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Mental Health as a Public Social Problem

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The anthropology of health defines the medical treatment as a social practice, which takes into consideration a person's social context, the differences between genders, the connection of personal and social. It accents the characteristics of social systems, values and manifestations of social crises through basic concepts and discourses, like gender and culture. Besides the consideration of health and disease, it enables also the consideration of a person in a highly industrialized society and of a culture as a totality. The phenomenon of destructive ways of manifesting psychic crises requires the recognizing of mental health as a social problem.

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I. INTRODUCTORY STARTING-POINTS AND RESEARCH PROBLEM

The research question of the article is derived from the presumption that the phenomena as riskiness, insecurity, anxiety, unhappiness and lack of connection are immanent to the risk societies and that contemporary social structure forms individuals with an undefined and instable identity, which manifest itself in the form of numerous mental distresses and because of which the contemporary personal distresses are a sociological, aggregate phenomenon.

Bauman (2002: 202) states that insecurity, instability and vulnerability are the most diffused and painful characteristics of the modern world. "The phenomenon that all these concepts try to embrace and to articulate is an experience composed of *insecurity* (of situation, rights and survival), *uncertainty* (regarding their duration and future stability) and *danger* (of the human body, self and their excrescences: property, proximity, community)." (ibid: 203) The passage into the late modern society (Giddens) means the individual's exclusion from traditional ties, religious systems and social relations, the pluralization of life styles and the competition of values have contributed to the downfall of relationships that gave meaning to an individual's life (Beck, Beck - Gernsheim, 2006). The risk, mentioned by Beck, appears especially on an

individual's level and it also brings a risk into personal, intimate relationships that seemed natural and untouchable until that moment.

Contemporary anxiety is connected to the feeling of uncertainty regarding the social situation and social roles and the incessant pressure to adapt and change identity, which lead to feelings of stagnation and emptiness, inexistence and insignificance that go along (Stein, Vidich and Manning White, 1962: 134). Fromm-Reichmann believes that the numerous emotional and mental states, indicated by psychiatrics as anxieties, are in fact states of loneliness or fear of loneliness in the individual's psychological isolation and alienation from oneself and other people. Personal sources of anxiety are confusion, psychological disorientation and uncertainty regarding norms, values, ideologies and the general sense of things (ibid: 131–132).

The totality of a person's extensions includes the individuals' relation towards themselves, others, their position in society and it reflects itself by their entire activity.

The paradigm of anthropology of health supposes that health and illness are cultural constructs and that their manifestations are part of the cultural patterns of a specific society, which establish the concepts of normality and abnormality, the concepts of illness and health of a specific culture. Different suppositions of an illness demand to take into consideration the social extension of a person's life and an expanded health model, i.e. the bio-psychological model, based on the biologic, psychological and social determinism of health (Kaplan, Sallis and Patterson, 1993).

With a defined research question, *how can a person actualize himself and preserve or return his mental health, taking into account his biologic endowment, the concepts and perceptions of modernity and consequent psychic crises*, we want to redirect the research attention from the question 'what is a person' to the neglected question 'who is a person' and its living and social extensions.

The main stress of this article is the definition of a person as a social, free and responsible being, who is intrinsically motivated and whose behavior is purposive and proactive. This kind of thinking is in opposition to more enforced conventional approaches, which treat a 'mental illness' exclusively as a physiological biochemical dysfunction within a person, wherein the modern neuropharmacology and an increasing consumption of medicaments have an important role in

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eliminating unwanted feelings and behavior. By this type of understanding we avoid the discussion of the basic factors of the augmentation of mental distress and we overlook the role of the most important agent in the social events – the individual, whose behavior is reflected in the face of modern society.

II. THE CONCEPTUALIZATION OF MENTAL HEALTH

In contrast to the modern era, the late-modern era is more inclined towards humanism and the ethic attitude, which influences the differently conceptualized occurrence of the phenomenon of mental health.

