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 guidelines[1] 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 disorder[1] (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 populations[3] 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 OPCD 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.