
CHAPTER 14

PERSPECTIVES ON WORK
WITH TRAUMATIZED
YOUNG CHILDREN

*How to Deal with the Feelings
Emerging from Trauma Work*

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Sometimes the Judge should stop changing us from house to house. They should listen to what kids have to say in their heart.

—STATEMENT BY 12-YEAR-OLD LAZARO, who then drew a picture of a “heart with ears” for Judge Cindy Lederman of the 11th Circuit Juvenile Court, Miami

Traumatized children “pull” many different reactions and responses from therapists, first responders, and nontraditional first responders. In this volume, many different clinical approaches to work with traumatized children have been described. The goal has been to include “state-of-the-art” strategies for evaluation and treatment for very young traumatized children so that practitioners, first responders, and others interested in learning more about children exposed to trauma and helping them will find useful information in this book. While different evaluation and treatment strategies have been presented, one area that has not yet been covered relates to the intense feelings that can emerge for therapists or other intervenors when working with traumatized children and families. Recently, a talented mental health professional who works in a supervisory capacity for a commu-

nity mental health agency commented about how difficult it is to maintain consistency of staff when working in settings serving traumatized children, especially those under supervision of child protective service agencies and those in foster care. In response to her concerns, we spent some time discussing both the lack of preparation for therapists related to the difficulties of working with this high-risk often traumatized population as well as the often limited support available to those who work in this field. As is well illustrated in the diverse chapters in this book, it is not only therapists who may be traumatized by working with young children who are suffering, but also traditional “first responders” such as police officers, firefighters, emergency medical technicians, and nontraditional first responders such as teachers, judges, and even members of the media. As a part of their everyday jobs, all of these individuals may continually be exposed to trauma for which they rarely received support, help, or even someone to talk to about the intense feelings that often accompany trauma exposure. Juvenile court judges, particularly those who must decide the fate of very young abused and neglected children in dependency court, with caseloads that are frequently as large as 150 children each week, have shared how difficult it is to see and hear horrific stories every day about parents or caregivers who are supposed to protect and nurture their children. Police officers also must respond to domestic violence calls and deal with the needs of the victims and the aggression of the perpetrators; most often they do not have the time, knowledge, or resources to attend to the needs of the children who witness or are victimized by the violent incidents. Rarely are any of these professionals provided time to talk about how this work makes them feel; there is barely enough time to meet with these high-risk families and attend to their immediate needs.

In this chapter, I focus on the areas that are often not discussed concerning those who work with traumatized children and are particularly important when intervening or treating very young children who may pull even more from therapists and first responders due to their vulnerability and helplessness. The areas include vicarious traumatization, burnout, compassion fatigue, and countertransference, all of which impact by bringing up very strong feelings and emotions in the therapist or intervenor that are frequently an integral part of the work. When not addressed, however, such reactions can interfere with and even sidetrack the therapeutic progress.

VICARIOUS TRAUMATIZATION, BURNOUT, AND COMPASSION FATIGUE

Vicarious traumatization, the experiencing of posttraumatic symptoms similar to those experienced by victimized patients, can occur in therapists (Neumann & Gamble, 1995). They may experience somatic symptoms

such as nausea, headaches, intrusive thoughts, difficulty with sleep, emotional numbing, feelings of personal vulnerability similar to those of their patients, the victims of trauma. It is important to recognize, especially for therapists who have had less experience working with traumatized patients, that these signs and symptoms, though disturbing, may actually be expectable reactions to trauma work. McCann and Pearlman (1990) have defined vicarious traumatization as negative transformation in the therapist's internal experience that can result from exposure to the traumatic experiences shared by patients. When therapists suffer from vicarious traumatization, they may experience intrusive imagery that can be highly distressing and interfere with their ability to function in their work. Burnout, which is endemic to working with trauma victims, refers to the reduced effectiveness that is often accompanied by feelings of helplessness, hopelessness, frustration, anger, or cynicism. Burnout most commonly results from repeated exposure to traumatic situations with the accompanying human suffering and injuries. Treaters do not want to turn down calls, and yet over time they may become aware that they are functioning less well, both in their work and in their personal lives. With chronic exposure to trauma, especially when young children are involved, treaters may eventually find it difficult to continue with the work as they begin to feel helpless and hopeless themselves. These feelings may be exacerbated for therapists who themselves are parents of young children. It is recognized that burnout is more likely when the therapist is isolated, overwhelmed with work, has little supervision and/or consultation, and experiences little progress or success with the work. All of these reactions are prevalent in work with trauma victims as well as in the aftermath of a large-scale disaster or terrorist attack. Individuals need time off, the ability to talk about their experiences, support from peers and colleagues, supervision related to difficult and painful encounters, and recognition of the quality of their work.

