologically and emotionally vulnerable when they entered therapy. After all, they were looking for answers to psychological problems and had to presume that the therapists were experts in these matters. Indeed, as one of us has already pointed out, "Two psychic processes have to be present to create the soil for the development of false memories. There are a reduction or suspension of critical judgment, and a narrowing of a focus of attention, precisely the necessary attributes for the development of a hypnotic trance" (Lief, In press).

We also note the many ways the craze of recovered memories of childhood sexual abuse resembles the transient mental illnesses occurring during an "ecological niche," Hacking's (1998) label for a niche in time during which a mental illness appears and disappears. Historical examples are the hysteria and fugue states appearing during the end of the 19th century. In Hacking's (1998) view, several vectors come together to form the basis for the development of a transient mental illness. One is a change in medical diagnosis, a shift in the taxonomy of illness at the same time that new cultural forces are arising, usually involving a polarity between virtue and crime. In the case of false accusations of incest, the polarity is between the virtue of a safe developmental environment for children and the crime of pedophilia.

Another possible interpretation of this data could be that therapists are now much more cautious and are no longer advising patients to confront their parents with accusations. Given the guidelines from the professional organizations (e.g., Position Statement on Therapies Focused on Memories of Childhood Physical and Sexual Abuse, Approved by the Board of Trustees of the American Psychiatric Association, March 2000), it is likely that many therapists have reconsidered their past practices. Both textbooks and continuing

education programs have also incorporated warnings about the dangers of memory recovery techniques.

Finally, the efforts of many professionals who have been so effective in educating the public about the problem have likely exerted a powerful influence in producing the decline in accusations. Knowledge about the false memory problem is now essentially universal in the American public, affecting patients, therapists, and families alike. Thus, people who are accused now can raise questions about the validity of the charge and get information from many sources. They do not need to contact the foundation to get information. Perhaps all of the above are contributing factors to this exponential reduction in the accusations of sexual abuse in families in which such behavior would be unusual.

What We Have Learned About the Recovery Process

Perhaps the most important things we have learned in this process of studying recovery relate to its elements: memories, recovered memories, and false memories. We can say that these elements are universal experiences in that all people have memories, all recover memories, and all have false memories from time to time. With the occasional false memory, people seldom check its veracity because the stakes are so low. However, it remains true that the only way to determine the historical truth of a memory is with external corroboration. The problem with the population of refusers in our article is that they find ways to avoid such corroboration and any contact with those who suggest its importance and necessity.

Through this work, we have come to recognize the great value in the term *false memory syndrome*, particularly as it has been defined by Kihlstrom (1992): “[W]hen the memory is distorted, or confabulated, the result can be what is called *false memory syndrome*—a condition in which a person’s identity and interpersonal relationships are centered around a memory of traumatic experience which is objectively false but in which the person strongly believes. Note that the syndrome is not characterized by false memories as such. We all have memories that are inaccurate. Rather, the syndrome may be diagnosed when the memory is so deeply ingrained that it orients the person’s entire personality and lifestyle, in turn disrupting all sorts of other adaptive behaviors. False memory syndrome is especially destructive because the person assiduously avoids confrontation with any evidence that might challenge the memory. Thus it takes on a life of its own, encapsulated and resistant to correction. The person may become so focused on the memory that he or she may be effectively distracted from coping with the real problems in his or her life. It should be noted as well that even when the memory is valid, or of unknown (and unknowable) validity, the person can take on an identity as a survivor that is not necessarily in the best interests of getting on with life.”

Given our recognition of the accuracy of Kihlstrom’s (1992) description of the problem, we were originally impressed by anecdotal reports that recovery was often a rather slow process occurring in stages. The three stages we have identified here are simple and yet adequately distinct to offer some value for study. The survey results indicate important distinctions among people in these stages—distinctions that may help explain the process of recovery and that may need to be considered by those who want to facilitate recovery.

Thus, those people who remain as refusers seem to have a hardened belief system. They shun contact with those who do not confirm their beliefs; they make their accusations public more frequently; and, by definition, they refuse all contact with the accused and thus any possibility of reflection in the company of the supposed predator. They may still be in contact with their original therapists.

