alcohol use) as well as concurrent medication and mental state.

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Physical morbidity of psychiatric patients

SIR: I was a little troubled by the study of Honig *et al* (*Journal*, July 1989, **155**, 58–64) looking at the physical morbidity of psychiatric patients. A recent and well conducted study by Ziber *et al* (1989) suggests that, considering all classes of psychiatric patients, the standardised mortality ratio was 2.3. The major causes of death were related to dysfunction of the cardiovascular and respiratory systems, probably because of excessive smoking. Another recent study, by Casadebaig & Quemeda (1989), on mortality among psychiatric in-patients, also commented upon an excess of deaths through cardiovascular and respiratory disease.

The age of patients in the study by Honig *et al* was only 45 years, and hence slightly below the age of major risk for such complications. It is however very narrow-sighted of them not to comment upon the likely illnesses which face the slightly older group of psychiatric patients and not to emphasise the important health education role of the psychiatrist.

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Benzodiazepines unabashed

SIR: It was refreshing to read Kräupl Taylor's article on benzodiazepines (*Journal*, May 1989, **154**, 697–704), following the bashing this particular group of drugs has been subjected to recently. I have used various benzodiazepines to treat anxiety states in the past few years and find them extremely useful. As with any other drugs there should be indications to use them and they can be abused by way of over-prescribing both by doctors and by the public. Whatever the research workers might say, in my opinion, there is a minority of patients who seem to benefit from them even on long-term therapy (more so on a *pro re nata* basis), and I do not think this is due to psychological dependence alone.

I was most surprised to hear about the recent proclamation issued by the Royal College of Psychiatrists pertaining to the duration of benzodiazepine therapy. I think this is an insult to the clinical judgement of doctors, and furthermore could cause confusion among the public. We all can have strong opinions about various aspects of drug therapy, but we should not necessarily impose these on others. (I am reminded of a clinical director who sent out a circular to all the staff members and residents prohibiting the use of intramuscular diazepam, and of another instance where a decision was made to ban the use of triazolam in a leading psychiatric department in Canada.)

In the light of these developments it is also interesting to note the course taken by some of the leading research workers. In the initial phase they bring out numerous research papers describing the virtues of the drug, in the middle phase they are busy publishing papers on the side-effects of the drugs, and lastly they bombard us with research work pertaining to the withdrawal effects of the drugs, and go a step further in condemning some doctors for being over-zealous in prescribing these drugs. Most of us are aware of this scenario and tend to take all kinds of psychiatric research and especially 'new and dramatic developments in psychiatric research' with a pinch of salt.

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Remission of psychotic symptoms after burn injury

SIR: Self-incineration is a rare but dramatic way to attempt suicide. Its symbolism as a form of political protest (Crosby *et al*, 1977), or religious phenomenon (Topp, 1973), its relationship to underlying psychiatric disorders (Jacobson *et al*, 1986),