

Correspondence

Clozapine withdrawal syndrome

There is no standardised protocol for the management of clozapine withdrawal syndrome following a red alert. This is one of the worst case scenarios with clozapine and it is not mentioned in the Maudsley guidelines¹ or any other reliable guide. We have had 3 patients with a red alert in the past 9 months. They were doing very well on clozapine for 5, 13 and 17 years respectively, with no previous amber or red alerts or significant side-effects. Since the acute withdrawal of clozapine one patient is not psychotic but not as alert or spontaneous as he was on clozapine, one has been acutely psychotic in hospital for 3 months and one is fragile but seems to be settling on aripiprazole.

A literature search revealed patchy reports of clozapine withdrawal syndrome but no consensus on what steps to take to reduce the relapse of psychosis, hospital admission and delirium or other acute physical illness following acute clozapine withdrawal.

Cholinergic rebound is a real possibility and the use of anticholinergics should be basic advice in this situation. Use of varying antipsychotics is the obvious second step.

We had two patients on anticholinergics and they had no major autonomic symptoms. The third patient is in hospital. An algorithm of what to do when faced with a red alert would be a useful addition to the psychiatric pharmacopeia.

Eugene G. Breen, Consultant Psychiatrist, Mater Misericordiae University Hospital, Dublin, Ireland; email: ebreen@mater.ie

1 Taylor D, Paton C, Kapur S. *The Maudsley Prescribing Guidelines in Psychiatry* (Twelfth Edition). Wiley-Blackwell, 2015.

doi: 10.1192/pb.41.6.366

Living with obsessional personality

Obsessive–compulsive and related disorders are defined in DSM-5 and include obsessive–compulsive personality disorder¹ (OCPD) or anankastic personality disorder in ICD-10.² Its prevalence is believed to be 1–2% in the general population, but it occurs much more frequently in psychiatric populations³ and is under-recognised and poorly researched,⁴ although it is beginning to gather greater awareness.⁵

In a clinical setting such patients can appear to function well and are often high achieving, so it can be difficult to ascertain what problems to target in treatment. However, family members and partners are often acutely aware of the difficulties of living with someone with OCPD and can provide valuable collateral information to mental health services.

OCPD is a personality type where the need for perfectionism in all aspects of life takes precedence. Individuals with OCPD hold high standards which originate from dysfunctional beliefs thought to be established in early adolescence.⁶ Straying away from these rigid beliefs can cause inner cognitive dissonance, leading them to push their beliefs onto others, creating difficulties in social interactions. Inflexible cognitions such as ‘my way is the correct way’, ‘I must own the

truth’ and ‘all is not well unless it’s done this way’ are deeply ingrained, so that they are resistant to acknowledging alternatives to their ways of thinking.⁷ In OCPD, inadequacies are only recognised in others and the external environment and patients do not harbour ego dystonia or question themselves.

On the surface, people with OCPD can appear confident, warm, organised and high-achieving; their meticulous standards can benefit them in certain professions. However, as with any personality disorder, overexpressed traits will cause dysfunction and OCPD frequently occurs with psychiatric comorbidities.⁴ OCPD traits include preoccupation and insistence on details, rules, lists, order and organisation; perfectionism that interferes with completing tasks; excessive doubt and exercising caution; excessive conscientiousness, as well as rigidity and stubbornness.^{1,2} Imagine this is a description for a potential partner. Undoubtedly, loved ones on the receiving end of the relationship will experience exhaustion, unhappiness and frustration. Living with people who have a fixed mindset and impose their opinions and outlook on life can lead to devastating effects.

Rigidity and inflexibility

People with an obsessional personality are often imprisoned in their own cage of fixation and therefore they cannot compromise. They are unable to change their views and may jeopardise relationships or their own personal or professional development as a result. They are willing to lose anything as they cannot break through the wall of obsessiveness.

Black or white, nothing in between

Dichotomous thinking features in obsessional personality – there is no acceptance of a grey area or anything left to chance. There is often tunnel vision, an inability to see beyond one’s own standards and views. Anything that challenges this leads to resistance, frustration and anger. Perceiving everything in black or white gives an element of control. If something cannot be categorised as such, it causes inner turmoil, as it undermines a perfectionist’s view of the world.⁷ An ‘all or nothing’ cognitive distortion maintains the high standards and if these are not met, it leads to dismissal of those who fall short of such standards.

