

Gender-Based Violence in Women and Mental Disorders

To the Editor: Dr Rees and colleagues¹ studied the prevalence of gender-based violence (GBV) among women and the relationship with mental disorders and psychosocial function. However, they did not comment on the possible role of intergenerational transmission of violence: children exposed to violence have a high chance to abuse or be abused in their adult life.² In the article, Table 2 shows that women who reported any childhood nonsexual trauma had the highest prevalence of GBV later in life (55.77%), which is higher than any other patient characteristic described in the table. Unfortunately, the researchers did not investigate the association between nonsexual childhood trauma, GBV, and mental disorders. Early support for children exposed to violence may be an important factor to prevent intergenerational transmission and therefore GBV and associated mental disorders, just as social support is important to reduce GBV and the negative mental health effects of GBV.³ The authors collected data on social support but used it only as a control factor.

We support an integrative approach to the provision of services for GBV and mental health disorders and agree that existing programs might not be equipped to treat both. However, women experiencing GBV are often not ready cognitively or emotionally to take advantage of existing health care programs.⁴ Therefore, initial intervention should not focus on treating disorders but may need to first improve women's readiness to change. Mentor support for mothers is one example of an intervention that focuses on increasing social support and preparing women to accept further treatment.⁵ During this support, mental health problems can be diagnosed, and when a woman is ready to accept mental health care, an integrative approach including both GBV and mental health assistance can be offered.

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Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr van Rosmalen-Nooijens reported being a PhD student working on a project to support children, adolescents, and young adults who witness intimate partner violence. Dr Lo Fo Wong reported receiving governmental and nonprofit grants for a research project on mentor mother help for interpersonal violence; working as a trainer on recognizing partner violence; and receiving travel expenses to a World Health Organization consultation group meeting on violence against women. Dr Lagro-Janssen reported receiving governmental and nonprofit grants to study partner violence.

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2. Ehrensaft MK, Cohen P, Brown J, Smailes E, Chen H, Johnson JG. Intergenerational transmission of partner violence: a 20-year prospective study. *J Consult Clin Psychol*. 2003;71(4):741-753.

3. Coker AL, Smith PH, Thompson MP, McKeown RE, Bethea L, Davis KE. Social support protects against the negative effects of partner violence on mental health. *J Womens Health Gend Based Med*. 2002;11(5):465-476.

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5. Taft AJ, Small R, Hegarty KL, Watson LF, Gold L, Lumley JA. Mothers' AdvocateS In the Community (MOSAIC): non-professional mentor support to reduce

intimate partner violence and depression in mothers: a cluster randomised trial in primary care. *BMC Public Health*. 2011;11:178.

In Reply: The strength of the epidemiological study we reported is that it showed a robust association between GBV and a range of common lifetime mental disorders, conditions that are severe and disabling in their effect. Such epidemiological studies are not ideal for examining developmental pathways. While structural equation modeling using cross-sectional data can map complex associations involving early childhood abuse, subsequent GBV, and mental disorders, the paths that emerge can only be suggestive, given that the data are gathered at one point in time and are based on retrospective recall of the chronology of events. Longitudinal studies are the ideal method to trace the sequencing of these phenomena. Even then, the task presents formidable challenges because of the difficulties in obtaining a candid account of early abuse either from parents or children.¹ In addition, in interpreting the association of childhood nonsexual abuse and GBV, it needs to be acknowledged that these types of abuse can occur concurrently in an abusive family environment. For that reason, caution needs to be exercised in inferring with a high degree of specificity the relationships between different types of abuse.

Although social support can moderate the mental health effects of abuse,^{2,3} identifying its precise role using epidemiological studies presents difficulties. For example, a violent partner may actively alienate a woman from social supports, or severe depression may inhibit the woman from accessing available supports. In the absence of more detailed information about the individual and her social environment, we have applied the conservative approach of treating social support as a control variable.

The high rates of GBV and of associated mental disorder reported in our study mean that professionals will encounter women with a combination of both problems in multiple contexts. It is doubtful therefore that a single approach or a standard sequence of interventions will match the needs of all women. For example, where a woman has severe depression and is not at immediate risk of violence, psychiatric attention may be the most pressing need, whereas protection and social support may be the overriding requirements for a woman in imminent danger of ongoing intimate partner violence. The key point is that a range of interventions should be considered to tailor the response to the individual needs of each woman and to promote her empowerment and independence in the process.

Protecting children from witnessing or experiencing GBV must be a public health priority. Safeguarding women's rights to live without violence not only will ensure protection of their own mental health but will also assist in promoting the mental health and well-being of their children. Successful interventions will also have the broader public health effect of interrupting the insidious cycle of GBV, mental disorder, and disability.

