from Cartesian dualism fail to advance clinical neuroscience or the practice of psychiatry. Dr Persaud will, of course, be aware of the compelling evidence for changes in brain function and structure in both depression and obsessive–compulsive disorder, the main indications for NMD (Drevets, 1998; Szeszko *et al*, 1999).

The argument that there is a lack of randomised controlled trial (RCT) data to support NMD applies equally to a range of 'cutting edge' medical and surgical procedures. The proportions of medical and surgical treatments based on RCT data are 53% and 24%, respectively (Ellis *et al*, 1995; Howes *et al*, 1997). In such situations, prospective clinical audit becomes the tool of choice. If Dr Persaud demands that NMD cease because of the absence of robust RCT support, then he must surely demand the same rigour from other interventions such as heart transplantation or dynamic psychotherapy.

With respect to the issue of consent, in Scotland NMD does not take place unless the patient provides informed consent and the Mental Welfare Commission for Scotland agrees both that it is an appropriate treatment and that consent is valid. Regrettably, Dr Persaud continues to trade on the outdated image of patients receiving NMD against their wishes. Indeed, he implies that chronic intractable mental illness robs patients of their capacity to provide informed consent. It is demeaning to assert that individuals are incapable of evaluating the risks and benefits of a treatment simply because they have a mental illness. Perhaps it is the failure to appreciate this perspective that leads to excessive concern for the 'stigmatised profession of psychiatry'? Believing ourselves to be persecuted perpetuates outdated views of psychiatry, and does nothing to reduce the stigma of mental illness.

Declaration of interest

K.M. has received payment for lectures on the management of depression from various pharmaceutical companies. K.M. and M.S.E. run the Dundee Neurosurgery for Mental Disorders Service.

Drevets, W. C. (1998) Functional neuroimaging studies of depression: the anatomy of melancholia. *Annual Review of Medicine*, **49**, 341–361.

Ellis, J., Mulligan, I., Rowe, J., *et al* (1995) Inpatient general medicine is evidence based. *Lancet*, **346**, 407–410.

Howes, N., Chagla, L., Thorpe, M., *et al* (1997) Surgical practice is evidence based. *British Journal of Surgery*, **84**, 1220–1223.

Persaud, R./Crossley, D. & Freeman, C. (2003) In debate: Should neurosurgery for mental disorder be allowed to die out? *British Journal of Psychiatry*, **183**, 195–196.

Szeszko, P. R., Robinson, D., Alvir, J. M., *et al* (1999) Orbital frontal and amygdala volume reductions in obsessive–compulsive disorder. *Archives of General Psychiatry*, **56**, 913–919.

D. Christmas, K. Matthews Department of Psychiatry, Ninewells Hospital and Medical School, Dundee DDI 9SY, UK

M. S. Eljamel Department of Surgical Neurology, Ninewells Hospital and Medical School, Dundee, UK

Author's reply: My necessarily abbreviated arguments against the continued practice of NMD are intended to be within the spirit of the debate section of the *Journal*. A debate necessarily requires two sides. Given that the title of the debate I was given included the term 'mental disorder' I am confused that an objection should be raised to my nod towards the well-recognised controversy over the modern phrenological localisation of psychiatric disorder. But I am perhaps mostly perplexed by the failure to see that the use of an irreversible surgical treatment directly applied to the brain necessarily demands much higher standards of certainty over its benefits than something like dynamic psychotherapy, particularly given the political context of a profession with obvious public image difficulties. Anyone aware of the widespread coverage that our debate received in the Scottish newspapers would be immediately impressed by this public relations context, which is precisely the area the coverage focused on.

R. Persaud The Maudsley Hospital and Institute of Psychiatry, Croydon Mental Health Services, 49 St James' Road, West Croydon CR9 2RR, UK

Stigma and somatisation

In their exhaustive review of the impact of globalisation and culture on depression, Bhugra & Mastrogianni (2004) highlight the role of somatisation in many parts of the world, where it often accounts for 'common presenting features of depression' (p. 16). Emphasising both the ubiquity and cultural aspects of somatisation, they cite an earlier characterisation of common mental disorders that refers to the 'black box of somatisation' (Bhui, 1999). In doing so, however, they miss an important explanatory feature of this process with substantial practical and clinical significance – that is, the role of stigma. Despite increasing availability of effective treatments, many people with depression (perhaps even a majority) do not seek professional help because of the stigma associated with the illness. Efforts to clarify the impact of stigma are crucial for explaining cultural aspects of illness-related experience and meaning, and highly relevant for planning interventions that are culturally appropriate and locally effective.

As one effort towards elucidating the experience of depression, in a study in Bangalore, India, we examined the role of self-perceived stigma (Raguram *et al*, 1996). We found that greater severity of depression was associated with higher stigma scores, but more somatisation was associated with less stigma. Through qualitative analysis of patients' narratives, we also demonstrated that patients viewed depressive, but not somatic, symptoms as socially disadvantageous. Somatic symptoms were considered to be less stigmatising since they resembled illness experiences that most people could expect to have from time to time. Consequently, studying the work of culture clarifies the nature of somatisation. From a Western vantage point, somatisation may appear enigmatic, but attention to stigma helps to illuminate the internal structure of the black box.

Bhugra, D. & Mastrogianni, A. (2004) Globalisation and mental disorders. Overview with relation to depression. *British Journal of Psychiatry*, **184**, 10–20.

Bhui, K. (1999) Common mental disorders among people with origins in or immigrant from India and Pakistan. *International Review of Psychiatry*, **11**, 136–144.

Raguram, R., Weiss, M. W. & Channabasavanna, S. M. (1996) Stigma, somatisation and depression – a report from South India. *American Journal of Psychiatry*, **153**, 1043–1049.

R. Raguram National Institute of Mental Health & Neurosciences, Bangalore 560 029, India

M. Weiss Department of Public Health & Epidemiology, Swiss Tropical Institute, Socinstrasse 49, Basel, Switzerland

Author's reply: Drs Raguram and Weiss are right to point out the role stigma plays in help-seeking. We agree that many people with depression will not seek help from Western medical sources. The problem

https://doi.org/10.1192/S0007125000165225 Published online by Cambridge University Press