Compassion fatigue, another component of vicarious traumatization and burnout, is defined as a form of caregiver burnout among psychotherapists related to caring, empathy, and emotional investment in helping those who suffer (Figley, 2002; McBride, 2003). To avoid compassion fatigue, self-care is necessary that includes more effectively managing caseloads, limiting compassion stress, and dealing with traumatic memories. Wilson and Lindy (1994) thoughtfully described the empathic strains—including tendencies for overidentification and avoidance—for therapists working with torture victims and other patients with severe posttraumatic stress disorder (PTSD; see also Nader, Dudley, & Kriegler, 1994). Some of their findings are directly relevant to work with children and families exposed to community and domestic violence. At times, the stories told by the children and families are so painful that therapists may wish to prematurely solve problems and bring closure to the work, which can result in limited success, failure, or early termination of the therapeutic work. The desire to “rescue”

the family, while unrealistic, often interferes with the effectiveness of the therapeutic interventions. In contrast, the therapist may feel so overwhelmed and helpless that he or she withdraws emotionally from the patient, again leading to limited treatment success, treatment failure, or premature termination.

COUNTERTRANSFERENCE

Countertransference is defined as the therapist's emotional reaction to the patient based on his or her unconscious needs and conflicts as distinguished from conscious response to the patient's behavior. Countertransference may interfere with the therapist's ability to understand the patient and may adversely affect the therapeutic technique (American Psychiatric Association, 1994, p. 32). When first beginning work with traumatized young children, most intervenors and therapists are altruistically motivated by wishes to be of help. In the case of young children, therapists work with the children to help them process the trauma and support their normal development so that they are able to cope with and, as they grow older, understand events to which they should not have been exposed. At the same time, while doing this therapeutic work, many therapists experience their own strong feelings about the children's traumatization that may include fear, anger, sadness, confusion and even, as mentioned above, a sense of helplessness and hopelessness similar to that experienced by the children. For children exposed to community and family violence, intervenors or therapists must be able to be available and listen, as it is difficult to predict what will be shared. It is crucial to keep an open perspective in order to gain an understanding of the causes of the violence, what can be accomplished, and how much the children's futures have already been compromised. There may be complex feelings of vulnerability that alternative with those of optimism and pessimism. Frequently, there may be uncertainty about the child's future, especially if the family is violent and chaotic. Thus for the therapist, mixed with the wish to help can be feelings of fear, danger, and (at times) helplessness.

Many people do not want to think about countertransference issues with traumatized children. One of the main reasons is that they may be painful to consider and difficult to discuss. Almost 10 years ago, shortly after we began the Violence Intervention Program for Children and Families (VIP) and had started our work with the New Orleans Police Department (see Osofsky et al., Chapter 12, this volume), twin boys, almost 3 years old, were referred to our child clinic at Louisiana State University Health Sciences Center and brought in by their maternal grandparents, who had been given custody of the children by Child Protective Services (CPS) after their father shot and killed their mother. These little boys had witnessed their mother's murder by their father and, as a result, showed disorganized, ag-

gressive, “out-of-control” behaviors. They showed little ability to control their behaviors, and even in the playroom they were “all over the place.” Typically, we observe children in the playroom and videotape their play with permission for purposes of supervision and to review the progress of the case. As I observed the little boys and reviewed the videotape, I found myself becoming more and more angry and realized that it was because I was distressed that these little children had to go through something as horrible as witnessing their mother being shot by their father. I also realized immediately, however, that such feelings would not be very helpful for either the treatment or the supervisory process. I wondered further if the therapist might also be experiencing a similar range of emotions as she provided treatment for the little boys and helped to support the grandparents who had lost their daughter. Being aware of the feelings engendered in me as well as the helplessness and hopelessness that sometimes accompanies work with traumatized young children, I was able to use my feelings to help understand the current inner confusion and distress of the boys and provide more effective supervision and guidance to the therapist.