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Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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Sleep-Disordered Breathing and Cognitive Impairment in Older Women

To the Editor: In their study, Dr Yaffe and colleagues¹ concluded that older women with sleep-disordered breathing are more likely to suffer cognitive decline. However, the patients in both study groups, with and without sleep-disordered breathing, had mild cognitive impairment at baseline (mean Mini-Mental State Examination [MMSE] scores of 25.1 and 24.9, respectively). Almost 5 years later, both groups received another cognitive assessment. The authors found 44.8% of women with sleep-disordered breathing developed mild cognitive impairment or dementia compared with 31.1% of those without it. Because patients in both groups started the study with mild cognitive impairment, what percentage developed dementia? How did the MMSE scores change over time? In addition, the authors used different instruments in the 5-year cognitive assessments, making it difficult to appreciate the difference between the 2 groups over time.

Why did patients initially diagnosed with sleep-disordered breathing (an apnea-hypopnea index of 15 or more) not receive treatment with continuous positive airway pressure or bilevel positive airway pressure, the standard of care for such patients?

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Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

1. Yaffe K, Laffan AM, Harrison SL, et al. Sleep-disordered breathing, hypoxia, and risk of mild cognitive impairment and dementia in older women. *JAMA*. 2011;306(6):613-619.

In Reply: Drs Gianakos and Mehra raise concerns that participants in our study may have already developed mild cognitive impairment at baseline. The cognitive test scores presented in Table 1 in the article were results from the shortened version of the MMSE, which is scored out of 26 points, rather than the 30-point scale of the full MMSE. Although we cannot be sure that participants in our cohort did not have some subtle pre-clinical cognitive impairment at baseline and that this was greater among women with sleep-disordered breathing, the 2 groups had very similar mean (SD) test scores: 24.9 (1.2) for women without sleep-disordered breathing and 25.1 (1.1) for those with sleep-disordered breathing ($P = .22$). In the analysis, we also addressed this issue by excluding any suspected cases of cognitive impairment before the 5-year follow-up cognitive assess-

ment, defined as those participants with a physician's diagnosis of dementia or Alzheimer disease or a low cognitive test score. In addition, when dementia and mild cognitive impairment were analyzed separately, the associations with sleep-disordered breathing were similar, albeit with reduced power (unadjusted odds ratio for mild cognitive impairment or dementia, 1.80 [95% CI, 1.10-2.93]; for mild cognitive impairment, 1.88 [95% CI, 1.04-3.40]; for dementia, 1.70 [95% CI, 0.88-3.27]).

We appreciate the issue of standard of care for patients with sleep-disordered breathing. Because the Sleep and Cognition Study was an observational research study and not a clinical assessment, participants received a feedback report of their polysomnography results that could be shared with their physicians; however, we were not able to initiate or provide treatment. Despite these limitations, we believe that our results confirm an association between sleep-disordered breathing and risk of cognitive impairment and warrant future research in the field.

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Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Yaffe reported that she is a consultant for Novartis; serves on data and safety monitoring boards for Pfizer, Medivation, and the National Institute of Mental Health; is a board member for Beeson Scientific Advisory; has grants pending with the National Institutes of Health, the Alzheimer Association, the Department of Defense, and the American Health Assistance Foundation; and has received funding for expenses unrelated to the activities listed from the Alzheimer Association, the National Institutes of Health, Beeson Scientific, the Japan Geriatrics Society, Wake Forest University, and the State of California Department of Human Services. Dr Stone reported no disclosures.

Organ Transplantation and Regulation in China

To the Editor: In their Commentary, Drs Shi and Chen wrote that "[t]he Chinese government has strictly followed the guiding principles of the World Health Organization for organ transplantation."¹ However, the guiding principles require that prior to organ removal, consent must be obtained.² The preamble of the guiding principles gives further direction by stating that protection of "vulnerable persons from coercion and improper inducement to donate organs" is of particular concern.² Yet Shi and Chen wrote that "sentenced convicts have become the main organ source for transplantation." According to the World Medical Association, prisoners are not considered to be in a position to give consent freely.³

The authors mentioned that "traditional culture plays an important role in preventing some volunteers from donating organs," yet the reluctance to donate organs is deeply rooted in Chinese culture. Between 2003 and 2009, there were only 130 voluntary organ donations in all of China.⁴ In 2010, the Chinese Red Cross Society and the Chinese Ministry of Health launched a pilot program for voluntary organ donation, which generated fewer than 100 organs.⁴ According to a survey conducted by the Guangzhou Medical College, 41% of correspondents attributed their reluctance