havioral change—is remarkable. While this reduction did take 25 years and is still far from complete, I believe today’s environment, with extensive electronic media, may facilitate more rapid behavioral changes in a public that is increasingly concerned and sophisticated about health matters. Thus, while prevention is not a panacea for cost containment in health care, it is our best hope and strategy for improving population and individual health, and for thereby indirectly exerting a powerful moderating effect on the rate at which health care expenditures increase. Our greatest problem has been leadership in public health, or a lack thereof, and health care reform offers an opportunity to demonstrate some.

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Screening for Interpersonal Violence

In a recent two-part article, “Remembering Satan” (The New Yorker, May 17, 1993:60, and May 24, 1993:54), Laurence Wright details the fallibility of recovered memories as he tells of a 1989 satanic cult investigation in Olympia, Wash. In closing, he notes, “Whatever the value of repression as a scientific concept or therapeutic tool, unquestioning belief in it has become as dangerous as the belief in witches.”

Dr Acheson,1 in her excellent editorial on domestic violence, urges physicians to look beyond the medical domain in depressed patients for clues for oppression (a social condition characterized by the physical and mental subjugation of the powerless). Those of us who serve in the primary care sector are being urged by our leadership to screen patients for interpersonal violence. This includes almost everyone since most of us are in relatively powerless situations sometime during our life. In our haste to screen for abuse, I am concerned that we not get caught in that witch-hunt described by Wright.

The US Preventive Services Task Force2 has made an extraordinary contribution in the development and publication of evidence-based practice guidelines. We, in the primary care sector, should await their assessment of screening and early detection of abuse before wholesale adoption.

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Denial is different from repression. Our society has repeatedly denied both the prevalence of woman abuse and the magnitude of its effects. Women who are beaten, controlled by insults and threats, or sexually assaulted by their intimate partners can feel isolated and somehow blameworthy; they can doubt their right to safety and protection, but they do not generally repress the memory of what is happening to them.

To survive violent childhood sexual abuse or extremely traumatic events at any age may call for extreme psychological defenses such as repression. Skill, experience, and discretion are essential to anyone who works with a person remembering and reexperiencing traumatic events that have been repressed. The article in The New Yorker, “Remembering Satan,” indeed documents a lack of these attributes in those who investigated this particular case, discards the survivors’ “memories” of cult rituals (which were suggested to them by the investigators), but leaves little doubt (especially as their father confessed) that children were sexually abused. “Still, there was nothing very unusual about a community leader’s being caught in a disgraceful act,” the author comments on the second page of the article. “In the ordinary course of events, he would probably have been spared a prison sentence and assigned instead to psychological counselling. His case would have long since been forgotten” (The New Yorker, May 17, 1993:61). It is in this climate of minimization and denial that most survivors of abuse choose to tell or not to tell what they have experienced.

In making an analogy between screening for a history of domestic violence and a “witch-hunt,” Dr Carmichael may be disregarding the origin of the phrase. Witch-hunts swept through Europe in the 15th and 16th centuries after the misogynist treatise Maleficus Maleficarum (The Witches’ Hammer), naming women as the root of all evil, was officially circulated to all Catholic judges and magistrates. Officials were advised to torture suspected witches until they confessed. This resulted in what has been referred to as the “women’s holocaust.” Approximately 50,000 women were executed as witches, an average of 600 per year in some German cities.1 It seems a twisted analogy to call current efforts to stop violence against women a witch-hunt.

In the study by Saunders et al,2 no repressed memories were being uncovered and no form of coercion was used to elicit information about woman abuse. Most of the women’s physicians had never asked them about domestic violence. The Conflict Tactics Scale, the instrument used in a questionnaire to family practice patients who visited their physicians, purposely asks about the whole spectrum of behavior in conflict situations, including behaviors that could be considered both nonviolent and constructive, as well as those that are defined as abusive. While this is a useful research tool, others have shown that one or two simple questions can usually screen for a history of abuse by an intimate partner.3 It is not the screening technique that causes interpersonal violence to be so prevalent.