The concept of mental health was transformed and it also became a social and psychological phenomenon. The integration of a psychological view of a personality in medicine indicates the defining of mental health by dividing the personality in the individuals' relation towards themselves, the realization of potentials, the independence from social influences, self-respect, feeling, the perceiving of the world and the control of one's own life. Researching a behavior and performing social roles, meeting social expectations linked to defined roles, the quality of interpersonal relations, the relation towards the social environment and defining normal and abnormal or deviant behavior from the standard of specific roles, all that define mental health as a social phenomenon (Freeman and Giovannoni, 1969). The factors of mental health are determined by the factors of a psychological, biological, social, economic or cultural source, which originate from a family structure or from the quality of interpersonal relationships (ibid: 678).

The World Health Organization still considers the diagnosis as the key presumption of an illness, while Levi Strauss stated the definition that "the health of an individual spirit includes taking part in a social life, like the rejecting of the social life (but this rejection is possible only in the modalities imposed by the social life itself) corresponds to the occurring of mental disturbances. The forms of mental illnesses are characteristic for any society and percentage of individuals affected by these disturbances, they are constitutive for a special type of balance, specific for every independent society. So, for example, in societies that know shamanism, the shamanistic behavior is accepted as normal." (Levi Strauss and Mauss, 1996: 237–238).

In the second half of the 20th century the followers of antipsychiatry, Foucault (Madness and Civilization, 1961), Szasz (The Myth of Mental Illness, 1960) and Goffman (Asylums, 1961) defined mental problems socially functionally. Szasz (1982) understands the meaning of the mental illness phenomenon as a hidden fact that most of the people's lives are an incessant struggle, not for the biologic

existence but for the peace of mind or any other value or signification. He claims that the mental illness is a myth: "the concept of mental illness is used especially to hide the fact that for most of the people their lives are a struggle for life, not in the sense of biologic survival as much as in the sense of assuring one's 'place under the sun' " (Szasz, 1960: 118). Szasz points out the powerlessness of hospitalized people also by not taking into account and by devaluating their judgment.

White (1988: 20) believes that "insanity is a political-biologic rebellion against the repressive normality, the fear and the concordance wherein people are afraid to think and behave differently." Rovatti offers a similar definition: "we can define insanity as difference and fear of difference. An insane person is a certain prototype of a different person: as in the past when people shut an insane person in a special institution in order to confirm their own normality, as today the separation and ousting of different people continue, so a group can consolidate their own certain identity." (Rovatti, 2004: 9)

Properly speaking, "a mental illness is for now only an assumption in the cognitive-theoretic sense. We can neither prove it nor disprove it. The supposition of an illness harms the people marked in this way. It leads to a life stigmatization, which works as a self-realizing prophecy" (Lamovec and Flaker, 1993: 88), the Pygmalion effect (Rosenthal) when an individual behaves in accordance with the ideas and expectations of another person, without at first really having the problems attributed to him by others. The concept of stigma is established, defined by Goffman as a discrediting identity, where an 'abnormal' difference conceals all the other characteristics and marks them to the point of setting the owner of such attribute in an inferior position in the society. It is about a relation, dependent on the normative expectations of the environment (Goffman, 1981).

The predominating biological model of modern psychiatry is openly criticized by the Irish psychiatrist Linch, who believes that "the medical approach to mental distress is based on unproven suppositions, especially on the theory that the basic cause of a mental distress is biological that it is an issue of biochemical imbalance or genetic irregularity or both. Psychiatry convinced itself and the public in general that this is not a supposition, but it is a proven fact [...] After several decades the intensive psychiatric research still cannot determine the biological cause for any psychiatric condition. The insufficiency of biological proofs confirms the uncommon fact that not one psychiatric diagnosis can be confirmed with a biochemical, radiological or any other laboratory test. I am not familiar with any other medical profession that would cure people based on a supposed biochemical irregularity." (Lynch v Glasser, 2003: 6)

In accordance with Lynch's critics Glasser (2003) comprehends mental health separately from 'mental illness' which he does not acknowledge, because he comprehends all 'psychopathological' behavior as creativity of the brain through which a person wants to reduce frustration and satisfy the basic needs. By understanding the holistic behavior of the choice theory he exchanges cause and consequence – the chemical balance in the brain is the consequence of chosen behaviors (to satisfy the needs) and of created beliefs (on the basis of the perceptual system).

