International Journal of Applied Psychoanalytic Studies
Int. J. Appl. Psychoanal. Studies 11(2): 101–113 (2014)
Published online in Wiley Online Library
(wileyonlinelibrary.com) **DOI:** 10.1002/aps.1401

Soul of an Agency: Psychodynamic Principles in Action in the World of Community Mental Health

FRANK C. SACCO, ELAINE CAMPBELL AND MARY LEDOUX

ABSTRACT

Community mental health has undergone a number of evolutions since Lyndon Johnson declared a War on Poverty and gave birth to the community mental health movement. This paper describes a philosophy of treatment involving long-term psychotherapy to resistant and multiple problem families in disadvantaged communities. The agency's primary philosophy is described as a psychoanalytic frame that guides treatment from a secure attachment site (clinic) in the community. The interventions use home and community based therapists with supports from psychiatry, psychology, and therapeutic mentoring. The focus of all treatment is for high-risk families to remain in the community and not burden corrections, courts, child welfare, or juvenile justice systems. Therapy forms the connection that can help families navigate schools, medical providers, courts, and social service systems. The agency forms the positive attachment site; clinicians come and go. The net effect is sustained connection to families that would have otherwise been broken apart by domestic violence, school crimes, addiction, gangs, poverty, homelessness, and community violence. Copyright © 2014 John Wiley & Sons, Ltd.

Key words: psychoanalysis, psycho-dynamic therapy, community mental health, high-risk families, medicaid

Community mental health has gone through many evolutions since its appearance in the mid 1960s as part of the war on poverty initiated by Lyndon Johnson. Initially, psychotherapy and psychology in general were limited to ivory tower, academic, and highly theoretical applications of psychology to a very limited audience. The community mental health movement ushered in the need to bring the mental health services into the community. Historically, this was accomplished using federal block grants to catchment areas representing regions of various states.

During this phase of community mental health, there were a host of various types of approaches to coping with difficulties that existed in disadvantaged

communities plagued by social deviance such as high unemployment, domestic violence, serious and persistent mental illness, criminality, and addiction. It was clear that waiting for individuals with these difficulties to enter into a world of traditional mental health was limited. This was also influenced by the evolution of the de-institutionalization movement which forced community mental health to become more active in the community in response to the need to take people out of large State run facilities for chronic mental illness and intellectual disabilities. This was most notable in Massachusetts and the Federal decision of Mass Association for Mental Health versus Michael S. Dukakis an attempt to create a Northampton. The de-institutional movement in Massachusetts was initiated in the early 1970s and swept across the major state agency systems of care including the chronically mentally ill, and intellectually disabled, juvenile justice and delinquency, and child welfare and the overlap of delinquency and child welfare known as status offenders in Massachusetts. In other states in subsequent decades there was a movement to study how to best respond to the specialized needs that were emerging (Beigel & Levenson, 1972; Williams & Ozarin, 1968; Sarason, Levine, Goldenberg, Cherlin, & Bennet, 1966). The Mental Health Act was guided by a report for the Joint Commission of Mental Illness and Health's report titled *Action for Mental Health* (1961) called for centers to be available regionally to prevent the impact of mental illness on the client and community.

Also, at this time, the proliferation of single families also increased as a result of increased incarceration rates within certain cultures and social economic status (NAACP.org), and provided an unintended financial reward for fatherlessness through unregulated welfare policies. President Reagan declared a war on drugs and the anthem of "just say no" was echoed by the First Lady. This resulted in the societal criminalization of human weaknesses most often found in many people suffering from substance use disorders.

During the early 1980s, managed care of Medicaid became the central payment mechanism in the delivery of community mental health. Services that were originally funded in block grants were now being billed to third parties such as Medicaid for those women and children in the child welfare system as well as adults with disabling mental health and intellectual disabilities. This system created a funding and service delivery framework that later evolved into a system of care for community mental health for all levels of behavioral health. Managed care began in the private sector and evolved as a primary component of serving the Medicaid population (Dickey *et al.*, 1998; Dickey, Normand, Norton, Rupp, & Azeni, 2001). This shifted costs away from purely federal dollars given to geographical areas, to shared federal-state funding that followed the individual client based on eligibility for entitlements.