Only their perception and method is correct

In OCPD there is a compelling need to do things in a particular way, which is perceived by the individual as the best, right and only way. Often it is based on little evidence or logic. Any objections lead to long arguments – such individuals, though unable to fully justify their position, vehemently maintain their beliefs. This can apply to any situation, from the banal to the most complex and significant.

This inability to shift in attitude can have detrimental consequences on relationships. It causes distress, oppression and exhaustion for the partners. The need of individuals with OCPD to remain firm in their perspective is more important than compromising in a situation. The cost of this may be losing a job or severely damaging relationships.

Low threshold for feeling hurt and humiliation

This is one of the major issues to work with when living with people with an obsessional personality. They have a very low threshold for feeling hurt and cannot cope with criticism. Any criticism is perceived as an attack on their already perfect standards and they are left feeling out of control. To avoid such criticism, they spend a long time making the 'correct' decision or remain indecisive and exercise extreme caution to avoid failure.⁷ This results in rumination and fixation and can cause deep hatred, anger and sadness.

Judging everyone with one's own standards

This is one of the major social deficits in people with OCPD and leads to a lack of emotional connection with others. There is immediate judgement of other people against their own gold standards, which are impossibly hard to achieve consistently. The individual with OCPD will quickly recognise the minutiae of flaws and expose them to the surface. Every aspect of the person's character is heavily scrutinised. Any 'flaw', however insignificant to others, will outweigh all other tremendously positive qualities of the other person and will result in disapproval. The patient with OCPD will be unable to focus on anything but the flaw and will see that as the main attribute of the person.

This very selective perception is entirely based on their own personality. In long-term relationships, this leads to incredible friction and will arouse negative emotions and grudges. There will be ongoing rumination against that person because of the perceived faulty behaviour or habit. This grudge will result in the individual with OCPD expending a great deal of effort to compel the other to change their behaviour. There may be a constant fixation on this, leading to the other person feeling oppressed. There may be constant pressure, nagging, criticising and altercations. There is no room for reasoning. This understandably leads to termination of relationships. This is frequently a repeating cycle of events but with a different person, situation or challenge to their standard. It is often found that people with OCPD fare well with those who are either very tolerant and patient, or have a passive, dependent personality (these people avoid conflict, rely on others to make decisions and will not challenge their partners' ways).

Tobias A. Rowland, Psychiatry Senior House Officer, **Ashok Kumar Jainer**, Consultant Psychiatrist and **Reena Panchal**, Psychiatry Senior House Officer, Coventry and Warwickshire Partnership NHS Trust, Coventry, UK; email: Tobias.Rowland@covwarkpt.nhs.uk

- 1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th edn (DSM-5)*. APA, 2013.
- 2 World Health Organization. *The ICD-10 Classification of Mental and Behavioural Disorders*. WHO, 1992 (<http://www.who.int/classifications/icd/en/GRNBOOK.pdf>).
- 3 Fineberg NA, Reghunandan S, Kolli S, Atmaca M. Obsessive-compulsive (anankastic) personality disorder: toward the ICD-11 classification. *Rev Bras Psiquiatr* 2014; **36** (Suppl 1): 40–50.
- 4 Reddy MS, Vijay MS, Reddy S. Obsessive-compulsive (anankastic) personality disorder: a poorly researched landscape with significant clinical relevance. *Indian J Psychol Med* 2016; **38**: 1–5.
- 5 Drummond LM. Handbook on Obsessive–Compulsive and Related Disorders. *BJPsych Bull* 2017; **41**: 239.
- 6 Phillipson S. When the going gets tough . . . the Perfectionist takes control. OCD Online, 2016. Available at: <https://www.ocdonline.com/going-gets-tough>.