Countertransference can work in different—sometimes unexpected—ways to influence responses. A number of years ago, the VIP team was working with a group of mothers, all of whom had sons who had been murdered. We were helping them start a group called “Moms Against Violence” with the goal of outreach into the community to help other mothers who had lost children to violence. We started by meeting as a group during which each person shared her own experiences of previous losses in her life. I realized as the discussion went on that some of the stories were difficult to hear and I recognized that, for me, losing a child was one of the worst things I could imagine. And so I listened to the stories, supported people as they shared their stories of loss and their grief, and at the end of the day went home and said to my family, “I’m going to bed.” I had young children myself and recognized (in a way that ultimately proved useful to them) that, at that time in my life, it was difficult to hold and process the grief of so many mothers. Interestingly, a few years later, one of my colleagues responded to a call from a school where a 6-year-old child had been killed by an automobile that raced right through the school zone. This social worker often responded to crises in the school. However, he came to me later in the day and said that he felt shaky and thought someone else should follow up on this situation. As we discussed it further, we both realized that one of his three children was 6 years old and that the tragedy hit “too close to home” for him to be able to hold and process the loss and grief in that school. These two personal examples illustrate how powerful our own countertransference reactions may be with trauma survivors and how important it is to be sensitive to these reactions.

Other countertransference issues are important and unsettling at times to the therapist. For example, when therapists feel helpless, they may be re-

flecting their patient's sense of being helpless and pessimistic about the future. Winnicott (1964/1987), in describing objective and subjective forms of interaction, emphasized hate in the countertransference and the importance of recognizing such hate if one is to do effective work. Especially when children's behaviors are disruptive and aberrant, when parents are unappreciative and insensitive to their children's needs, and when individual reactions of grief remain refractory to the therapist's interventions and dismissive of the therapist, he or she may experience anger even though reluctant to acknowledge it. Poggi and Ganzarain (1983) have described how the recognition and use of countertransference hate can be helpful in the treatment of difficult patients. Recognition of such reactions and their antecedents can similarly be useful in working with victims of violence and other traumatic experiences.

TERMINATION ISSUES FOR CHILDREN EXPERIENCING PREVIOUS LOSSES AND TRAUMATIZATION¹

It is important to understand the "meaning" of termination for children experiencing previous losses and trauma. Termination is planned for children at a time that seems appropriate related to the symptoms, conflicts, and concerns of the child and—for the young child—of the parents or caregivers. However, there is usually an understanding that treatment may be resumed at a later stage in development if these issues or new ones should arise. Because development may be fluid, patterns of growth or "derailment" may occur again and may need to be addressed when the child is older. Termination may occur quickly or slowly depending on the needs of the child, or at times, because the child or therapist may be leaving. In our training program, often therapists are in training for 1 year and must terminate their patients by necessity. While we are mindful of this timing in assigning cases, disruptions occur every year. From the outset of treatment it is crucial to sustain the parent or caregiver and the child in their relationship, and this goal may become even more important with termination.

In child therapy, the therapist works in tandem with other significant caregivers to achieve positive outcomes. The child's relationship with the therapist replicates (and often repairs) aspects of other relationships. The therapist must also take into account other influences on the child, including school, child-care settings, extended family members, etc. Ultimately, the parent or caregiver is the most significant ongoing relationship for the child and will provide guidance and direction. Often individual therapy and parental guidance may be needed to strengthen that relationship and help support it in the course of the termination process.

It is very important to recognize and support the developmental needs of young children in the course of termination. Many children, especially at

times of stress, are extremely vulnerable to changes in routine. They also are highly sensitive to changes in their primary caregiver and the other significant relationships in their lives. Multiply stressors may have a cumulative effect on children with the number of risk factors and stressor decreasing children's competence and ability to cope.

For high-risk children who have experienced previous losses and/or trauma, termination may re-create feelings that have emerged with earlier loss of relationships, loss of safety, and loss and stability and reliability. Losing a significant relationship early in life can impact profoundly on a child, especially if such a loss results in continuing instability. Children may experience loss of relationships through death of a parent or primary caregiver, or through parental abandonment, divorce, separation, long-term illness, incarceration, or other disruptions due to substance abuse or mental illness. Children may experience a loss of safety if they are exposed to community and/or domestic violence at a young age. Children may also be traumatized if they have serious illness including hospitalization with painful procedures themselves, experience or witness abuse or are involved in an automobile accident. Loss of stability or reliability can result from experiences of loss, especially if they result in disruption in routines or in their environment. Their routines and environment can be disrupted with changes in residence, changes in day-care staff or location, as well as neglectful caregiving without established routines. With loss of stability, children's sense of security is threatened and they may feel an overwhelming sense of helplessness.

