



TRAINING THE FAMILY THERAPIST

A Model for Family Therapy Training

:Based on parallel processes between training and treatment

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At the Bouverie Clinic, Melbourne, a training programme in family therapy has been developed over the past 8 years. The programme has three levels of training. A basic assumption of the programme is that family therapy is a general theory of behaviour as well as a specific technique. Its essence is the exploration and change of here-and-now family transactions. Systems theory, on which the training programme is based, is a qualitatively different conceptual framework from individual theory. It is argued that the models and methods of family therapy should be used in teaching family therapy. Ten principles of family therapy which are utilised in teaching are described.

We have been teaching family therapy at Bouverie Clinic, Melbourne, since 1971. In this paper we would like to give an overview of the training programme and detail our basic assumptions and ideas about the teaching and learning of family therapy. These assumptions and ideas have come from eight years of experience.

Firstly, we will give an outline of the training programme in its present state of evolution.

There are three levels of training corresponding to levels of expertise and experience in family therapy.

Level I is an introduction to the basic concepts and processes of family therapy. It also presents the significance of family therapy as a treatment approach. It consists of eight units, usually given as a four-day workshop focussing on the central ideas of family therapy (Developmental phases, Structure, Communication, Affective processes, Transactions). Each unit utilises didactic and experiential components and about 30 students at a time participate in a workshop. To date over 500 people have completed Level 1. Completion of Level 1 or its equivalent is required for participation in Level II.

Level II provides training in basic family therapy skills. It is based on a half-day session weekly for the academic year, for groups of 10 to 12 participants. Participants are required to see families in their own agency. Over 150 professionals have completed Level II.

Level III is for practising family therapists, i.e. professionals who are concentrating on family therapy as the major aspect of their therapeutic work, and who may eventually take on teaching and supervising responsibilities. About 50 people have completed Level III, thus becoming eligible to join the recently established Victorian Association of Family Therapists.

The main body of this paper is an elaboration of the basic assumptions and principles underlying all levels of training. As an orienting statement we would briefly like to present the basic assumptions we hold about family therapy.

1. Family therapy is a general theory of behaviour, as well as a specialised technique. Family therapy is not only a form of intervention, but also a conceptual framework which provides an overview for understanding and resolving the gamut of problems in human behaviour. (Bloch & La Perriere, 1973).

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At the Bouverie Clinic trainees work in many areas of the health and welfare field. Only a minority work in child-centred agencies. There are trainees from chronic mental hospital wards, alcoholism treatment centres, community health centres, teaching hospital psychiatric units, school counselling services, and the Community Welfare Department. All the usual disciplines are represented, and all the trainees claim to find a family therapy approach relevant to their central areas of professional concern.

2. The essence of family therapy is the exploration (and disequibration) of the here-and-now family transactions that maintain dysfunctional patterns and symptoms. Psychopathology is seen as a relationship problem. Individual reactions are maintained, and amplified until they are symptomatic, by the system of interpersonal relations, in which the individual is involved. (Watzlawick, et. al., 1977).

3. "Systems thinking" is qualitatively different from "individual thinking". Each is a different way of seeing, a different epistemologic framework for understanding the developmental and historical bases of "why" a behaviour started. "Systems thinking" is concerned to ask "how does a behaviour keep going?"

The conceptual shift from what we have called "individual thinking" to "systems thinking" is a discontinuous one. How to learn to conceptualise in systems terms and to think interactionally is an epistemologic problem, not a technical one. It is like learning a new language. The question is: "How to teach this new language, this different way of seeing behaviour and symptoms?"

4. The models, metaphors and methods of family therapy should be utilised to teach family therapy. This last assumption requires further explanation.

We do not believe that the traditional one-to-one supervision system used in teaching individual psychotherapy is appropriate for teaching family therapy. Rather we believe that it is logical to base family therapy training methods on family systems theory, in the same way that therapeutic strategies should be based on the theory. Both training and therapy are attempts to influence people's behaviour and both are on-going clinical processes which we believe have many parallels.

The experience and processes of learning family therapy will be reflected in the ways the trainee performs therapy with families.