The private market in insurance was shaped by relying on evidence-based approaches to mental health that focused on time-limited, highly structured, compact interventions that use cognitive-behavioral interventions to alleviate minor psychological distress commonly found in the mostly employed members.

DOI: 10.1002/aps

This population of privately insured clients is often referred to as the "walking well", many of whom are treated in the community by individual or group practices or in hospital outpatient clinics. The community mental health center has become the main provider of services to the more chronic and seriously disturbed children, families, and adults.

The newest shift in delivery of community mental health is being ushered in by the Affordable Care Act (ACA). Populations are divided into quadrants:

High Behavioral Health, High Medical Health	High Behavioral Health, Low Medical
Low Behavioral, High Medical	Low Behavioral, Low Medical

Community mental health centers often treat the High Behavioral Health groups. The ACA is using a community outreach approach that fosters prevention and primary care to manage groups with chronic conditions such as serious mental health disorders, obesity, asthma, diabetes and hypertension. The ACA is attempting to redesign the delivery system to reach out and manage these high risk populations using home and community-based care. The ACA takes the community mental health movement one step further and is striving to attach high risk populations to preventive care designed to minimize the health and financial burden of unmanaged chronic conditions frequently occurring in the Medicaid population. Attachment to a clinic with outreach capacity creates an outpost and a platform for delivering services to families rather than always reacting medically or criminalizing disruptiveness and anti-authority behavior.

A TRAUMA CLINIC'S TARGET POPULATION

This population can be described as the high risk group of individuals who if left unmanaged will create needless spikes in medical and state agency related costs (Sacco, Twemlow, & Fonagy, 2007) as well as decreasing the quality of life within families and communities. Many live in poverty while struggling with trauma-based symptoms leading to social deviance, disruption, violence, addiction, and homelessness. The attachment of traumatized families to a community mental health center can become a method of managing high risk families in the community and building a bridge to promoting healthier lifestyles within disadvantaged communities. The net result of this intervention is not only improved quality of life for the client but also the community such as schools, after school activities, and general quality of life indictors.

It should be noted that the approaches outlined herein are targeted for high risk individuals that have frequently been in contact with state agency systems either through child welfare, juvenile justice, special education, court, corrections, or other state funded agencies. Contact of families with these agencies generally indicates that they are suffering from some type of environmentally-induced conditions that have impaired their ability to function normally within society. This chronic exposure to trauma and unhealthy lifestyles frequently results in

DOI: 10.1002/aps

highly dysfunctional families generating high costs in states' medical, human service, corrections, courts, special education accounts. If unmanaged, these families often suffer multi-generational mental disorders caused by exposure to trauma. These families can create a never-ending drain on society's public health and behavioral health resources. This population is clearly targeted in the ACA as the highest user of medical resources if not managed by prevention. Many of the children in these families suffer from lifetime chronic diseases including asthma, diabetes, obesity, and as they age, hypertension and other heart conditions. This is clearly recognized in the new era of the ACA which targets and incentivizes the states to create methods to engage these families in a relationship that focuses on making progress in areas of primary health.