Therapeutic work and termination with foster children and others with significant loss experiences involves helping them work through conflicts about earlier relationships, helping them deal with the trauma that accompanies loss, mourning the loss of the biological parent (even if this parent was not a great parent), and recognizing and re-creating early life experiences in the therapeutic relationship. Within a developmental perspective, the therapist can help the child work through conflicts and feelings, help to develop a sense of trust and stability, deal with the feelings of emptiness, despair, anxiety, and grief that emerge in many cases, and help the child understand these or cope with them at the time of termination. It is important at the time of termination to support the child's ego functions to deal with the loss by helping the child mourn the loss of previous caregivers, work on restoring developmental integrity, help her work through her trauma, including reexperiencing the trauma, and work on developing trust in new relationships. The goals are to help her develop enough inner stability to cope adequately with future loss and stress, recognize, depending on her age, that she may not have completely mourned the loss of her biological parents and may not be able to complete that process until she is older. For the young child and for child-parent psychotherapy, during termination the therapist may acquire the role of surrogate attachment figure

providing both a haven of safety and being a transference object (Lieberman & Van Horn, 2003).

The end of treatment and also the end of sessions represent a valuable opportunity for providing the child with corrective emotional experiences of separation and loss. Through the therapist's responses, the child learns that the image of the loved person can be kept when that person is no longer present. The image and associated memories can be brought back to mind at times of emotional need and used for comfort and support. At the end of treatment, it is often useful to go through a brief review of how things were at the beginning of treatment and how they are now. Preschoolers often need concrete reminders of how much time is left before the final session. Finally, it is crucial to use parental support to help the preverbal and young child with the sadness of good-byes.

Termination is a crucial time for children who have experienced multiple losses. First, it may provide both the child and parent with their first experience of nontraumatic loss. Further, a good and supportive termination process can provide the child with a new "script" and a way to face and navigate the losses he or she will inevitably face in the future.

THE NEED FOR REFLECTIVE SUPERVISION

An important way to provide support and guidance for therapists and intervenors working with traumatized children and families is through reflective supervision (Shahmoon-Shanok, Gilkerson, Eggbeer, & Fenichel, 1995). Reflective supervision, a process requiring reflection, collaboration, and regularity, provides an opportunity for therapists or intervenors to deepen and broaden knowledge, discuss reactions to experiences, discuss individual goals and progress, and develop and refine their individual style through self-understanding. Reflective supervision is carried out regularly in a safe and trusting environment. Through this type of supervision, the therapist learns how to understand and provide relationship-based treatment for infants and toddlers in the context of their families, as well as different ways to build on the capacities, resilience, and resourcefulness of children and families. In reflective supervision, the supervisor introduces and reinforces the idea that emotions and feelings are crucial to understand work with infants and families. Further, by recognizing our own emotional responses, it is possible to recognize, understand, and respect the emotional responses of infants, toddlers, and their families. The trusting environment allows the supervisee to feel free to express anxieties, concerns, and feelings that may arise in the course of the work, which with traumatized children and families may be very intense. By sharing and discussing the feelings in a safe environment, the therapist will then be in a better position to under-

stand and to “hold,” if needed, the intense feelings that arise in the course of treatment of the young children and family.

Dealing with countertransference issues is an integral part of reflective supervision. Often working with traumatized children and families brings up for the supervisee strong feelings toward the young traumatized child and, even more often, the parent. Reflective supervision allows the therapist to express and better understand these feelings so that they will not interfere with the development of a working alliance and impede the progress of the treatment. Issues of vicarious traumatization, burnout, and compassion fatigue will also come up in the course of this type of supervision, especially if the supervisor is attuned to these issues. Examples of such problems were illustrated earlier in this chapter. With this type of supervision, the supervisor and supervisee can step back from the immediate intense experience of the work in order to better conceptualize what is being observed and what may be happening. The supervisor also encourages the supervisee to talk about what he or she “thought” and “felt” when a particular event occurred. This type of supervision takes into account ambiguity that may come up in the course of the work as well as areas of confusion for both the supervisee and the supervisor. An important part of the work with young traumatized children and families is to just “be there,” and this type of supervision helps support the therapist in this role. The open communication that occurs in supervision can be a model for communication between professionals and parents, as well as parents and children.

CONCLUSION

Work with traumatized young children and families pulls a great deal from the therapist as well as others in the child’s environment. Therapists who work with children and families exposed to community and family violence, and those who have suffered at a young age from many disruptions and losses, may repeatedly suffer from vicarious traumatization, burnout, compassion fatigue, and strong and confusing countertransference. Powerful feelings may be evoked in therapists working with trauma victims, and in some situations the therapist may also be traumatized. They may also find themselves feeling very sorry for the children—wanting to rescue them—and, at the same time, angry with the abusive, neglectful, or just unfeeling parents. Supervisors of new trainees seeing traumatized young children become familiar quickly with the feelings that emerge in these therapists, who want to protect and care for them, thinking that these children would be better off if they could take them home with them. They may feel frustrated as they work with the caregivers to help them become more sensitive and responsive parents. Some trainees may feel that if they could just get the child out of the situation, everything would be much better.

