

1 Mental Health as a Public Social Problem

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5

6 **Abstract**

7 We define the concept of mental health on the basis of the realization that mental health is
8 not just a health phenomenon anymore, but also a social and psychological one. By defining
9 mental health separately from mental illnesses, it is placed into the concept of public health,
10 which exceeds the medical definition of the determination of a "mental illness". The
11 anthropology of health defines the medical treatment as a social practice, which takes into
12 consideration a person's social context, the differences between genders, the connection of
13 personal and social. It accents the characteristics of social systems, values and manifestations
14 of social crises through basic concepts and discourses, like gender and culture. Besides the
15 consideration of health and disease, it enables also the consideration of a person in a highly
16 industrialized society and of a culture as a totality. The phenomenon of destructive ways of
17 manifesting psychic crises requires the recognizing of mental health as a social problem.

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31 Keywords: mental health, social perspective, anthropology of health, late modern society, choice theory.

32 **2 I.**

33 **3 Introductory Starting-Points and**

34 Research Problem he research question of the article is derived from the presumption that the phenomena as
35 riskiness, insecurity, anxiety, unhappiness and lack of connection are immanent to the risk societies and that
36 contemporary social structure forms individuals with an undefined and instable identity, which manifest itself
37 in the form of numerous mental distresses and because of which the contemporary personal distresses are a
38 sociological, aggregate phenomenon. ??auman (2002: 202) states that insecurity, instability and vulnerability are
39 the most diffused and painful characteristics of the modern world. "The phenomenon that all these concepts try to
40 embrace and to articulate is an experience composed of insecurity (of situation, rights and survival), uncertainty
41 (regarding their duration and future stability) and danger (of the human body, self and their excrescences:
42 property, proximity, community)." (ibid: 203) The passage into the late modern society (Giddens) means the

5 THE CONCEPTUALIZATION OF MENTAL HEALTH

43 individual's exclusion from traditional ties, religious systems and social relations, the pluralization of life styles and
44 the competition of values have contributed to the downfall of relationships that gave meaning to an individual's
45 life (Beck, Beck -Gernsheim, 2006). The risk, mentioned by Beck, appears especially on an individual's level
46 and it also brings a risk into personal, intimate relationships that seemed natural and untouchable until that
47 moment.

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

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

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

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

67 The main stress of this article is the definition of a person as a social, free and responsible being, who is
68 intrinsically motivated and whose behavior is purposive and proactive. This kind of thinking is in opposition to
69 more enforced conventional approaches, which treat a 'mental illness' exclusively as a physiological biochemical
70 dysfunction within a person, wherein the modern neuropharmacology and an increasing consumption of
71 medicaments have an important role in eliminating unwanted feelings and behavior. By this type of understanding
72 we avoid the discussion of the basic factors of the augmentation of mental distress and we overlook the role of
73 the most important agent in the social events -the individual, whose behavior is reflected in the face of modern
74 society.

75 4 II.

76 5 The Conceptualization of Mental Health

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

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

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

96 In the second half of the 20th century the followers of antipsychiatry, Foucault (Madness and Civilization,
97 1961), Szasz (The Myth of Mental Illness, 1960) and ??offman (Asylums, 1961) defined mental problems socially
98 functionally. Szasz (1982) understands the meaning of the mental illness phenomenon as a hidden fact that most
99 of the people's lives are an incessant struggle, not for the biologic existence but for the peace of mind or any
100 other value or signification. He claims that the mental illness is a myth: "the concept of mental illness is used
101 especially to hide the fact that for most of the people their lives are a struggle for life, not in the sense of biologic
102 survival as much as in the sense of assuring one's 'place under the sun' " ??Szasz, 1960: 118). Szasz points
103 out the powerlessness of hospitalized people also by not taking into account and by devaluating their judgment.

104 ??hite (1988: 20) believes that "insanity is a political-biologic rebellion against the repressive normality, the fear
105 and the concordance wherein people are afraid to think and behave differently." Rovatti offers a similar definition:
106 "we can define insanity as difference and fear of difference. An insane person is a certain prototype of a different
107 person: as in the past when people shut an insane person in a special institution in order to confirm their own
108 normality, as today the separation and ousting of different people continue, so a group can consolidate their own
109 certain identity." ??Rovatti, 2004: 9) Properly speaking, "a mental illness is for now only an assumption in the
110 cognitive-theoretic sense. We can neither prove it nor disprove it. The supposition of an illness harms the people
111 marked in this way. It leads to a life stigmatization, which works as a self-realizing prophecy" ??Lamovec and
112 Flaker, 1993: 88), the Pygmalion effect (Rosenthal) when an individual behaves in accordance with the ideas
113 and expectations of another person, without at first really having the problems attributed to him by others. The
114 concept of stigma is established, defined by Goffman as a discrediting identity, where an 'abnormal' difference
115 conceals all the other characteristics and marks them to the point of setting the owner of such attribute in an
116 inferior position in the society. It is about a relation, dependent on the normative expectations of the environment
117 (Goffman, 1981).