The theorists from the field of positive conceptualization of mental health defend the need for the separation of mental health continuums and mental illnesses. Downie (in Tudor, 1996: 24–25) explains the idea of separation of both concepts as a division that enables an individual to have a diagnosed mental illness and at the same time to reach a high level of mental health and well-being. Seeing as the concepts of mental health and mental illness would belong to the same continuum, there would be only two options – an individual could be mentally healthy or mentally ill. The distinction between mental health and mental illness and the acknowledgement of mental health as a positive concept which is not defined by the absence of mental illnesses, are also being defended by Tudor (1996), Adams, Amos and Munro (2002). Tudor stresses that the line of separation between the two concepts is often erased. Mental health is still connected to the sphere of mental illness, what classifies both in the same continuum (Tudor, 1996: 24). Glasser (2003) defines the mental health problem as an independent entity and not just as the absence of illness. The socio-emotional components of life, like a satisfying family life, friendly relationships, position in a community, physical and mental health estimation, and their insufficiency express themselves through social deprivation (Andrews and Withey, 1976; Bradburn and Caplovitz, 1965; Inkeles, 1998).

Glasser's definition of mental health is radically constructed and it demolishes the concepts of normality and abnormality established in the society. The understanding of mental health is positioned in the context of good and satisfying relationships with close people, which enables a person to satisfy their psychical needs. The definition is conceived in such a manner that an individual is introduced to the reflection of their own feeling and behavior and it directs them to a subjective experiencing and active functioning. At the same time it warns us of the fact that mental health should be a part of public health.

III. THE MANIFESTATION OF MENTAL CRISES IN MODERN SOCIETY

The psychologisation of mental health is becoming a socially more acceptable form of

manifesting emotional dissatisfaction in the modern, highly developed society. The expression of distress with mental pain runs parallel with the processes of individualization, which triggers disintegrative processes on the level of social relationships, culture and an individual's identity.

It is estimated that 50 million people (11 per cent of the European population) suffer because of mental crises, which are diagnosed as mental disorders within the medical model. Depression is the most diffused medical problem in the EU, which according to the data from the member countries still remains socially and culturally more acceptable for the women. In the EU, 17 per cent of adult women and 9 per cent of adult men suffer from depression (EUROPE, 2008).

According to the World Health Organization data, mental health problems are still increasing, and the medical experts predict that in 2020 depression will be the most frequently diagnosed illness in the developed world (EUROPE, 2008).

Alcoholism is considered to be the most frequent form of addiction in the western world (Glasser, 2000: 209), culturally and socially the most acceptable and tolerated form of destructive behavior. The researches show that the (ab)use of alcoholic drinks represents one of the key problems of public health. Numerous negative short-term and long-term medical and social results appear in peoples' medical conditions, their disease and mortality rate. An excessive use of alcohol also has economic effects, due to a lower productivity, diseases, premature deceases and expenses in medical care, traffic and judicature (traffic accidents caused by drunk participants, temporary absence from work because of diseases, injuries and poisoning, which are a direct consequence of alcohol consume, etc.) (ibid).

In the last forty-five years the frequency of suicides in the world also augmented – approximately 60 per cent. Suicide is the leading cause of premature death in Europe – 58.000 cases per year, there are ten times as many suicide attempts (EUROPE, 2008).

The usage of illegal drugs is augmenting, wherein the age limit of the users is lowering.

In the period from 1999 to 2005 in EU the percentage of people receiving medical treatment for the first time because of cocaine problems augmented from 11 to 24 per cent of all new people who are receiving a treatment. More than 12 million Europeans used cocaine once in their lives, its usage is most diffused among young adults. The drug is still in the domain of men (at a ratio of five men to one woman), but drug abuse is also becoming socially acceptable for girls (Institute for health protection of the Republic of Slovenia, 2010).

