benzodiazepine metabolites. Thus it appears from the available data that fluvoxamine is relatively safe in overdose compared with the tricyclic antidepressants.

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Attitudes to anxiety

SIR: We are grateful to the late Dr Kraupl Taylor (*Journal*, May 1989, **154**, 697–704) for his timely reminder that anxiety disorders are true psychiatric disorders rather than perjorative labels. The very first patient we saw after reading his article gave such a clear example of this prejudice that we felt moved to write.

Case Report: The patient, a 34-year-old married white male labourer, presented to our anxiety disorders clinic with a five-year history of panic attacks and generalised anxiety. The severity of his illness may be judged from his opening statement: "If you can't help me then I'll have to jump off the [Clifton Suspension] bridge". The onset of this disorder was in 1984, with a sudden, spontaneous, severe panic attack. He immediately took a taxi home, but during the journey diverted it to the local casualty department. The principal symptoms he described were bilateral chest pain and paraesthesiae. He was examined and was "reassured" that his symptoms were only due to anxiety.

He remained disabled, despite relaxation training, for 2 years, and was reassessed in 1986 by a cardiologist for continued episodes of faintness and chest tightness. This consultant's view was that there was no evidence of heart disease, and he stated that "the right policy was to reassure him strongly in the hope that they [the panic attacks] would go away". He was subsequently prescribed diazepam by his GP. However, because he was frightened of becoming addicted, he did not take the drug. Following this he was prescribed propranolol, which he found ineffective. He has continued to suffer, and his continued employment has been jeopardised by frequent absences from work caused by panic attacks.

This case serves to emphasise how underestimation of the personal suffering caused by anxiety may lead to inadequate treatment, and potential damage to family life and employment. In the light of this and the many other examples we have seen, we strongly support Dr Kraupl Taylor's point of view. We suggest that the present negative attitudes towards the illness concept of anxiety and the consequent anti-benzodiazepine climate of opinion causes much extra suffering for those people least able to tolerate it.

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The epileptic arsonist

SIR: The recent article by Carpenter & King (*Journal*, April 1989, **154**, 554–556), makes compelling reading. The association between epilepsy and arson is a fascinating one, and we would like to describe a further case seen recently in our unit.

Case Report: Ms B, a 26-year-old woman, was referred to our unit following an incident in which she set fire to a shop in her locality. This was one of a series of fires set by this lady, and she had received a diagnosis of personality disorder at another psychiatric institution. The patient was initially maintained on chlorpromazine therapy, and during her stay she set another fire on the ward. Careful reassessment of her case revealed that her fire-setting behaviour occurred in response to "a male voice", which she heard intermittently. EEG studies were performed, and revealed gross abnormalities consistent with an epileptic focus in the temporal lobe. The patient was started on carbamazepine therapy, and her auditory hallucinations have ceased. She remains much more settled on anticonvulsants alone, and there has been no recurrence of her fire-setting behaviour.

This is another case of arson associated with epileptic activity. The excellent response to anticonvulsants has led to a change in the diagnosis in this patient. Unlike Drs Carpenter & King's case there was no evidence of alcohol use or brain injury in this patient's history. Her progress has been most encouraging. Her legal status is currently under review, and the diagnosis of epilepsy should have considerable bearing on the outcome of her case.

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