118 The predominating biological model of modern psychiatry is openly criticized by the Irish psychiatrist Linch,
119 who believes that "the medical approach to mental distress is based on unproven suppositions, especially on the
120 theory that the basic cause of a mental distress is biological that it is an issue of biochemical imbalance or genetic
121 irregularity or both. Psychiatry convinced itself and the public in general that this is not a supposition, but it
122 is a proven fact [?] After several decades the intensive psychiatric research still cannot determine the biological
123 cause for any psychiatric condition. The insufficiency of biological proofs confirms the uncommon fact that not
124 one psychiatric diagnosis can be confirmed with a biochemical, radiological or any other laboratory test. I am not
125 familiar with any other medical profession that would cure people based on a supposed biochemical irregularity."
126 (Lynch v ??lasser, 2003: 6) In accordance with Lynch's critics Glasser (2003) comprehends mental health
127 separately from 'mental illness' which he does not acknowledge, because he comprehends all 'psychopathological'
128 behavior as creativity of the brain through which a person wants to reduce frustration and satisfy the basic
129 needs. By understanding the holistic behavior of the choice theory he exchanges cause and consequence the
130 chemical balance in the brain is the consequence of chosen behaviors (to satisfy the needs) and of created beliefs
131 (on the basis of the perceptual system).

132 The theorists from the field of positive conceptualization of mental health defend the need for the separation
133 of mental health continuums and mental illnesses. Downie (in Tudor, 1996: 24-25) explains the idea of separation
134 of both concepts as a division that enables an individual to have a diagnosed mental illness and at the same
135 time to reach a high level of mental health and well-being. Seeing as the concepts of mental health and mental
136 illness would belong to the same continuum, there would be only two options -an individual could be mentally
137 healthy or mentally ill. The distinction between mental health and mental illness and the acknowledgement
138 of mental health as a positive concept which is not defined by the absence of mental illnesses, are also being
139 defended by Tudor (1996), Adams, Amos and Munro (2002). Tudor stresses that the line of separation between
140 the two concepts is often erased. Mental health is still connected to the sphere of mental illness, what classifies
141 both in the same continuum ??Tudor, 1996: 24). Glasser (2003) defines the mental health problem as an
142 independent entity and not just as the absence of illness. The socio-emotional components of life, like a satisfying
143 family life, friendly relationships, position in a community, physical and mental health estimation, and their
144 insufficiency express themselves through social deprivation ??Andrews and Withey, 1976; Bradburn and Caplovitz,
145 1965; ??nkeles,1998).

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

152 6 III.

153 7 The Manifestation of Mental Crises in Modern Society

154 The psychologisation of mental health is becoming a socially more acceptable form of manifesting emotional
155 dissatisfaction in the modern, highly developed society. The expression of distress with mental pain runs parallel
156 with the processes of individualization, which triggers disintegrative processes on the level of social relationships,
157 culture and an individual's identity.

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

163 According to the World Health Organization data, mental health problems are still increasing, and the medical

164 experts predict that in 2020 depression will be the most frequently diagnosed illness in the developed world
165 ??EUROPE, 2008).

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

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

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

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

183 The usage of substances shows the purpose of choosing a destructive and ineffective behavior, maybe even
184 more than other painful behaviors -getting depressed, suffering from a phobia, etc. Alcohol or any other drug
185 imitates or activates the chemical activity of the brain that induces a feeling of comfort. That gives a person
186 a feeling that one or more of their needs are being satisfied and that they have control over their life (Glasser,
187 2003).

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

197 8 IV.

198 The Definition of the Research Plan and of the Research Methods

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

208 The case study represents the client's story and their interpretation of the problems, the therapist's
209 understanding of the client's problems through the concepts of the choice theory, a summary of parts of the
210 conversation that are important for the reestablishment of the relationship, for discovering the client's world of
211 qualities, for understanding the client's endeavors, for the client's shifting from the convictions of psychology of
212 external control to the convictions of the choice therapy. The case study also includes the record of the therapist's
213 internal dialogue and his professional inclusion (the therapist mediates the knowledge of the choice theory to the
214 client). It is also an explicit presentation of the establishing and developing of the therapist-client relationship in
215 the sense of therapeutic means for attaining an end. Ultimately the practical work is a review of the amelioration
216 of mental health through the study of the choice theory and that has an important contribution to an individual's
217 autonomy, a necessary independence from the therapist. Qualitative case studies with a deep insight into the
218 socio-psychological reality of a chosen group of people represent at the same time the the process itself-the case
219 study includes at least six séances with the client, which means that they are watched for at least three months,
220 in most cases for a year.

