

controlled trials using these prescribed approaches. There has also been no randomised controlled trial comparing the different types of debriefing. Therefore, until there is evidence there is no support for using one type of debriefing over any other.

Debriefing is a “grassroots” intervention that is popular among many health and allied practitioners. Some of them are likely to continue to advocate its use in spite of the lack of empirical support for it. Organisations such as banks and hospitals are likely to continue using it since there is no comparable broadly acceptable early intervention that is comparatively low cost. The continued use of debriefing might not matter (other than to taxpayers and shareholders) if studies had found that psychological debriefing had no effect or a positive effect on recovery. But this is may not be the case. Distress after trauma typically reduces over time, stabilising at levels that are proportional to the initial traumatic event.⁷ For debriefing to be worthwhile it should at least accelerate the downward trajectory of distress. What should concern practitioners, organisations, and researchers is that not only does the evidence indicate that this is not happening, but it also indicates that debriefing may prolong the process of recovery.

Why should this happen? Research shows that certain factors probably have an impact on the recovery process, such as the perception that a trauma was life threatening, the person’s premorbid psychiatric state, and the presence of serious ongoing stressors.^{7, 8} Other factors may also affect recovery—for example, people’s expectations of their responses and reactions.^{7, 8} It has been suggested that debriefing “medicalises” normal distress by generating in an individual the expectation of a pathological response.⁵ Personality and coping style may also interact with debriefing and affect recovery. However, this relation is likely to be complex. For example, a tendency to avoid rather than

confront emotionally distressing experiences is associated with poorer outcomes after trauma, suggesting that people with this tendency will need help in confronting or discussing the trauma. However, an exposure that is too brief, such as in debriefing, may exacerbate, rather than ameliorate, distress.⁵

These are still hypotheses without supporting evidence. But since they bear directly on how an early psychological intervention after a trauma might proceed they are worthy of attention. There is little evidence to support current debriefing practices, and little is known about why debriefing might adversely affect recovery. There does, however, continue to be a great need for an early intervention that is demonstrably effective after a trauma.

Justin Kenardy *associate professor in clinical psychology*

School of Psychology, University of Queensland, Brisbane Q 4072, Australia
(kenardy@psy.uq.edu.au)

- 1 Kenardy JA, Webster RA, Lewin TJ, Carr VJ, Hazell PL, Carter GL. Stress debriefing and patterns of recovery following a natural disaster. *J Trauma Stress* 1996;9:37-49.
- 2 Bisson J, Jenkins P, Alexander J, Bannister C. Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *Br J Psychiatry* 1997;171:78-81.
- 3 Raphael B, Meldrum L, McFarlane A. Does debriefing after psychological trauma work? *BMJ* 1995;310:1479-80.
- 4 Mitchell J. When disaster strikes . . . the critical incident stress debriefing procedure. *J Emerg Med Serv* 1983;8:36-9.
- 5 Wessely S, Rose S, Bisson J. A systematic review of brief psychological interventions (“debriefing”) for the treatment of immediate trauma-related symptoms and the prevention of post traumatic stress disorder. In: Cochrane Collaboration. *Cochrane Library*. Issue 4. Oxford: Update Software, 1999.
- 6 Small R, Lumley J, Donohue L, Potter A, Waldenström U. Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth. *BMJ* 2000;321:1043-7.
- 7 Carr VJ, Lewin TJ, Webster RA, Kenardy JA. A synthesis of the findings from the quake impact study: a two-year investigation of the psychosocial sequelae of the 1989 Newcastle earthquake. *Int J Soc Psychiatry Psychiatr Epidemiol* 1997;32:123-36.
- 8 MacFarlane AC. The longitudinal course of posttraumatic morbidity: the range of outcomes and their predictors. *J Nerv Ment Dis* 1988;176:30-9.

Driving after repair of groin hernia

It is usually safe after a week with repairs that do not put tissues under tension

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Surgeons have traditionally advised patients recovering from groin hernia repairs not to drive for a month or two. This is based on the concern that postoperative pain could prolong reaction times and, to a lesser degree, that there is a risk of early recurrence as a result of the inertial forces that occur during a sudden impact or stop. However, preclusion from driving, particularly in the major cities around the globe, can have socioeconomic consequences.

Fortunately, by alleviating traditional concerns (and restrictions) about driving, the modern method of hernia repair is improving not only patients’ physical wellbeing but their social and psychological recovery as well.

The pain that follows the repair of hernias in the groin is caused by mechanical and chemical stimulation of large, myelinated nerve fibres (A- α fibres) or small, unmyelinated nerve fibres (C fibres). Mechanical stimulation of somatic tissues, such as that which occurs when tension is created on the fibroconnective

tissue of the groin, causes pain both directly—through mechanical stimulation of A- α and C fibres—and indirectly—through the release of chemical substances that further stimulate the C fibres.¹ Such chemical substances include hydrogen, potassium, bradykinin, serotonin, histamine, acetylcholine, proteolytic enzymes, and prostaglandins.¹⁻⁵ In addition, the same chemical substances cause visceral pain by stimulating the C fibres that innervate the hernia sac (peritoneal sac) that is excised and ligated during the traditional repair.

The traditional method of hernia repair, which includes forceful approximation of the fibroconnective tissues of the groin, is associated with undue tension on the suture line, which leads to somatic pain through C and A- α nerve fibres. In addition, ligation of the hernia sac results in visceral pain, caused by mechanical stimulation and ischaemic changes in the peritoneum that lead to the release of chemical substances. Fortunately, modern hernia repairs avoid approximating tissues under tension by using a layer of synthetic

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mesh. These repairs are associated with a reduction in postoperative pain because they eliminate the somatic component of the pain (the tissues are not put under tension) and because the hernia sac is not ligated, leading to a reduction in the visceral component of the post-herniorrhaphy pain.