Countertransference responses can inform and enrich treatment, and unacknowledged or unexamined responses can damage both the client and the therapist.

It is important to recognize that many survivors of traumatic exposure do well. Their involvement with the trauma may be minimal and their symptoms, if any, may be relatively short lived. Others may be severely traumatized, having witnessed horrendous scenes and having lost loved ones. Therapists must be prepared to listen, to absorb the traumatized children's concerns, to "hold" them, and to help them emotionally to "get back on track" and to return to their normal developmental functions. Ann Masten (personal communication, May 2003) discussed resilience as the ability of the child, often with intervention, to return to a normal developmental trajectory after having experienced trauma. In an earlier publication, I have discussed violence exposure for children as derailing their normal developmental trajectory and the therapeutic work being helpful to them to be able to get back on track (Osofsky, 1995). They cannot right the wrongs, nor can they erase the scars; however, they can be helped and supported in their development. As Selma Fraiberg (1987) so sensitively stated, working with children is a little like having God on your side. For clinicians who continually consult, treat, and supervise others who work with traumatized young children, dealing with issues of countertransference, burnout, and compassion fatigue is an integral part of the work. Each therapist must find his or her own way to deal with the overwhelming affects that are often aroused. Whether it takes working with a supportive team, self-care, or some other method, there must always be some type of support to be able to effectively do the work.

Nader (1994) provided important guidelines to help therapists with the strong feelings that can emerge and countertransference reactions when working with traumatized children. First, the therapist needs to develop a willingness to hear anything and to be able to "hold" the information and feelings to help the child. Second, it is crucial that the therapist recognize the phasic nature of trauma recovery. The healing will come over time, and there may be a need for occasional "time-outs" from direct focus on the trauma. Third, as has been emphasized in this chapter, it is crucial as part of the work that issues of burnout and countertransference be an integral part of training and supervision.

For clinical work with traumatized children other guidelines are also important:

- Don't be afraid to talk about the traumatic event.
- Provide consistency and predictability.
- Be nurturing and affectionate in appropriate ways and contexts.
- Discuss your expectations for behavior with the child.
- Talk with the child and explain things to him or her.

- Watch for signs of reenactment, avoidance and reactivity.
- Protect the child from traumatization if possible.
- Give the child choices and a sense of control.
- If you have questions, ask for help.
- Get supervision and consultation; do not work with trauma cases in isolation.

Mental health professionals and others who work with traumatized young children invariably have their own stories about a case or circumstance that was particularly difficult for them to deal with and that has “haunted” them over the years. Due to the nature of the work and often the personalities of the treaters, self-care is often something that people do not do for themselves. Although the United States continues to be a violent society where children are exposed to violence, many people continue to deny that even very young children are exposed and traumatized. Recently, I was talking with a little boy whose parents had just been divorced and who fought a great deal before they separated. I asked him what he did and how he felt when they fought. He said he tried to stop them. Then he said thoughtfully, “I used to be much braver then.” He was 4 years old when they separated. Although many would prefer to deny it, even very young children are traumatized by violence exposure. The behavioral reactions, symptom picture, intensity, and severity vary depending on developmental and situational factors, including the age of the child, proximity to the event, familiarity with the victim or perpetrator, and—perhaps most important—the presence of an emotionally available parent or caregiver. Thus, caring for the caregivers when trauma occurs is an important and crucial component to help support the child. For very young children, traumatization of caregivers means that it may be more difficult for them to listen to their child, hear their story, and provide support. Further, parents may have less patience when they too are traumatized and may become more easily irritated as well as less resourceful in handling their children’s stress. Treatment approaches that are effective in helping traumatized young children and families are varied. They may include working individually with the parents or caregivers to support them and help them deal with and process their trauma and, at the same time, working individually with the young child most often through play. However, treatment will also need to be relationship based, recognizing that issues and conflicts emerging between the parent/caregiver and the child may be crucial for healing to occur. Finally, less frequently addressed problems are those of countertransference, burnout, and vicarious traumatization, all of which occur when working with victims of trauma. These issues have been overwhelmingly evident in recent years in our work with first responders, police, firefighters, and EMS (Emergency Medical Service) workers, as well as therapists—all trying to help the many traumatized children and families

when they themselves have been traumatized by the horrific events that have occurred. Perhaps here the dicta “Heal Thyself” and “Do No Harm” are important for mental health professionals and others working with trauma victims.

NOTE

1. The ideas on termination in this section have been influenced by an unpublished paper by Michele Many, LCSW, Department of Psychiatry, Louisiana State University Health Sciences Center, New Orleans.

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