The psychotherapy is long-term with many of the adults suffering from personality disorders, especially Borderline Personality Disorders. The children suffer from attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), Oppositional and Conduct Disorders. This model is designed for high risk populations living in the community and are most frequently referred by child welfare and juvenile justice sources. Child maltreatment has been shown in a study of 738 youth followed for 18 years to significantly increase the risk of developing a personality disorder (Johnson *et al.*, 1999). Reflection on the clients' weekly experiences in regular psychotherapy is the main engine driving the soul of this type of clinic. The clinic's primary goal is to increase the client's reflection and decrease mindless reactions. Home and community-based therapists bring reflection to the most chronically or seriously ill people of all ages damaged by trauma and still functioning in the open community. This outreach with psychotherapy uses a variety of techniques to promote self and other reflection as described by Bateman and Fonagy (2000):

> the association between parental reflection and child security is strongest when there is adversity in the mother's history. We have suggested that the likelihood of intergenerational trauma and adversity is reduced by the mother's capacity to reflect on her own and other's thought and feelings related to her history. (p. 76)

The clinic maintains the drum beat or becomes the attachment replacement shattered by maltreatment. The therapy helps clients stay psychologically safe and functioning in the community by keeping the dialogue moving in supportive psychotherapy focused on the client's reflective capacity. This attachment philosophy has to be referred to as mentalization-based therapy (Bateman and Fonagy, 2000) whose primary goal is to "identify primary beliefs and link them to affects" (p. 254).

THE SOUL OF THE CLINIC: CREATING A SECURE PSYCHOLOGICAL BASE

The approach suggested in this paper outlines a theoretical concept of how a community mental health agency can become a secure attachment site for use in

DOI: 10.1002/aps

reaching this high-risk population in disadvantaged communities. The agency's core treatment philosophy becomes the soul of the clinic. This soul of the clinic is the driving force behind all the interventions that are applied to clients who may remain attached for years to the clinic and have multiple therapists, psychologists, and psychiatrists involved in their treatment as well as the therapy for other family members. The approach described here applies a psychodynamic frame using home and community based psychotherapy delivered to serious and chronic populations that exist in disadvantaged communities. The long-term connection to clients and families is achieved by the agency having a dedicated hour that offers a safe place to reflect on highly dramatic, dangerous, risky, and shameful behavior. These hours may be with different therapists over the years, but the soul of the clinic serves as a substitute attachment site. Supervision is consistent and offers therapist the opportunity to reflect on their experiences delivering therapy in the individual or family's home, community, or school.

The community mental health clinic providing primarily home, school and community, based psychotherapy and consultation services can become an attachment site acting as staging structures in the community actively engaging families in solving problems and reducing the impact of serious emotional disturbances on family and community life. The clinic may offer a variety of services that range from family therapy, individual therapy, play therapy, psychological evaluation, psychiatric evaluation and medication monitoring, case management, and therapeutic mentoring. These services are currently offered using a managed care model of Medicaid reimbursement relying on the use of medical necessity criteria. Psychotherapy and all services need to be carefully documented and justified based on progress made in specific areas of personality growth and functioning.

Using psychotherapy within the medical model in the community creates a way for the family to engage in a variety of psychotherapy and supportive services that can assist them in the tasks of interfacing with a complicated network of systems, beginning with the school, state agencies, court, and other resources established by the Federal, State, and regional government to support those individuals. This attachment point is most needed in families that are crippled by the impact of trauma that is environmentally induced and often compressed over generations.

The clinic as an attachment site can offer sustained and predictable support. The individual psychotherapist may transfer, move to a different job, or not be available for psychotherapy when the client needs help. The agency or clinic is responsible for ensuring that this occurs in the most ethical fashion possible. Thus, the family becomes attached to the agency rather than the specific psychotherapist that is delivering the supportive and expressive services at any one time. The family develops a relationship with the clinic and various members of the family may be receiving different services but from the same clinic. The people may vary as professionals grow, but many families can remain connected using psychotherapy for the time necessary to raise their children and

DOI: 10.1002/aps

to transition them into productive members of society. This can take upwards of 10 to 20 years.

Massachusetts Medicaid allows for upwards of weekly contact with children and bimonthly contact with adults who exhibit serious mental health conditions and can be managed using this type of psychotherapy over time. The essence of this long-term expressive-supportive approach is suggested as an approach to traumatized families thrown out of balance by either intense traumatic experiences or compressed generational trauma that has impaired their capacity to function normally within the community. The psychotherapy is not geared to any one symptom or condition, but is the basis for a connection to a family. The cost savings result from the decrease use of higher cost services such as inpatient hospitals, emergency rooms, residential placements, court costs, and corrections.

