Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Recognition of Sexual Abuse

To the Editor: In her editorial "Recognition of Sexual Abuse,"[1] Dr. Hendricks-Matthews makes a statement that could have serious negative consequences for women who have been sexually abused. She states:

> Even family physicians who are highly experienced in counseling patients should not undertake counseling abuse victims unless they have specific training in this area. Referral to appropriately trained mental health professionals would be the proper next step in most situations.

She then states that "These resources exist in most communities . . . ." Although we do not disagree with referral to experts, we are aware that in the rural areas of our state there is often no mental health service of any kind.

The data on the availability of services are not clear. Even when mental health care is available, there are few mental health providers who are truly experienced in counseling sexual abuse victims. Thus, if physicians, already reluctant to deal with abuse, discover a patient who has been sexually abused and follow this advice, patients, who having revealed their pain and suffering, will suffer more by being left to their own resources in trying to heal the pain. We do not think Dr. Hendricks-Matthews intends this outcome, but considering how sensitive physicians can be to the danger of litigation that can occur if one does not follow "expert" opinions or guidelines, this advise might not be the best.

Also, having reviewed a great deal of the literature for our own abuse research, we have not read anything to support the above statement. Do we know what "ideal" counseling should be for these patients? Is no counseling better than imperfect counseling? Certainly, the principle of "do no harm" should be strongly considered if a physician wishes to counsel such patients, but perhaps a good listener can do much for these women. We should all work together to discover the key elements of the most effective counseling for abuse victims and not let them suffer in silence until we have the "perfect" counselors who are ready to help them.

Our own research and that of Walker, et al.[2] and others[3-5] indicate that there are great numbers of patients in primary care who need these services, and yet we doubt there are resources to handle all these patients adequately, even using mental health providers who are not expert in sexual abuse counseling. We need to encourage all primary care providers who believe they are competent in counseling skills to use them. As they open up the emotional wounds of these women, they must be open to referring them to those who are more skilled in sexual abuse counseling, if needed and if available. Until we have readily available services throughout the country, let us continue to help primary care providers recognize abuse by educating them about the prevalence and epidemiology of sexual abuse and then train them to provide counseling services, if they are so inclined. This, we believe, will be of greater benefit to abused women then to discourage the provision of such services by primary care providers until they are "experts."

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References

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3. Walch AG, Broadhead WE. Prevalence of lifetime sexual victimization among female patients. J Fam Pract 1992; 35:511-6.
4. Felitti VJ. Long-term medical consequences of incest, rape, and molestation. South Med J 1991; 84:328-31.
5. Lechner ME, Vogel ME, Garcia-Shelton LM, Leichter JL, Steibel KR. Self-reported medical problems of adult female survivors of childhood sexual abuse. J Fam Pract 1993; 36:633-8.

Obstetrics in Family Practice

To the Editor: Sakornbut and Dickinson[1] provided a service to our specialty by further confirming the importance of role models and hospital privileges in family practice residency training environments. On this issue of comprehensive women's health care, family practice residencies have been understaffed, underfunded, and politically manipulated by the amputation of hospital privileges.[2] As a member of the American Academy of Family Physicians (AAFP) Task Force on Obstetrics, 1989–1993, I believe the importance of maternal and fetal medicine to the overall welfare of our specialty cannot be over-