The usage of substances shows the purpose of choosing a destructive and ineffective behavior, maybe even more than other painful behaviors – getting

depressed, suffering from a phobia, etc. Alcohol or any other drug imitates or activates the chemical activity of the brain that induces a feeling of comfort. That gives a person a feeling that one or more of their needs are being satisfied and that they have control over their life (Glasser, 2003).

Getting drugged is a dysfunctional form of solving problems. A drug can rapidly and without any effort relieve one's distress, solve the conflicts and improve a bad condition, but the satisfaction lasts only as long as the effect of the drug. In order to regain a good feeling, one has to get drugged again, which leads to addiction. Besides getting drugged with a substance, drugging with detrimental behaviors, the so-called nonchemical form of addiction - it is about the process of drugging by behavior, which has the characteristics of a psychoactive substance, a changing neurochemical activity of the brain (Carnes, 2006), can also be classified as modern drugs (feeding, consumption, computer games, internet contents, gambling games, etc.), which represents a modern way of manifesting dissatisfaction and a destructive attempt to gain control over one's own life that could be extremely risky and also potentially fatal for a person.

IV. THE DEFINITION OF THE RESEARCH PLAN AND OF THE RESEARCH METHODS

In the empirical research field of the article we orientate from pathogenesis towards salutogenesis, towards regaining mental health. There were five examples of destructive forms of manifesting dissatisfaction included into the research – mental health problems, psychosomatic problems, obsessive thoughts and compulsive behavior, sexual addiction and difficulties in growing up. The elaborated case studies are supervised and appropriate from a psychotherapeutic point of view, congruent with the chosen psychotherapeutic concepts. The examples were analyzed and interpreted by the choice theory, which was chosen as an interpretative tool for the explanation of the origin of psychical crises and which has also led us to the answer to the question, how should a person act and behave in order to preserve or regain his mental health in spite of the biological endowment and the embedment in a specific socio-cultural environment.

The case study represents the client's story and their interpretation of the problems, the therapist's understanding of the client's problems through the concepts of the choice theory, a summary of parts of the conversation that are important for the reestablishment of the relationship, for discovering the client's world of qualities, for understanding the client's endeavors, for the client's shifting from the convictions of psychology of external control to the convictions of the choice therapy. The case study also includes the record of the

therapist's internal dialogue and his professional inclusion (the therapist mediates the knowledge of the choice theory to the client). It is also an explicit presentation of the establishing and developing of the therapist-client relationship in the sense of therapeutic means for attaining an end. Ultimately the practical work is a review of the amelioration of mental health through the study of the choice theory and that has an important contribution to an individual's autonomy, a necessary independence from the therapist. Qualitative case studies with a deep insight into the socio-psychological reality of a chosen group of people represent at the same time the process itself- the case study includes at least six séances with the client, which means that they are watched for at least three months, in most cases for a year.

The analysis of the material was realized in accordance with the basic procedures in the grounded theory, also named inductive theory (Mesci, 1998: 33). The distinction of this theory is the theoretical sampling – it is an intentional assortment of units that would contribute to further development of the theory on the basis of previous knowledge and in the current of analyses of acquired data. With an accurate definition of the characteristic of the content of defined phenomena we determined the notions that represented the conditions in which activities and interactions appear, where these phenomena express themselves and the consequences that they cause. By coding the data we opened the data for an analytic proceeding, defined the concepts, their characteristics and dimensions and we installed them into the context. In the continuation we linked them together and combined them in concepts of a higher level and category. Through the method of constant comparison, we searched for similarities and differences and for particularities of individual phenomena, developed generative questions and formed ad hoc hypotheses. We examined simultaneously the hypothesis in the data, annotated analytic notes (*memos*) that are used for supporting the process of data analyzing, and later we used them as a description of theoretical cognitions. We followed the basic task of the grounding theory, i.e. the research of connections. We turned towards searching common points of different problems and 'diagnoses' in the area of mental health, we studied the factors that have an influence on the manifestation of psychic crises, the characteristics of an individual's consideration and activity, and the larger socio-cultural context of psychic crises manifestation and treatment.