Psychodynamic Principles

Intervening in problems on the front lines of community mental health requires that the agency's philosophy be flexible enough to accommodate a wide range of interventions. This is where the "psychodynamic frame" offers the structure to deliver to clients in their homes and community the opportunity to reflect with a therapist. Also, the client has an agency advocate and back-up offered by the public health clinic's 24/7 phone support, therapy support such as therapeutic mentoring and case management, as well as psychiatric and psychological services for advocating in various systems such as school and court.

The behavior and conditions that are exhibited with these families are complex and frequently involve serious conditions such as ADHD, PTSD, Borderline Personality Disorders, Oppositional and Conduct Disorders, destructive behavior disorders, and Major Affective Disorder. Gabbard and Wilkinson (1994) highlight the need for a flexible approach in coping with the countertransference experienced in treating borderline clients. These conditions can be paralyzing to families and parents who eventually lose their ability to support and maintain a safe home for the family. This begins the destructive downward spiral of the dissolution of the family and the increasing involvement of the State. Children become at risk when parents lose their protective capabilities. This is the point where a variety of psychotherapies can be woven together within this psychoanalytic frame that insists on a certain series of values in the delivery of the therapy services.

Therapists are free to use behavioral approaches, family approaches, expressive art therapies, and any other ethical psychotherapy. The goal becomes focusing on prevention, early intervention, and supportive alternatives to destructive traumatic life circumstances. The individual techniques that are used are de-emphasized and the structure of how these services are delivered is guided and supervised to seek out primary beliefs, linking affects and trauma, and working to improve reflective functioning for all clients regardless of age or type of problem. Freud (1924) insisted on scouring the unconscious to ensure that therapists can be the most helpful to their clients. This creates a mindset of an "obsession with

DOI: 10.1002/aps

the other." This focus on the ongoing experiences of the client is the hallmark of the psychodynamic approach applied to all interventions. This long-term work with high-risk families in disadvantaged areas demands openness and the use of eclectic approaches with intense clinical supervision stressed so in psychoanalysis.

Practitioner Principles

Therapists travel weekly to a family's home and meet with the entire family or more typically individually with parents and children. The primary mechanism fostered in this frame is "open dialogue", active listening, and predictable connection times. Therapists can use the resources of the clinic's child psychiatrist and medical staff, the psychology department and internship program, and therapeutic mentors. The focus of all psychotherapy is the development of a comfortable frame for psychotherapy for clients with high needs and low motivation. The universal job of the therapist is to build "buy in" to the therapy. Therapy focuses on creating an open outlet for adults and children exposed to trauma. Open expression is created using whatever opportunities present themselves in any one therapeutic situation. Children play with toys, draw, act out their fantasies and fears, create play scenarios expressing their wishes, and establish close relationships with the regular visitor. Adults in therapy frequently replay old, failed strategies for living life and will re-enact drama associated with poor caretaking and vulnerabilities to addictions, prostitution, domestic violence victimization, child removal, incarceration, emergency room usage, and poverty experienced in homelessness, housing instability, multiple moves, disrupted school, and placement away from home.