We find that with those people who return but do not discuss the accusations with their family—returners—their wish to be connected to the family outweighs the importance of continued assertion of the accusations. What may be more likely is that returners’ beliefs about the accusations vacillate. Indeed, very occasionally, a returner becomes a refuser again. Although they reject discussion of their accusations, they seem willing to set them aside when in the company of their families. Future studies of the returners and retractors will illuminate this issue of ambivalence and vacillation.

Finally, people who ultimately reject the accusation and reconcile completely with their families—retractors—have a number of important characteristics. Most retractors had returned to the family first and only later retracted the accusations. This indicates that the recovery is, as we suspected, a process taking some time and following stages. The retractors studied by Ost et al. (2002) did not claim that family pressure brought them to recovery but rather that time, reflection, and external events combined to free them from their beliefs.

Retractors tend to be younger than either returners or refusers—a fact that may indicate that they originally had not separated as much from the family as had the older refusers and returners and so could more easily give up their identities as victims. It might also be that the younger people had not yet formed their own families, whereas the older ones had formed networks that supported their beliefs. Our evidence shows that the families of retractors report more interventions from mediators in the recovery and that the family itself was much more unified in its belief about the falseness of the accusation and in the desire for reconciliation.

Other points mentioned by families of retractors as encouraging them to re-establish their family ties were life change events such as birth, marriage, moves, and death or illness in the family. In addition, as mentioned in comments within the survey, issues that drew retractors’ attention to their problem included deterioration of their emotional state

in a therapy that continued to demand their allegiance to these beliefs, their education about the FMS, and their realization of the likeliness of its application to themselves. Data from retractor studies (deRivera, 1997; Nelson and Simpson, 1994) and FMSF newsletter comments indicated that escaping from victim groups and other influences such as their provoking therapists were helpful to retractors.

All these facts suggest that there may well be many families living with a returner in which there is an unspoken or quietly understood but unacknowledged retraction. There are others, though, in which the family takes first an agree-to-disagree position (and may stay at that point for years) and in which movement occurs at some opportune moment. It takes two parties to reconcile, and if both are not willing, it does not happen.

Former patients have spoken eloquently about the difficulties:

"I'm so sorry. I didn't understand the pain, distrust and confusion the lie would cause. And when I did, I was so scared and guilty I tried to hide from it" (FMSF newsletter, November 1995).

"Here's where your daughters are probably stuck. I could not face the horrible thing I had done to my parents, so I had to believe the memories were true. Even though I got away from that horrible therapist, I could not go back to my entire extended family and say that I was temporarily insane and nothing had happened. It was easier for my self-esteem to pretend that I had been sexually abused by someone, and it was still my parents' fault because they should have protected me" (FMSF newsletter, December 1998).

"All those years of therapy and flashbacks couldn't have been for nothing" (FMSF newsletter, April 1999).

"It took me a number of years to fully believe that my memories were false. Then I didn't want to apologize because it would have opened things up for discussion—which I was afraid of. What was most helpful to me was that I knew my parents loved me despite my allegations" (FMSF newsletter, March 2000).

Guidelines for Professionals

From the data we have, we are confident that the recovery from FMS is a slow and staged process. The recovery is encouraged when the family is unified behind the recovery and is willing to accept a returner status as a first stage. Efforts to demand a full retraction early on in the process may lead to increased resistance on the part of the accusers and slow the

process further. Suggestions that the accuser leave the company of the provoking therapist and the network of therapies that encourages the belief are not unreasonable proposals to be promoted in recovery. Much effort in maintaining communication of some sort with the accuser appears to be valuable and can be made in most families, either through some mediating members or through reminders of continuing affection. We have learned that many of our returners and retractors are helped by a mediator who can remind the accuser of the value of returning to the family by emphasizing its strengths. However, much patience is required by all in this process, and much help of an encouraging kind needs to be offered to the accused to sustain both the enterprise and hope.

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