We concluded the analysis with the formulation of a theory, a contextually bounded theory, which represents a reflection of observations, considerations, inferences, regularities, legalities, typologies, etc. of an individual's forms of behavior, acts, convictions, whereat we took into consideration the psychotherapeutic, psychosocial and socio-anthropological aspect.

We started a method of analysis of qualitative data, case studies exacting and of a long duration by the analysis of the text and by defining terms for notions that seemed the most appropriate, and we also used notions from the theory we chose for the interpreting of the material, i.e. the choice theory. For the coding we used the procedure of direct naming. In this way we named a single description directly with a determined denomination or code, without comparison with other descriptions or search for synonyms, contraries, associations. We continued the open coding with the procedure of categorizing and classifying data. Then we united cognate notions by categorizing them into units. We modeled the notions by abstracting the common characteristics of several different descriptions. The analysis of the notions and categories characteristics followed, in accordance with the choice theory, and the selection and definition of categories (we left the notions determined only operationally) regarding the research problem. We performed the so-called axial coding. In this phase we eliminated also the irrelevant notions – too distant and non-connected with other notions and with the research problem. We compared the obtained and defined units among them, we searched for and constructed relations among them and we organized them into supposed relations, we performed the so-called selective coding (Glaser and Strauss, 1967; Strauss and Corbinova, 1990). There was a theoretical frame formed in the concluding phase, which followed the formulation of forms and gave theoretical interpretations and explanations. Based on the coding of the text we formed forms that we identified in the analysis as distinctive behavior, 'figures', 'structures' – we present them later in the article.

The analysis of case studies was performed by means of the program for processing qualitative data, ATLAS.ti. The program was used as an expedient for the technical facilitation of the coding proceedings, the development of concepts and their connection into larger units and for establishing correlations among the units. We added the newly formed proper relations to the network of relations that are automatically formed by the program, and in this way we embraced all the recognized relations in the analyzed text.

V. CONCLUDING CONCEPTUALIZATION

The discussed material was full of implicit theories ('theories in use' by Schon), those are hidden comprehensions of the clients, comprehensions that the clients do not know or say, but are evident from the viewpoint of the legitimacy of chosen theories. The material is working, implicit, which we say or explain through the client's reflection, realizations. This is taken into consideration also by the case study, completed by the therapist's internal dialogue (the interpretation of the

perceived), which simultaneously explains and makes people aware of the client's behavior.

In the point of saturation when the data became repetitive and redundant for further work, it was possible to grasp from the analysis of the material determined behavioral patterns of the clients, which speak in favor of the chosen theory.

Form one: the clients persistently recognize themselves in the roles of victims of other people's actions, they themselves have no power or influence, because they understand their actions and consideration as causal-consecutive.

Form two: they consider others guilty for their problems – external factors –close people or past events, which they have no influence on.

Form three: the clients put a lot of energy in attempts to exercise control over others or in withdrawals of control for other part. For that they use controlling or other destructive behavior.

Form four: all the treated clients in their last important relationships experienced constraining and controlling behavior. In some cases those actions were 'hidden' behind care, love, good-intentions, etc. especially from the mother's side.

Form five: the clients received an authoritative form of education from the parents as a rule. Some of them show that distinctively in the therapeutic process also in connection to low self-esteem and low self-confidence.

Form six: the destructive effects of actions of the psychology of external control on personal relationships and on an individual's mental health are evident.

Form seven: the client's intensive concern with symptomatology is present.

Form eight: without exception, in the 'background' of the client's problem there is a momentary unsatisfying and to him an important relationship. 13

Form nine: the clients try to appease their psychic needs in ways that are unsatisfying for them or even frustrating and destructive, which they express with somatization and mental suffering.

Form ten: a psychical bad feeling id connected to the client's dysfunctional conviction.

Form eleven: the formation of individual dysfunctional convictions is connected to the social construction of sexes, which is a result of an androcentric culture, a patriarchal tradition and sexism.

Form twelve: psychic crises are directly connected to painful experiences, traumatic events, like violence, poverty, disease, personal loss, separation, etc.