While the therapist struggles to keep certain goals in mind, the frame demands that therapists seek the client's experience of life. This takes the form of open dialogue with some re-directing and a more active giving of direction than would be proper in a traditional analysis of an individual in a consulting room. The frame also has a very strong emphasis on the role of development in the understanding of human behavior. The frame is obsessed with what Anna Freud has coined "the best interests of the child." The psychoanalytic frame is an agency philosophy that seeks to refrain from taking away a therapist's ability to apply his or her skills with the clients. Many therapists rely on dialectical behavior therapy (DBT), cognitive-behavioral treatment, and other "non-psychoanalytic" treatment within the psychoanalytic frame. The psychoanalytic frame is simply good clinical work involving: (a) good supervision; (b) strong commitment to understanding the life problems for seriously traumatized children and families; (c) secure, long-term support during high risk periods. The clinic forms an agency attachment structure for high-risk families and individuals built over time and provides support and advocacy through therapy and back-up support. Countertransference is huge in this complicated system and the frame must keep asking the question: is this for my client's benefit or mine? The psychoanalytic frame is the mindset modeled by leaders such as Karl Menninger and Anna Freud. The idea of the best interests

DOI: 10.1002/aps

of the child is the essence of Anna Freud's message. This is the central guiding principle forming the soul of this type of clinic.

The psychodynamic frame involves a commitment to understanding the family's experiences rather than applying recipes to specific symptoms. Psychoanalysts refer to this experience of being in therapy as a feeling of being contained or held as described by Winnicott (1958/1965) and Bion (1959). The psychoanalytic frame is preoccupied with understanding the client's experience and a single minded dedication to communicating this understanding to the client. Psychoanalysis views human experience as the primary ingredient for psychotherapy. Managing the relationship between the client and the therapist is driven by that single golden rule of the "obsession with the other" or the management of countertransference. This is the essence of the psychodynamic frame. The focus of the treatment is managed in weekly supervision. This offers a dual reflection on the client's experiences.

When the primary element of the psychopathology targeted is the trauma resulting from the toxic experiences of being a victim or the perpetrator this approach to psychotherapy offers a way to create a positive presence in areas of high-risk. Every human has a different way of processing and defending against their own personal experiences and the psychotherapist is challenged to understand the client's struggle. In the modern world of managed care, this focus on the personal experience of the client needs to be structured to fit within the Medicaid reimbursement regulations promulgated by States. This requires basing the treatment in terms that can be defended through medical necessity and following a coherent treatment plan from diagnosis to problem behavior with consistent documentation of progress.

Rogers (1961) identifies two types of psychotherapy in the humanistic movement as being either expressive or supportive. Psychoanalytic techniques incorporate these elements of therapy into the very fabric of every thought the analyst has about the ongoing experiences of the client. In both humanistic psychology and psychoanalysis, there is a deep interest in how the person experiences the trauma. For children, it is a clear symbolic representation available in their play and this is often the approach that is most useful for children living under traumatic circumstances. As they age, teenagers become difficult to manage and disruptive and often respond more to a type of supportive and more action oriented intervention that may combine mentoring, case management, as well as individual and parent or family counseling.

The psychodynamic frame insists that the experience be the primary starting point of the treatment. Managed care is primarily interested in the reduction of needless high cost procedures. These managed care entities are beginning to recognize the value in engaging this high risk population in a sustained and positive relationship that can be used to build on other skills and activities such as health and safety. This approach does not take a well researched cognitive method and does not strive for fidelity on any one approach to therapy. Dodge (2011) speaks eloquently for the need for the regional approach to develop to child welfare

DOI: 10.1002/aps

policy. This emphasis on regional social context is true as well for psychotherapy within the community where it is infinitely more complicated to do therapy with clients who have complicated social systems (educational, home, and community). Intervention always takes place in a different context, often in high risk areas with many distractions, risks, and the recent presence of a traumatizing person or group of people.

The very intensity of the population calls for the use of another psychoanalytic approach to practice which is the intensive clinical supervision. Psychotherapist's working in the community and client's homes are overwhelmed with deep and often regressive and primitive defenses. Psychotherapists join a family in the community and can easily be trapped by heavy countertransference evoked by individuals who struggle with environmentally induced Personality Disorders. Therapists quickly become tempted and lured by highly charged and often provocative behaviors exhibited by clients of all ages. Intensive clinical supervision and documentation are used to ensure that the psychotherapist does not become trapped in a countertransference enactment that is a very frequently part of the psychotherapy. This is most often seen when a family is engaged in a complicated network of services including child welfare, the court, and other state agencies. The psychotherapist can easily be pulled into a splitting or a projective identification and become the target of false allegation or become the splitting wedge in a community treatment intervention. The clinical supervisor meets frequently with the psychotherapist and the primary focus of this supervision is client experience and benefit, as is typical in psychoanalytic training and practice.

