CMDR McKenzie response to adverse letters in JMVH of October 2010 re: PTSD article

CMDR Douglas McKenzie

I acknowledge the impassioned responses to my contentious article on PTSD (JMVH- Apr 10) and I would expect nothing less from my mental health colleagues. Independent commentary by one with no vested interest in diagnosing and managing PTSD should be embraced as part of robust debate regarding this fashionable condition. I hasten to remind the respondents that my paper was submitted under the terms pertaining to the "View from the front" category, being a personal view of my experience investigating and co-managing PTSD patients over 16 years; it is not a formal research article. I note that the respondents have not addressed my concerns.

The increasing breadth of the diagnostic parameters that satisfy PTSD has enabled a large number of situations to qualify for the disorder. As for its dubious offspring – 'vicarious', 'late-onset' and 'suppressed' PTSD – these further confuse the situation. I am often astounded how, after one or two consultations, a diagnosis of PTSD can be made on the basis of an unverified story and alleged symptoms. All too often reports have conclusions such as 'this person has PTSD' whereas a more objective clinician might write 'this person states he has symptoms consistent with post-traumatic stress'.

I am encouraged by editorial opinion in a recent British Journal of Psychiatry (197, 2010) "Reflections on PTSD's future in DSM-V" which states, in part, 'the current proposal for DSM-V, in which 21 symptoms are grouped into four clusters, allows for 10,500 ways to meet minimum requisite criteria! This expansion is beyond anything experienced for other diagnoses' (editor's exclamation mark). Furthermore the editorial states ' continuing controversy over how to operationalize PTSD in DSM-V has led to the suggestion that the diagnosis might best be relegated to the manual's appendix for experimental criteria sets……this approach can also serve to remind clinicians that PTSD in its present form should not be reified to the status of a distinct disorder in nature….'. Dr. Summerfield, occupational psychiatrist, Institute of Psychiatry, King's College writing in the same journal in April (342, 2011) makes some interesting comments regarding the UK police, inter alia, " regarding treatment of PTSD , professionally directed attention to the past, sometimes years previously, and to emotion, seemed anti-therapeutic rather than curative" and " the medicalization of non-specific symptoms, allied to social rewards that create perverse incentives, reliably prolongs disability" and his final comment " But above all we need a culture change in mental health service practice". These insightful and perceptive commentaries are long overdue.

It appears to me that mental health specialists are on a diverging path from 'coal face' health practitioners (MOs, nurses and medics) from whom I have had significant support. I believe that the latter should have input into the diagnostic process as they are responsible for the day to day management of PTSD patients. The current ADF Health Directives 264 & 289 describe the mental health management responsibilities of ADF primary care physicians, who are the designated Clinical Case Managers, and are held 'ultimately responsible'. My private Medical Defence Organization has advised me that this implies ultimately responsible for any adverse outcome and thus medico-legally liable.

To reiterate the thrust of my original paper I am convinced, from my personal observations, that PTSD is excessively diagnosed and that there should be a paradigm shift in the way this popular condition is diagnosed, managed and rewarded. A good starting point would be to conduct an accurate, holistic assessment of the patient with less emphasis on counselling and self-pity but with a more rapid return to normal duties.