Form thirteen: the client's chosen, especially destructive behavior are connected to sex and social acceptance.

Form fourteen: the clients have problems with establishing and developing satisfying relationships.

Form fifteen: the change in the perception and understanding of our own actions and actions of others makes it possible for the client to appease his basic

psychical needs more effectively and to regain control over his own life.

Form sixteen: the regaining of control over one's life or the amelioration of mental health is directly connected to an effective appeasing of psychical needs in relationships with others.

As a generalization, originated from the basis of the analysis of the material and of the elaborated paradigmatic model, we present the elaborated strategy of the client's 'behavior' with an 'illness' and the strategy of the client's renewed control over his life.

Strategy A: 'The loss of control over one's own life.

a) The assuming and/or performing of controlling behavior

The clients try failingly to appease their psychical needs with them, which manifests itself in numerous painful ways.

b) Causative-consecutive deliberation ration and action

The internalized deliberation that people are beings of reaction, who just react to others' behavior and do not have any possibility of choice. The clients avoid the cognition that they alone, directly or indirectly, chose the very thing they complain about.

c) The position of the 'nutshell'

Until a person persist in the role of a victim and they blame others for their unhappiness and dissatisfaction, their life quality cannot improve, and by that neither their well-being. The client's key realization must be that they can control and also change only their own behavior and not others.

d) Persisting in bad, unsatisfying relations

People remain for years in unhappy, unconnected relations, where they try to appease their basic needs in painful ways. They often express their dissatisfaction with complaints, disapproval, but they do not link the unhappy relations to the mental health problems.

e) Orientation towards a physiological and emotive component of holistic behavior

Emotional (sadness, fear, anger, anxiety, etc.) and physical (unrest, pain, general bad state of health, etc.) feelings are the most frustrating and painful for an individual. This is why they orient themselves towards them and by that they remain in the magic circle of unhappiness and suffering. The active component of the holistic behavior remains practically inactive until the entry into the therapeutic process.

Strategy B: 'The assuming of control over one's own life.'

a) The orientation towards the client's world of qualities

A person's internal, personal, unique world is represented by a group of people, things, events,

convictions, values, etc. and it is taking shape since birth, all our life, and it represents the best ways we want to appease our needs. The recognition and taking into consideration a person's world of qualities are necessary for the search of more effective ways of appeasing needs, which represents the creation of a life of quality and the improvement of health. 15

b) The orientation towards choosing more effective behaviors and deliberations

When a client learns how to remove the external control from his life, he starts to change his actual unsatisfying relations. The change in the perception and understanding of his own actions and the actions of others enables him a more effective appeasing of the basic psychical needs and the reassuming of control over his own life. The client's key cognition is that he can control and also change only his own actions not the actions of others.

c) Care for an (equilibrated) appeasing of psychical needs

Orientation towards appeasing psychical needs by taking into consideration the client's personal world of values, convictions, figures, ideas, etc. a regard for reality and search for solutions, better choices within the given possibilities (environment).

d) Taking care of relations and/or establishing new ones

A person cannot appease all of their psychical needs without a basic consciousness that they are a free being who can choose – a series of behaviors and self-perception and the perception of others –, and that they are a social being who can successfully appease their needs only in a satisfying relation with other people.

e) The meaning of the relation therapist-client.

The relation therapist-client represents the basis of the whole psychotherapeutic process. We derive from the conviction that the meaning of the relation between the therapist and the client is the one that surpasses the level of single theoretic models and is the key for a 'successful' therapy, despite the essential conceptual separation of different therapeutic modalities. In the relation with the client, the therapist follows the value of human dignity, they accept and respect a person in all of their uniqueness and entity and they do not announce nor control their behavior.