Concern about the recurrence of a hernia in the groin from the inertial force of an impact or sudden stop while driving is based on the fact that it takes between six and eight weeks for a hernia defect to heal when its repair has involved forcefully approximating the edges of the defect. A sudden increase in intra-abdominal pressure resulting from the inertial force of an impact or sudden stop can potentially disrupt the suture line of the repair. However, hernia repairs that do not use tissue tension are not at risk for this since the technique does not involve pulling together and suturing the edges of the defect. Rather, the recovery period is solely dependent on the amount of postoperative discomfort, which is minimal and usually does not require narcotic analgesics. Many prospective and randomised studies comparing laparoscopic hernia repair with tissue approximation under tension and with open repair carried out without tissue tension have concluded that open repair without tension and laparoscopic repair are equally associated with decreased postoperative pain.⁶⁻⁸ More importantly, a meta-analysis of randomised controlled trials of laparoscopic versus open inguinal hernia repair showed that repairs carried out without tension, whether open or laparoscopic, result in less postoperative pain and faster recovery.⁹

The reduction in postoperative pain and the risk of recurrence associated with the different types of hernia repairs carried out without tissue tension have allayed concerns over allowing patients to return to normal daily activities, including driving. Now, patients can resume driving as early as one week or less after

surgery depending on their comfort and whether they are using narcotic analgesics. In fact, the postoperative handout at our clinic clearly says that "Your physical activities are in no way restricted."

As Ismail et al point out in this week's issue of the *BMJ* (p 1056), modern techniques of hernia repair have changed the pattern of convalescence after this surgery.¹⁰ These days individual variations in postoperative pain and the use of opiates (if any) should be considered. Those who drive different types of vehicles need different advice. More importantly, I agree with Ismail et al that national guidelines should be developed. Such guidelines would benefit hernia patients around the globe whichever side of the road they drive on.

Parviz K Amid *director*

Lichtenstein Hernia Institute, 5901 W Olympic Boulevard, Suite 207, Los Angeles, CA 90036, USA
(pamid@onemain.com)

- 1 Gyton AC. *Textbook of medical physiology*. 8th ed. Philadelphia: Saunders, 1991:507-31.
- 2 Bond MR. *Pain, its nature, analysis and treatment*. New York: Churchill Livingstone, 1984:3-33.
- 3 Cailliet R. *Pain mechanism and management*. Philadelphia: Davis, 1993:1-53.
- 4 Lawrence K, Kiebeskind JC. *Neural mechanisms of pain*. New York: Raven, 1984:53-104.
- 5 Maggi CA, Sicuteri F, Terenius L, Vecchiet L. *Pain versus man*. New York: Raven, 1992.
- 6 Horeysek G, Roland F, Rolsfes N. Die "spannungsfreie" reparation der Leistenhernie: Laparoskopisch (TAPP) versus offen (Lichtenstein). *Chirurg* 1996;67:1036-40.
- 7 Filipi CJ, Gaston-Johansson F, McBride PJ, Murayama K, Gerehardt J, Cornet DA et al. An assessment of pain and return to normal activity: laparoscopic herniorrhaphy versus open tension-free Lichtenstein repair. *Surg Endosc* 1996;10:983-6.
- 8 Kawji R, Feichter A, Fuchsjaeger N, Kux M. Postoperative pain and return to activity after five different types of inguinal herniorrhaphy. *Hernia* 1998;3:31-5.
- 9 Chung, RS. Meta-analyses of randomized controlled trials of laparoscopic versus conventional inguinal hernia repair. *Surg Endosc* 1999;7: 68-94.
- 10 Ismail W, Taylor SJ, Beddow E. Advice on driving after groin hernia surgery in the United Kingdom: questionnaire survey. *BMJ* 2000;321:1056.

Time to talk about rape

If men remember that women are their mothers, daughters, and wives they may change their laws

The global statistics on sexual assault against women are shocking. At least one in every five women experiences rape or attempted rape during her lifetime.¹ The recently published report from the United Nations Population Fund on the *State of the World Population 2000* is the latest of many official reports that have documented the size of the problem.² Yet despite clear documentation and the fact that much attention has been paid to the issue of sexual violence against women at international level, the problem is getting worse.

The UN report and other data make it clear that the incidence of rape and other forms of sexual violence is increasing worldwide.³ Yet even official figures underestimate the scale of the problem because the proportion of rapes reported to the authorities varies from 16% in the United States to 3% in South Africa (where even 3% amounted to 49 280 rapes in 1998⁴). The fourth world

conference on women in 1995 in Beijing considered violence against women to be one of the 12 critical areas of concern, and a "platform for action" was agreed by the 189 governments present.⁵ Yet the follow up conference in New York in 2000 agreed that the action had been woefully ineffective,⁶ and a Human Rights Watch report on six countries—Jordan, Pakistan, Peru, Russia, South Africa, and the United States—concluded that women were actually worse off.⁴ These six countries are not extreme cases; they reflect the situation for women in most countries.

Perhaps it is not surprising that international action to prevent sexual violence has failed when the judicial system is so often stacked against women who complain of sexual violence. In the United States, for example, some states do not treat sexual misconduct by guards on women prisoners as a criminal offence. In Peru some women have had to deliver police

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