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

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'Burnout syndrome' – from nosological indeterminacy to epidemiological nonsense

Imo[1] 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 conclusions[1] 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 review[1] 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.

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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

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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

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