VI. FINAL STATEMENTS AND INTERPRETATION

The analysis of the material confirms *the concept of sexually conditional and socio-culturally acceptable behaviors of manifesting psychical crises*. Men and women adjust psychical distress to a specific socio-cultural environment and to sexually acceptable behavioral patterns. 16

The mental health problems of women are closely linked to her social role, they are a network of past educational patterns and consolidate external expectations. Mental pain is manifested by forms that are attributed to women and are the consequence of socialization and later life experiences connected to it. Women express personal dissatisfaction within the accorded sexual roles and a determined cultural context. The form of mental pain manifestation are the result of the 'woman's' socialization. Women express personal dissatisfaction with a silent, inconspicuous 'woman's' behavior (Podgornik, 2012: 6).

The anthropologist Darja Zaviršek (1993: 104,105) establishes that depression as a behavioral cultural pattern is a typical manifestation of mental pain, which "is attributed to the female sex, creates different sexual ideologies and leads to many women with a sexually acceptable behavioral pattern, identifying themselves with it and they adapt the expression of their psychical distress to it". Resorting to a disease is also frequent, addiction to tablets, addiction to alcohol and addiction to food (refusing food, excessive eating, overeating and then throwing up and combinations of those), coffee, cigarettes are socially more acceptable for women.

The concept of factors that that are conditional to the formation of psychical crises is also connected to the socio-cultural environment. The intertwining of negative factors like class appurtenance, patriarchal sexual pattern, national appurtenance, physical violence, wrong care work, long period of living in a threatening and stressful relationship, unemployment, people's socio-economic problems are the basis for the manifestation of mental health problems.

From the presented socio-biographies the perception and performing of male and female roles in connection to the sex as a socially constructed category (gender), but not their sensibility for a social construction of both sexes is evident. In other words they understand their actions as a biologic determination of their sexual identity.

Their social roles do not deviate essentially from the ones defined based on a biologic function. Women realize the role of a family and home guardian and educator while men preserve the role of a family provider and representative in the public sphere and in comparison to women they benefit of a superior position. The convictions and actions of the clients reflect a traditional course of socialization, favoring of social roles regarding the 17 biologic gender. Their sexual identity is the result of commonly adopted norms and values of the culture that they belong to. They act appropriately in socially acceptable roles in view of the gender. The qualities in the domain of women's social gender are tenderness, sensibility, excessive sentimentality, passivity, willingness to subordinate, while in the domain of the male social gender are

rationality, aggressiveness, emotional stability and activity. This represents itself as an additional burdening in the manifestation of psychical crises. If the behavior does not suit the qualities connected to the gender, they experience a bigger stigmatization – the case of a depressed man and an alcoholized woman.

Demographic factors, gender, age, marital status, ethnical appurtenance and socio-economic status in interaction with personal qualities influence the formation of mental health problems and also their development and solving. Researchers (Pez et al., 2006) establish that the social network and relationships work as factors of chances or protective factors for the formation and development of mental problems.

From the present material, among the causes for the formation of mental crises, the use of actions of constraint and control as an universal characteristic of a specific behavior on the level of interpersonal relations stands out. *The construct of external control* is typical of the parents-children relations and for a relationship between two partners. These are relationships that represent an important figure in a person's world of qualities and to which great expectations are tied. The clients tried to attain these expectations with an external control, in the context of universal, i.e. behavioral psychology, all to the realization that internal control is the only one possible, because people are internally (intrinsically) motivated beings, so no external motivational factor, stimulus is effective in a long term. Furthermore, the ethnographic material used in this article also proves that forced and controlling actions are inevitably destructive for a person and his relationships.

The reason why we perceive a great part of reality (life situations) differently than others is situated in the personal world, in *the construct of the world of qualities*, which is proper to each person, and in *the construct of individual differences*. The showed therapeutic processes take into consideration the individual choices of behavior, chosen by individuals with different biological endowments in different environments, that have the key influence on a different development of a personality, besides the biologic differences and different 18 environments in which individuals live. By that, the individuals develop specific world of qualities that again influences the diversity of individuals (Lojk, 1999: 19).

The choice theory defines *the construct of holistic behavior* as a simultaneous activity of four components: activity, thinking, feeling and physiology (ibid: 80). Although by choosing the holistic behavior all four components still function, a person has a direct control over his activities and his thinking, while feeling and physiology depend on the two of them (ibid: 81–82). That is why the holistic behavior (mentally and physically), even if it is that unusual and pathological, of a disease (except when it is caused by a proved organic

pathology) in the organismic sense is always intentional (Lojk and Lojk, 2011: 313).