The mirroring effect, or parallel process, has been receiving increasing attention in the literature on teaching and supervision of individual psychotherapy. Ekstein and Wallerstein (1958) drew attention to the importance of parallel processes occurring between supervisor and therapist, and therapist and patient, and how parallel processes can affect the teaching and learning of psychotherapy. More recently Doehrmann (1976) has presented an empirical study of this phenomenon; in every one of 12 cases studied the supervisor-therapist relationship intensely affected and in turn, was affected by the therapist's work with his patient. Doehrmann's study suggests that the parallel process phenomenon is far more widespread than is generally believed.

To our knowledge there is no literature on the parallel process in family therapy supervision, but we are certainly struck by the pervasiveness of this phenomenon as it occurs in our teaching. A basic assumption of our training programme is a close correspondence between how therapy is learned and how it is practised. It follows, then, that the models, metaphors and methods of family therapy itself, should be utilised to teach family therapy.

How is this to be achieved? We have developed a training model which incorporates various features of family therapy. Ten principles of family therapy have evolved as the basis of our model.

1. Doing it in Public.

We utilize group settings for exploration and experimentation with new behaviours under conditions of real-time social interaction.

Family therapy derives much of its strength from its atmosphere of openness and self-disclosure, as compared to individual therapy which emphasises confidentiality and individual responsibility. Much of the therapist's task, especially in beginning stages, is directed to providing a safe place for exploring and experimenting with alternative possibilities in ways of relating, in a here-and-now, real present. The trainer has a similar task in

relation to the therapist; directing the formation of a learning space, with an emphasis on open disclosure and direct observation of the trainee's therapeutic work, and encouraging trainees to try out new alternatives. The stress is on public display, "do it and show it", rather than "talk about it". Yogi Berra, a famous baseball coach, once said "You can see a lot by observing".

To promote the direct participation and observation of therapy (either actual, simulated or videotaped) we use various formats. (see below). We believe that by emphasising public observation and sharing in the group we are promoting an experiential awareness of the power and significance of here-and-now (transactional) processes.

2. Everybody is an expert in family living.

We activate experiential knowledge of family living, and foster personal therapy styles in the trainees.

Much of the value of the public, direct observation emphasis of the learning space is in turn based on a respect for each group member's individuality and knowledge as an expert in family life. Everybody grew up in a family and maintains family attachments, and everybody's experience of "family" is different. In their own way each person "knows" about families.

We can activate this knowledge, especially the experiential components, by a number of family therapy techniques. These include:

Role playing in simulated families.

Family choreography. (Papp, 1976).

Exploration of genograms and families of origin of the trainees. (Carter and Orfanides, 1976; Guerin and Fogarty, 1972).

We think these techniques are helpful in that they give students experiences which are:

(a) Normalising

A sense of how all families are similar and "normal" from the viewpoint that all come to developmental crisis points during which conflicts and problems arise. What differentiates families is not so much that crises, conflicts and problems occur but that some families deal with and resolve them while others suffer from and amplify them.

(b) Differentiating

We believe we reinforce the recognition

of the uniqueness and validity of each person's experience. Everybody can say something about families.

In the group we promote sharing of trainees' experience by several techniques. These include "the go-around", and the use of "I-statements". We often direct the group to speak in turn, making a statement about the issue at hand from an "I-position". This is a term taken from Bowen (1976) and refers to a clear statement which is neither offensive nor defensive, of one's thoughts or feelings on a subject.

We think that these methods reinforce trainees to "trust in the courage of their own stupidity". (Balint, 1964). We hope to help trainees uncover their innate talents, and develop and value their own idiosyncratic ways of doing, thinking and learning about their own personal therapy style.

(c) Sensitising

We believe that the activation of family experience sensitizes a person to the influence and significance of their family attachments to their personal functioning. In turn this sensitizes trainees to both the hidden strengths and subtle traps seen with real families in therapy. (Carter and Orfanides, 1976; Guerin and Fogarty, 1972).

3. Learning through experience.

People learn differently, using differing models of thinking, imagery and feeling. Learning is most effective and intense when multiple channels, utilising differing modes, are used. These facts are applied by some family therapists who attempt to create settings where intense multi-channel learning can occur. Minuchin, (1974) refers to "enacting the therapeutic present", enacting the problem and then its solution in the here-and-now, which provides the new learning in an intense way, allowing change to proceed. Cognitive learning is not necessarily an essential part of this process and some family therapists are fond of saying that change precedes insight. We think this is an oversimplification, although a useful one as it does emphasize that insight alone is usually not enough for change. Cognitive learning must be balanced by experiential learning, and this is best achieved by creation of an

intense multi-channel learning context.

