the outside community, in which the therapeutic ward produces significant change. The authors say that this was not due merely to ward policy but that the degree of interaction in the ward community suggested that this was the appropriate move. Since the latter has not been demonstrated, one can only assume that there has been some degree of bias in discharge decisions.

Finally, the authors say that many other statistical calculations were computed but none proved significant, suggesting that they have selected the choicest of their results for publication. Perhaps if these had been reported, a fuller picture of the therapeutic inefficacy of the community ward might have emerged.

J. G. GREENE.
Psychology Department,
Gartnavel Royal Hospital,
Glasgow, G12 oXH.

MMPI PERFORMANCE IN CHRONIC MEDICAL ILLNESS

DEAR SIR,

Goldstein and Reznikoff in their recent article in the *Journal* (February 1972, **120**, 157–8) report significantly higher mean scores on the neurotic triad of the MMPI for haemodialysis patients as compared to general medical patients convalescing from minor medical conditions. Elsewhere their report states: 'The finding of significant elevations of Scales 1, 2 and 3, the neurotic triad, confirms results of other studies on haemodialysis patients employing the MMPI' (p. 157). Apparently the authors have equated 'significantly higher mean scores' with 'significant elevations' although the latter expression in MMPI parlance has the specific meaning of 'Scale elevations at or above T-score 70', i.e. scores significantly above the MMPI standard population mean (T-score 50). They do not say how they are warranted in making this equation.

The distinction is important, because only when T-scores reach or exceed the T-score 70 level does conservative interpretation indicate the possible presence of psychiatric illness.

Failing to state unequivocally that all or most of the haemodialysis patients obtained scores at or above the T-score 70 level, Goldstein and Reznikoff have left open the possibility that although the haemodialysis patients as a group obtained higher mean T-scores than the controls, none or only some of the individuals in the haemodialysis group obtained triad scores of significant elevations.

That haemodialysis patients would show *some* elevation on the neurotic triad (particularly on Scales 1 and 2) is of course to be expected: such non-critical elevations would accurately reflect the physical and psychological stress effects of their condition, without suggesting at the same time the presence of a neurotic condition. Alternatively, it is possible that the unpublished data of Goldstein and Reznikoff show that *some* of the haemodialysis *and some* of the control patients obtained significant neurotic triad elevations. Subject to the outcome of individual psychiatric evaluation one would have to assume that those individuals, whether haemodialysis or control patients, were in fact true neurotics. Obviously, neither the presence of kidney disease nor that of any other medical condition bestows immunity from neurotic illness.

Only if it were shown that neurotic triad elevations at or above T-score 70 were significantly more common amongst haemodialysis patients than amongst their matched controls would one have to face the possibility of mislabelling.

With reference to the computer statement frequencies presented by Goldstein and Reznikoff in Table I (p. 158), Fisher exact probabilities show that only three of the statements occur more frequently (at or beyond the 5 per cent level) in the computer-derived MMPI interpretations of the haemodialysis groups than in the control group: 'Normal male interest pattern for work, hobbies, etc.' ($p = \cdot0345$); 'Moderately depressed, worrying and pessimistic' ($p = \cdot0153$); Considerable number of physical complaints. Prominent concern with bodily functions' ($p = \cdot0442$). In view of the haemodialysis patients' objective condition, the latter two statements appear to have at least face validity. They give little support to Goldstein and Reznikoff's contention that 'Computer-derived statements may erroneously label patients as 'hypochondriacs' when in fact they are chronically physically ill' (p. 158).

As for the first statement, it seems more parsimonious to look for reasons why so few of the controls are said to have normal male interest patterns than to speculate, as Goldstein and Reznikoff do, about denial of physical weakness and reduction in sexual potency on the part of the haemodialysis patients.

T. J. P. VERBERNE.
Parkville Psychiatric Unit,
35–37 Poplar Road,
Parkville,
Victoria 3052,
Australia.

OXAZEPAM (SERENID D) DEPENDENCE

DEAR SIR,

I would refer to Dr. S. M. Hanna's article in the *Journal* (1) concerning oxazepam (Serenid-D) dependence. This occurrence is sufficiently uncommon (2) to indicate an alternative explanation.

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