It is possible to summarize two more concepts from the analysis of the material, connected to the help model that the clients received. *The concept of the medical help model* is based on the discovering and on the interpretation of symptoms and it defines their treatment. The main instrument is a pharmacological treatment, where a psychological approach does not have any special meaning. The medical model defends the conviction that mental disturbances are a product of biochemical changes, that can be treated with a pharmacological therapy. *The concept of the psychosocial help model*, which does not use medical diagnoses, but contextual descriptions of problems and disturbances, originated as a critique of the medical model. We should accentuate the systematic-ecological (holistic) concept that developed in the seventies and is based on the systematic theory – on the understanding of effective connections and interactions among people and their relation towards the environment in which they live. While solving the problem, the client (user) is an active participant, capable of solving his own distress and taking control over his life with professional help. In the eighties, the socio-constructivist model, connected to the humanistic and existential theory, starts to develop with the social constructivism. With this model the basic disciplines used are sociology, cognitive psychology, linguistics, anthropology, etc. and the client (user) is an expert in recognizing his own life situation. *The reality therapy*, substantiated by the choice theory that we established as the contextual and interpretative theory of the present article, belongs among the psychotherapeutic approaches with a constructivist and systematic background.

We conclude the attempt to form theoretic concepts with *the relationship therapist-client*, which represents the expedient and purpose in the reality therapy. The client (and the therapist) senses in the most genuine relationships, how the subject-object relationship changes into the subject-subject relationship. In the therapist-client relationship we are not concerned with the question of 'transfer' and 'contra transfer' as a process that in psychoanalysis enables the client to comprehend, and as a process that a psychoanalytic should be conscious of in order to avoid eventual problems in the relationship between him and the client. The reality therapy believes that a responsible personal connection between the therapist and the client is the best, the fastest and frequently also the only way for the client to learn how to develop his relationships with the people he needs (Lojk, 1999: 9).

VII. CONCLUSION

The paradigmatic move was performed in dealing with problems with mental health based on a

dialogue between anthropology, sociology and psychotherapy, which enables us to see a person and to consider them as a holistic being, with all their physical, psychical, social and mental extensions and their position in a socio-cultural environment.

We cannot understand a person's mental health problems without taking into consideration the social and cultural frames of their experiencing and expressing. From this point of view we try to define mental health as a part of good interpersonal relations, social networks, quality of life, satisfactory self-image and satisfying strategies for mastering the distresses in contrast to the negative concepts of mental health. Along that, we take into consideration the individuals personal history and biography, included in the research work, the socio-demographic and socioeconomic factors of the influence on mental health, outside of the medical treatment of mental health as the absence of mental illness.

The conviction of the indivisibility of mental and physical dictates a holistic and proactive understanding of a person's activity, that is why an approach oriented towards an individual is necessary. With the finished research work, I want to contribute to recognizing needs for a holistic approach in treating psychical crises, by placing a person's inter-subjective social world into a larger socio-cultural context.

We recognize the present research as a research of interpersonal relations, of a modern society person's holistic behavior, their response to the pain connected to the risks that it brings to the modern society. The material we studied is rich and it offers the recognizing of numerous social threads – socialization patterns, patriarchy, matriarchy, differences between the 20 genders, other factors, that determined the origin of psychical distresses, a person's creative system, reorganized behaviors as a response to personal crises and a person's other attempts to regain control over their life.

We analyzed a person's behavior and thinking in relation to the environment and persons that the client co-creates their life with. We researched two fields: the happenings in a person and in a (domestic) environment. Separately – individually became the social cultural perspective.

In the democratization of individualization it is about searching for a person's chance to successfully form and realize their life story by being conscious of the free choice, liberated from the restraints that determined their life style in the past. A person is the one that creates the nucleus of every human action with their own experiencing, and a man is the active subject that we cannot put in the place of an object, if we want them to preserve their human values.

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