The third psychoanalytic principle reflected in the treatment frame is based on the work of Anna Freud. As a community clinic offering psychotherapy, children are offered the opportunity to engage in expressive play therapy. This type of intervention works in conjunction with a host of other types of supportive services including therapeutic mentoring, consultation, psychological testing, and clinical consultations. The psychotherapist of the child referred for a long-term psychodynamic intervention frequently is living in substitute care or a highly unstable family in the community. In these cases, a regularly-scheduled time is offered weekly as an opportunity to express themselves. This is an open ended, experienced based-series of weekly sessions in which the child is encouraged to express their experiences. The children are assisted by the therapist in creating a container for frightening trauma experience. The children can express their ghosts and the therapist works slowly to foster the child's and his or her family's skill at mastering positive alternatives to the symptomatic solutions children formulate to cope with trauma.

Anna Freud pioneered the idea of children being at the center of a family's consciousness. Her early work with children separated from families due to the burning of London showed clearly the impact of disconnection from primary care givers (Freud & Burlingham, 1944). The trauma was abandonment of parents due to the Blitzkrieg. She understood the power of development and the need for children to be understood. She worked closely with Marie Montessori

DOI: 10.1002/aps

in trying to create a philosophy of mind for both clinicians and educators that valued the child's experience as the primary engine for therapy and education. Her commitment to the best interest of the child is alive in the soul of the clinic. The therapist in expressive play therapy meets regularly with the child and offers them a private theater in which the "ghosts of the nursery" can be chased away from their world. It is during this sacred individual time that the child is free to symbolically unweave the experiences that have caused such unrest, exhibited in the symptomatic behaviors requiring their involvement in treatment.

This central theory of Anna Freud needs to enter the modern and complex world with the same toxicity blasted at children. The need for the child therapist to work in the larger community and family is not an option with children living in these vulnerable families. It is not uncommon for the child's therapist to be connected to the family and a variety types of therapy or be more actively working with a psychiatrist, a case manager, or a therapeutic mentor. These supportive services provide a direct needs gratification component to the purely abstract relationship of psychotherapy.

Long-term psychodynamic treatment of families often requires engaging adults and teenagers in a series of psychotherapeutic interventions. Frequently, these adult's human weaknesses are criminalized and they frequently are engaged in substance abuse disorders. These adult clients are not liked anywhere they go and often poison families and communities with drug-seeking behaviors. Many are on methadone and homeless. This type of clinic can open its doors to this population. The goal, again, is to sustain a therapeutic relationship, medication management, and progress to healthier lifestyles. These adults often receive primary care from the emergency room and county correctional facilities.

INTEGRATION OF HEALTH AND BEHAVIORAL HEALTH

Psychoanalysis began as a medical profession and over time has been expanded to other professions including psychology and social work. Essentially, the psychoanalyst was the medical and psychological centerpiece of therapy that unfolded in a consulting room for highly motivated clients experiencing stress in the world. The paradigm has shifted dramatically and this was recognized early by Freud. In the early 1930s, Freud understood that his belief that psychoanalysis should be for everyone was impractical. This was documented when the Vienna Psychoanalytic Society officially handed over the practice of psychoanalyst for the common man to the then Dean of Smith College School of Social Work (Danto, 2005). Smith social workers implemented the psychodynamic frame into their practical ongoing activities of casework on the front line in projects such as Settlement Houses. Born in Vienna and nurtured by social workers at Smith School of Social Work, the application of Freud's ideas on analysis for the poor is the forerunner of this approach. The psychotherapy works with Medicaid-funded supports such as case management and therapeutic mentoring services offer an opportunity to move around and activate more positive health behaviors such as attendance in primary