We are seeking to help trainees integrate theory comfortably into their personal style: to “experience” or “get the feel of” theory so that abstract ideas get fleshed out into concrete, specific forms. To achieve this we have a number of techniques we call “structured experiences”. (Constantine, 1976).

Example: A structured experience teaching the Minuchin-Liebman structural model of the psychosomatogenic family. (Liebman and Minuchin, 1976; Minuchin et al, 1975).

We cognitively prime trainees with a theoretical article and a short didactic review of important structural concepts. We then set up a role play of a family with a severely asthmatic child, with instructions based on the operating transactional rules of a psychosomatogenic family.

In this role play, the mother and children are enmeshed, being over-involved with and over-responsive to one another. For example, when one cries they all cry. The mother and the asthmatic daughter are particularly close. There is a high degree of mutual concern, and nurturing and protective responses are constantly being elicited and supplied, particularly for the asthmatic child. The family rigidly denies any problems and they present as “normal” except for the sick child. They are very sensitive to signs of overt conflict. All conflict gets avoided, diffused or detoured. Detouring, is particularly common. Dyadic interactions are very difficult to maintain as a third family member joins in to convert the dyad to a triad. The child’s wheeze flares up if there is any sign of confrontation or anger between two people, especially between mother and father. Because of the very close coalition between mother and sick daughter, father tends to be excluded, peripheral and resentful.

The role play usually takes the following course: The family is sitting down having dinner when father returns from being away on business. He finds his daughter wheezing, and everybody ignores him as they focus on her. His attempts to help are ignored or rebuffed, he gets mildly angry and the daughter wheezes more. The girl’s mother and siblings hover around her, her father becomes even more excluded, leading to more frustra-

tion and anger.

The role play takes on its own momentum, and as the wheeze amplifies feelings of panic, helplessness, despair and suppressed rage develop in family members. A vicious circle is established (or, in systems theory jargon, a deviation – amplifying feedback (DAF) loop), “all the way to the hospital.”

This role play simulates a psychosomatic crisis in an enmeshed family system. Participants talk of their feelings of being trapped and overwhelmed and defenceless. High levels of anxiety are often generated in this role play, and de-roling does not occur easily. Participants feel caught and stuck in a highly charged unresolved situation which reflects the measure of the power of ongoing systems to regulate feelings and behaviours.

We pay careful attention to deroling and then complete the experience by showing a videotape of Ronald Liebman conducting a therapy session with a family of a severely asthmatic child. The family operate with the same transactional rules as in the role play. Participants express considerable relief from seeing the videotape. This completes the deroling and gives them a chance to see, feel and talk about how the theoretical model is helpful in changing this kind of family structure.

4. Feeding it back.

We explain feedback loops and their function in establishing systems.

Our question is “how to help the trainee-therapist become aware of and change the feedback loops which are stabilising the dysfunctional patterns in the family”? In the last example we described the deviation (or wheeze) amplifying feedback loop which stabilised daughter as asthmatic, mother as overprotective and overwhelmed, and father as excluded and resentful. The harder they all tried, the worse the situation became. Their attempted solutions seemed to intensify the problem. Often for the trainee the harder he or she tries to help a family the more serious the problem becomes. He is easily absorbed and oriented away from his function as a change-agent by getting caught up in the family system’s feedback loops. Often he behaves in ways that reinforce the very patterns which brought

the family to therapy in the first place. With the psychosomatogenic family, therapists frequently become over-cautious and over-protective, careful to avoid conflict; they 'walk on tip toes' and feel out of control.

The issue in teaching is: how to help the trainee become aware of the way he is affected by and in turn affects the family system, and how his behaviour may amplify rather than reduce the family's problem? This problem in teaching also occurs as a problem in therapy. The core task in both is to disequilibrate a system and realign relationships, in a field where the trainee/therapist is a part of the system.

How do we do this? We utilise techniques such as:

Video playback: This is a vital teaching tool. We find that considerable non-verbal, implicit learning can occur by reviewing videotapes, particularly if sequences are watched several times. Often (as with families seeing themselves on videotape) the lessons do not need to be spelled out for changes to be facilitated.

