

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.

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

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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).

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- 1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th edn (DSM-5)*. APA, 2013.
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'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}

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