value on the opportunity to learn about themselves through their observation of others' experience (vicarious learning). This more passive form of psychological work then shifts to a more active form if work continues in out-patient group therapy.

It also seems to us that there is a greater complexity in attempting to compare in-patient and out-patient reactions to a group experience than is evident in Dr Kapur *et al's* study. A sample of out-patients who have been specially selected for long-term therapy is likely to differ from a sample of in-patients on a number of important dimensions. For example, our own current work suggests that the level of functioning and the duration of the therapy experience are particularly important variables to consider.

Much remains to be clarified about the interrelationships between patient characteristics and response to group therapy. We hope that more British researchers will be exploring this difficult area.

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Assaults on Staff by Psychiatric In-patients

SIR: The paper by Haller & Deluty (*Journal*, February 1988, 174–179) is non-contentious in that it suggests the benefits of predicting the likelihood of patients' dispositions towards violence. However, it is also important that such information is not escalative towards promoting the very behaviour which is not desired.

Professors Haller and Deluty do not stress the importance of support and training for staff, especially when predictive tests need to be interpreted. In addition, anxiety levels are always a key factor in understanding violence. Thus it is essential that where patients are being treated in situations which increase the potential for violent acting-out, every opportunity is taken to assess and understand overt and covert anxieties. At these times it is also important to distinguish between verbal and actual physical aggression, because they are not the same. This is not made clear in the paper.

Means of prediction are important, but can be no substitute for the sensitivity and perceptiveness of staff. Furthermore, applications of these skills by staff can never be made safely without adequate training, supervision, and support.

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SIR: Dr Hewitt makes a number of interesting assertions in his letter, some of which I feel are correct, some incorrect, and some puzzling.

It is unclear to me how knowledge or information concerning *who* is likely to assault *whom* under *what* conditions could be escalatory or could promote "the very behaviour which is not desired". I agree with Dr Hewitt that predictors of assaultiveness derived from actuarial techniques cannot substitute for sensitivity and perceptiveness of staff. However, relying primarily on the sensitivity and perceptiveness of individual clinicians has been shown to be highly problematical. For example, Werner *et al* (1983) found that while psychologists and psychiatrists agreed among themselves as to which patients would be violent and what the critical predictor variables were, empirical correlations of violence with these variables indicated that the judges' predictions were rarely accurate.

Dr Hewitt writes that "anxiety levels are always a key factor in understanding violence", yet he provides no empirical evidence to support this assertion. On the contrary, our literature review revealed that no single variable is "always a key factor" in explaining or predicting violent behaviour.

I concur with Dr Hewitt that it is very important to distinguish between verbal and actual physical aggression. I am very puzzled, though, by his comment that, "This is not made clear in the paper". Throughout our paper, we criticise researchers in the field for not making this critical distinction.

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Psychotherapy and Dysmorphophobia

SIR: The paper by Bloch & Glue (*Journal*, February 1988, **152**, 270–274) was enjoyable and stimulating. I