- 7 Phillipson S. The right stuff obsessive-compulsive personality disorder: a defect of philosophy, not anxiety. OCD Online, 2016. Available at: <https://www.ocdonline.com/the-right-stuff>.

doi: 10.1192/pb.41.6.366a

'Burnout syndrome' – from nosological indeterminacy to epidemiological nonsense

Imo¹ conducted a systematic literature review of research on the prevalence of burnout among UK medical doctors, arriving at the conclusion that the prevalence of burnout in this population is 'worryingly high'. Problematically, it turns out that such a conclusion cannot be drawn in view of the state of burnout research. Indeed, there are no clinically valid, commonly shared diagnostic criteria for burnout.^{2,3} Given that what constitutes a case of burnout is undefined, how could an investigator estimate the prevalence of burnout, let alone conclude that burnout is widespread? As demonstrated elsewhere,^{2–5} the diffuse estimates of burnout prevalence actually rely on categorisation criteria that are nosologically arbitrary and devoid of any sound theoretical justification. It is disconcerting to observe that studies of burnout prevalence continue multiplying in spite of the publication of several warnings against such research practices.^{2–6}

Another problem bearing on Imo's conclusions¹ lies in the unknown representativeness (e.g. in terms of gender, age, place of residence, or family status) of the samples of UK medical doctors surveyed in burnout research. Although the author partly acknowledges this problem in the limitation section of his article, he does not seem to take full account of the consequences of such a state of affairs. This state of affairs implies that the results of the reviewed studies cannot be generalised to the population of UK medical doctors.

All in all, the review¹ is undermined by the very research it relies on. We recommend that researchers interested in burnout start at the beginning, that is to say, by establishing a reasoned, clinically founded (differential) diagnosis for their entity of interest. As long as investigators do not complete the required groundwork for establishing a diagnosis and remain unable to distinguish a case of burnout from either a non-case or an existing disorder, conclusions regarding the prevalence of burnout will be nonsense. An immediately available solution for effectively monitoring and protecting physicians' occupational health would be to shift our focus from burnout to job-related depression.^{2,7}

Renzo Bianchi, Post-Doctoral Lecturer and Researcher, University of Neuchâtel, Neuchâtel, Switzerland; email: renzo.bianchi@unine.ch; **Irvin Sam Schonfeld**, Full Professor, The City College of the City University of New York, New York City, USA; **Eric Laurent**, Associate Professor, Bourgogne Franche-Comté University, Besançon, France.

- 1 Imo UO. Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. *BJPsych Bull* 2017; **41**: 197–204.
- 2 Bianchi R, Schonfeld IS, Laurent E. Physician burnout is better conceptualised as depression. *Lancet* 2017; **389**: 1397–8.
- 3 Bianchi R, Schonfeld IS, Laurent E. Burnout: absence of binding diagnostic criteria hampers prevalence estimates. *Int J Nurs Stud* 2015; **52**: 789–90.
- 4 Bianchi R, Schonfeld IS, Laurent E. The "burnout" construct: an inhibitor of public health action? *Crit Care Med* 2016; **44**: e1252–3.

- 5 Bianchi R, Schonfeld IS, Laurent E. The dead end of current research on burnout prevalence. *J Am Coll Surg* 2016; **223**: 424–5.
- 6 Weber A, Jaekel-Reinhard A. Burnout syndrome: a disease of modern societies? *Occup Med* 2000; **50**: 512–7.
- 7 Bianchi R, Schonfeld IS, Vandell P, Laurent E. On the depressive nature of the “burnout syndrome”: a clarification. *Eur Psychiatry* 2017; **41**: 109–10.

doi: 10.1192/pb.41.6.367

Soft diagnosis, guidelines and hard choices

Thank you for this excellent and concise article outlining the complexities involved in neuroleptic malignant syndrome (NMS) in association with atypical antipsychotics.¹ It serves as a reminder of how guidelines and diagnostic criteria can, for all their clarity, lead to vexing and imperfect choices.

This article brings to mind recent clinical cases where empiric treatment of a soft NMS diagnosis led to challenging decisions. The trouble lay in following guidelines in a patient with very clear treatment-resistant schizophrenia who had improved with clozapine. After the withdrawal of the causative agent, the duration for which antipsychotic treatment should be withheld is not completely clear. There are recognised guidelines indicating at least 5 days and monitoring for symptom resolution, whereas other guidelines say to wait 2 weeks after symptoms have settled.^{2,3} In addition, the atypical presentation of clozapine-associated NMS itself can lead to uncertainty and serves as a frustrating obstacle which clouds the process of decision-making.¹ Moving forward, the

recommendation to avoid the precipitating antipsychotic does not provide a clear answer in further management of such a patient on clozapine where other options have proved insufficient or inadequate.⁴

Further difficulty then may arise in persuading someone that the medication, which is associated with such an unpleasant clinical experience, is the correct choice. Particularly when recurrence of NMS on rechallenge with antipsychotics was found to be between 30 and 50%.⁴

In clinical practice there often is no perfect answer and rarely does the right one present itself as the easy choice. An article such as this serves to highlight the challenges present in applying uniform guidelines to complex presentations.