Simulation exercises: This includes role playing and sculpting of families in therapy. Direct supervision via one-way screens and telephones: This allows immediate intervention when the action is happening, and helps the therapist maintain control and direction.

Group feedback: The trainee has access to the group, during or after the session. Sometimes the family also participates in these discussions. The format of direct supervision and group feedback can be varied according to the needs and possibilities of the system. We are using these methods increasingly. Montalvo has described these techniques in detail elsewhere. (Montalvo, 1973).

All of these methods can be seen as attempts to disequilibrate and realign family (or therapist-family) systems towards positive change. The training questions are: How to offer feedback that can be heard and used . . . and how to hear and use feedback that is offered? To achieve these goals requires a specific teaching focus on the techniques of problem-definition, task setting and confrontation. We would like to discuss each of

these now.

5. Problem-definition: Solving the solvable.

We are firmly against chasing rainbows and act vigorously to oppose any pull to diffusion, speculation or generality in our training groups. We continually ask; What are the problems and how can they be defined in such a way that solutions become available (rather than allowing problems to become overwhelming and immutable)?

When a trainee presents a case to a group he is encouraged to specify what it is he wants or needs help with. What is the question being asked? The immediate focus is on the macroscopic issue. What is the beginning* and what is obvious?

We find that trainees often dive into microscopic issues before having any sense of the broader frame of reference. Therapy founders more on the failure to define an adequate contract than any other single factor. The first order of business, both in therapy and training, is to reach agreement about the basic issues, and what can realistically be offered.

When the issues are clear, then further definition of the problem in transactional terms are attempted. Here we try to apply Jay Haley's definition of a problem as "a type of behaviour that is part of sequence of acts between people". (Haley, 1976). The achievement of a specific definition of the problem in transactional terms allows the definition of a solution based on altering the problematic transactional sequences. The solution can be set as a task.

6. Task-setting to get a job done.

We encourage the disciplined use of inter-actional task setting by invoking several rules in the group. We encourage short, specific statements based on observation of behavioural sequences. We actively discourage jargon, questions and speculations about deeper phenomena. Once this tone is set trainees become more adept at problem-solving communication and task-setting, both when acting as therapists with families, and as group

FOOTNOTE* The idea of starting at the beginning and explicitly building on a base is also incorporated into the programme by utilising a set of instructional objectives for family therapy trainees: interactional, behavioural goals in conceptual, perceptual and executive skills, as developed at the McMaster University. (Levin and Cleghorn, 1973).

members observing behind a one-way screen.

Example: A school counsellor, interviewed the parents of adolescent R., who refused to go to school. R's mother talked continually and his father appeared rather indifferent about his son's non-attendance. However it became clear that whenever father did make a comment, R's mother interrupted and started making excuses for her son. The following moves (or tasks) were suggested to the counsellor by the observing group: Engage father by sitting next to him and address him as head of the family. Make sure he is given a chance to finish his statements. Ask R's mother to sit back in her chair and tell her she needs a rest. At the same time compliment her on the concern she has for her children.

The counsellor took these suggestions and applied them in his own way. R's father became more active and, for the first time, started to accept responsibility for getting his son to school. R's mother was noticeably less tense and later said she was glad her husband was taking on this responsibility, as she had previously thought he was uninterested.

7. Confrontation.

Promoting differences and exposing conflict can be okay. We have already emphasised that we encourage differences of viewpoint and individuality in the group. By valuing differences we find trainees are less anxious about expressing variant ideas. Conflict over differences of view is not common, if a climate of acceptance of differences is promoted. When conflict does arise, the successful resolution can be a very positive experience. It is not conflict which is destructive in families or training groups, but the lack of effective conflict-resolution. To resolve conflicts effectively, the conflicts must be acknowledged and confronted, rather than avoided.

How to confront is frequently a problematic issue for trainees. We believe this is related to the common undervaluing and lowered estimation trainees have of their competence, which results in a tendency to be overcautious and avoid conflict more than is necessary. We confront these patterns (and hopefully provide a model for confrontation of similar patterns seen in families) by point-

ing out what the trainee is achieving, but not fully recognising. In our experience trainees need to be confronted much more with their strengths, than with their deficits.