DOI: 10.1002/aps

care visits, more orderly special education meetings, less need for court meetings, and increased participation in recovery groups or other natural community supports for serious emotional disorders. The relationship between the physical symptoms and the psychological factors contributing to them was where psychoanalysis was born. The age of repression (late 1880 to early 1900) led to hysterical medical symptoms such as fainting and phantom paralysis. Modern conflicts stem from overstimulation, under protection, and the non-stop bombardment with information and ever-present digital connection. Environmentally-induced trauma has created a cluster of behavioral health and medical conditions that reveal themselves in medical conditions, social deviance, and addictions. Many of the modern trauma-induced conditions require an integrated biological and psychological intervention.

The ACA is signaling the need to integrate the behavioral health and the physical health. The relationship between early onset diabetes, asthma, obesity, ADHD, and other conditions common in these families results in either improper medical or mental health care. When both are not provided or are mismatched under the ruse of social deviance, then psychotherapy becomes less effective in being able to redirect symptoms.

Psychotherapy in community mental health is now primarily dependent on Medicaid reimbursement. Medicaid is the payer of last resort, particularly under the pressures of the EPSDT (Early, Periodic, Screening, Diagnosis and Treatment). This is a bedrock principal of the Title XIX law covering the entitlements such as Medicaid and Medicare. In the United States, once a State creates a class of "entitled" persons, they become entitled to a variety of services provided by the State. As such, children are required to perform well-child visits. EPSDT states that if a screener identifies a serious emotional condition in a Medicaid child (under 22) then they are under obligation to respond to this difficulty. A recent decision in Massachusetts, Rosie D. v Romney, illustrated how a group of parents used EPSDT to impact federal consent decrees creating services for the state's Medicaid children. The case involved a challenge to the state to prevent placement by having home and community services. Teens were removed from their home and placed in residential rather than offer preventive care as dictated under EPSDT. The parents won and the state created new services offered in families' homes.

CONCLUSION

Longer term psychodynamic interventions provided in the home and in the community offered manage care the opportunity to reduce the higher cost placement such as inpatient, emergency services, and respite services in general. Regardless of the diagnosis, the behavioral patterns and the clinical unfolding of these various serious emotional disorders at different developmental stages share the common human experiences of being: disruptive, manipulative, selfish, draining, predatory, chronic drain on resources, high chronic disease and self-destructive health.

DOI: 10.1002/aps

Frequently these basic human experiences can be seen as annoying and often highly destructive human behavior such as drug seeking, illegal drug distribution from prescribed medicines, state custody of children and dissolution of the family, delinquency, medical drains, chronic emergency rooms for primary care, and other high risk behaviors that interfere with the quality of life in the community.

Resources are drained by clients with these behaviors when they are not engaged in some supportive services. The basic premise of the use of psychodynamic intervention is that it provides a way in which highly resistant and often difficult to manage patients can be engaged in psychotherapy. Psychotherapy can become a way to manage behaviors which drive needlessly high use of medical resources. Like its substance use disorder counterpart in Alcoholics Anonymous (AA), psychotherapy is a way to contain these behaviors and requires daily reinforcement.

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DOI: 10.1002/aps

Frank C. Sacco
Community Services Institute, Boston and Springfield,
77 Reed Street, Agawam,
MA, 01001, USA
fcsacco11@gmail.com

Elaine Campbell
Community Services Institute, Boston and Springfield,
1695 Main Street, Springfield,
MA 01103,
elaine.campbell@communityserv.com

Mary Ledoux
Psy.D., Community Services Institute,
540 VFW Parkway,
W. Roxbury, MA 02132,
mary.ledoux@communityserv.com

Int. J. Appl. Psychoanal. Studies 11: 101–113 (2014)
DOI: 10.1002/aps