Karol Antczak, Registrar in Psychiatry and **Elizabeth Cummings**, Consultant Psychiatrist, Cluain Mhuire Mental Health Service, Dublin, Ireland; email: karol.antczak@sjog.ie

- 1 Sarkar S, Gupta N. Drug information update. Atypical antipsychotics and neuroleptic malignant syndrome: nuances and pragmatics of the association. *BJPsych Bull* 2017; **41**: 211–6.
- 2 Semple D. *Oxford Handbook of Psychiatry*. Oxford University Press, 2013.
- 3 Taylor D, Paton C, Kapur S. *The Maudsley Prescribing Guidelines in Psychiatry* (Twelfth Edition). Wiley-Blackwell, 2015.
- 4 Bhanushali MJ, Tuite PJ. The evaluation and management of patients with neuroleptic malignant syndrome. *Neurol Clin* 2004; **22**: 389–411.

doi: 10.1192/pb.41.6.368

Review

Handbook of Secure Care

Edited by Geoffrey Dickens, Philip Sugarman and Marco Picchioni
RCPsych Publications, 2015, £45 (pb) 348 pp.
ISBN: 9781909726369

The *Handbook of Secure Care* is a useful book for those new to the field of forensic mental health and is most relevant to those practising in England and Wales. It examines the relationship between mental disorder and offending, with individual chapters on personality disorder, intellectual disability, autism spectrum disorder and acquired brain injury. Strangely, there is little on psychosis which is the fundamental diagnosis within secure care.

The work considers the needs of specific populations such as women, young and older people, and outlines the provision of secure psychiatric services for these groups. It focuses on the basic components of secure care and includes information on risk assessment and management, and on recovery. The latter chapter is of particular use in defining the challenges we face in secure care and ways to redefine our conventional thinking. The fundamentals of psychological treatment in secure care are clearly set out and there is a helpful description of the role of nursing within that setting.

There is discussion in the first chapter on the evolution of secure and forensic mental healthcare, as well as information on the number of secure beds, but I would have welcomed an analysis of the overall estate, the needs for planning and the methods of provision. Similarly, details on pathways into or out of secure care, or on the legislation that allows us to detain people within these settings would have been valuable.

Notably, there is a good chapter by Penny & Exworthy on human rights in secure psychiatric care – the Human Rights Act 1998 underpins much of what we do in secure care, making this especially relevant. It is followed by a chapter on quality assurance and clinical audit. It is my view that the human rights considerations and the quality improvement agenda are so crucial to our work that it would have been beneficial to place these chapters near the beginning of the book to emphasise their importance.

Lindsay Thomson, Professor of Forensic Psychiatry, University of Edinburgh, UK; email: l.d.g.thomson@ed.ac.uk

doi: 10.1192/pb.bp.115.052704



© 2017 The Author. This is an open-access article published by the Royal College of Psychiatrists and distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

BJPsych
Bulletin

'Burnout syndrome' – from nosological indeterminacy to epidemiological nonsense

Renzo Bianchi, Irvin Sam Schonfeld and Eric Laurent

BJPsych Bull 2017, 41:367-368.

Access the most recent version at DOI: [10.1192/pb.41.6.367](https://doi.org/10.1192/pb.41.6.367)

References

This article cites 7 articles, 0 of which you can access for free at:
<http://pb.rcpsych.org/content/41/6/367#BIBL>

**Reprints/
permissions**

To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

**You can respond
to this article at**

[/letters/submit/pbrcpsych;41/6/367](https://letters.submit.pbrcpsych;41/6/367)

**Downloaded
from**

<http://pb.rcpsych.org/> on December 14, 2017
Published by [The Royal College of Psychiatrists](http://www.rcpsych.ac.uk)