When it is necessary to confront weaknesses then this is done in a supportive way, using the "Yes-but" and "Yes-and" techniques, (Minuchin, 1974), and by focussing on the here-and-now problem of behaviour to be changed) and not on interpretations of motive). We know that trainees bring along their best solutions, just as families do. We work to frame ambivalences in the direction of new possibilities: what we call "normalising" the experience, and building on competences, not weaknesses.

8. Making it a good human experience.

One of the strengths of family therapy is the sense of aliveness, spontaneity and energy it can generate. These can be fostered in various ways which are equally relevant to training. We believe it is important to focus on success, strengths and humour rather more than weaknesses, failures and pathology. Nothing, as they say, succeeds like success. Early success experiences, even the most minor advances, provide the best base for further progress. We recall Ferber's first law of family therapy . . . "if you see something good, applaud wildly".

9. From Couch to Coach.

This is a phrase from Murray Bowen that conveys an attitude we think necessary for the therapist and the teacher. The teacher knows the game and studies his players whilst playing. He has many ways of improving their performance including those we have outlined. He is the rule-setter and boundary marker. He has control over the boundaries of the group, deciding what is and is not to be encouraged or permitted, what mistakes are allowed and what is in need of correcting. He is in control, but not controlling. Later he relinquishes this control as the team shows more adaptive patterns. He is careful to define the boundary around his own competence and take responsibility for it, without extending beyond into laying down absolutes, mandatory solutions or rigid commands. His message is: "There is no one correct way."

This is of course a description of an ideal type. We would only emphasize along with

Bowen, that you can only change yourself, not other people. (Bowen, 1976).

10. Respect for context.

This final principle refers to the need to be aware of the wider context and organisational framework in which the trainee works. He is part of a system, and the effects of this must be recognised. Sometimes, in both cases, such recognition can be crucial.

Family therapy is not universally accepted by any means. Agencies can be resistant to family systems approaches, just as families can. One particular form of agency resistance is where a trainee becomes the "identified family therapist" and is given special or difficult cases, or "the family" without the identified patient. Trainees can be actively discouraged, even scapegoated, as a result of loyalty conflicts between their home agency and their training group. To avoid such complications we pay considerable attention in groups to discussions of the organisational context of the trainee and how it effects their therapy. We are careful to negotiate contracts with agency chiefs, and we try to have more than one person in training from an agency. We encourage co-therapy pairing, and we are developing peer-supervision networks for our recent graduates. Occasionally we will intervene directly with the home agency.

We believe this is an effective and concrete way of sensitising trainees to the vitally important issue of the relationship of context to individual behaviour. Unfortunately, at times, the helping network can lead to the perpetuation of the problem instead of being part of the solution. (1).

We have outlined ten principles of family therapy that we apply in our training programme at Bouverie.

PRINCIPLES OF FAMILY THERAPY

1. Doing it in public.
2. Everybody is an expert in family living.
3. Learning through experience.
4. Feeding it back.
5. Solving the solvable.
6. Task-setting to get a job done.
7. Promoting difference and exposing conflict can be okay.

8. Making it a good human experience.
9. From couch to couch
10. Respect for context.

The training programme has evolved over several years with a continuing cycle of feedback and change between the trainees and us. Much of this has been at an informal level. Trainees report an increase in their confidence in seeing families, and in the quality of their therapeutic work. We have data that trainees increase the number of families they see, and that this trend continues after they finish the training programme. We are now developing more formal evaluation techniques.

When we decided to describe the training programme we discovered that the best framework for description was a family systems one. We did not originally set out to develop a training programme based on the principles of family therapy, and on reviewing the programme at a certain stage of its evolution were moderately surprised to find the parallels between the processes of teaching and therapy.

We have been studying the phenomenon of parallel processes between teaching and therapy. For example via video playback we are studying sequences of therapy before and after a trainee has conferred with an observing group. Changes in the therapist-family interaction following group discussion frequently are very obviously parallel to the therapist-group interaction.

In the systems terms, we believe we are talking about a principle that levels of a system are isomorphic; that what happens at one level is formally similar to or reflects, what happens at higher or meta-levels. Training is meta-to therapy. It is also, we are suggesting, a metaphor for therapy.

Or as that great systems thinker Marshall McLuhan (1968) amends Robert Browning —

Oh that a man's reach should exceed his
grasp
Or what's a metaphor.

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