221 The analysis of the material was realized in accordance with the basic procedures in the grounded theory, also
222 named inductive theory ??Mesec, 1998: 33). The distinction of this theory is the theoretical sampling -it is an
223 intentional assortment of units that would contribute to further development of the theory on the basis of previous
224 knowledge and in the current of analyses of acquired data. With an accurate definition of the characteristic of
225 the content of defined phenomena we determined the notions that represented the conditions in which activities

226 and interactions appear, where these phenomena express themselves and the consequences that they cause. By
227 coding the data we opened the data for an analytic proceeding, defined the concepts, their characteristics and
228 dimensions and we installed them into the context. In the continuation we linked them together and combined
229 them in concepts of a higher level and category. Through the method of constant comparison, we searched for
230 similarities and differences and for particularities of individual phenomena, developed generative questions and
231 formed ad hoc hypotheses. We examined simultaneously the hypothesis in the data, annotated analytic notes
232 (memos) that are used for supporting the process of data analyzing, and later we used them as a description
233 of theoretical cognitions. We followed the basic task of the grounding theory, i.e. the research of connections.
234 We turned towards searching common points of different problems and 'diagnoses' in the area of mental health,
235 we studied the factors that have an influence on the manifestation of psychic crises, the characteristics of an
236 individual's consideration and activity, and the larger socio-cultural context of psychic crises manifestation and
237 treatment.

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

242 We started a method of analysis of qualitative data, case studies exacting and of a long duration by the
243 analysis of the text and by defining terms for notions that seemed the most appropriate, and we also used notions
244 from the theory we chose for the interpreting of the material, i.e. the choice theory. For the coding we used the
245 procedure of direct naming. In this way we named a single description directly with a determined denomination or
246 code, without comparison with other descriptions or search for synonyms, contraries, associations. We continued
247 the open coding with the procedure of categorizing and classifying data. Then we united cognate notions by
248 categorizing them into units. We modeled the notions by abstracting the common characteristics of several
249 different descriptions. The analysis of the notions and categories characteristics followed, in accordance with the
250 choice theory, and the selection and definition of categories (we left the notions determined only operationally)
251 regarding the research problem. We performed the so-called axial coding. In this phase we eliminated also
252 the irrelevant notions -too distant and non-connected with other notions and with the research problem. We
253 compared the obtained and defined units among them, we searched for and constructed relations among them
254 and we organized them into supposed relations, we performed the socalled selective coding (Glaser and Strauss,
255 1967; ??trauss and Corbinova, 1990). There was a theoretical frame formed in the concluding phase, which
256 followed the formulation of forms and gave theoretical interpretations and explanations. Based on the coding
257 of the text we formed forms that we identified in the analysis as distinctive behavior, 'figures', 'structures' we
258 present them later in the article.

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

264 V.

265 9 Concluding Conceptualization

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

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

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

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

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

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

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

287 Form eight: without exception, in the 'background' of the client's problem there is a momentary unsatisfying

14 D) TAKING CARE OF RELATIONS AND/OR ESTABLISHING NEW ONES

288 and to him an important relationship. 13 Form nine: the clients try to appease their psychic needs in ways that
289 are unsatisfying for them or even frustrating and destructive, which they express with somatization and mental
290 suffering.

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

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

294 Form twelve: psychic crises are directly connected to painful experiences, traumatic events, like violence,
295 poverty, disease, personal loss, separation, etc. Form fifteen: the change in the perception and understanding of
296 our own actions and actions of others makes it possible for the client to appease his basic psychical needs more
297 effectively and to regain control over his own life.

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

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

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

304 a) The assuming and/or performing of controlling behavior

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

307 10 b) Causative-consecutive deliberation ration and action

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

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

314 11 d) Persisting in bad, unsatisfying relations

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

318 12 e) Orientation towards a physiological and emotive compo- 319 nent of holistic behavior

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

324 Strategy B: 'The assuming of control over one's own life.' a) The orientation towards the client's world
325 of qualities A person's internal, personal, unique world is represented by a group of people, things, events,
326 convictions, values, etc. and it is taking shape since birth, all our life, and it represents the best ways we want
327 to appease our needs. The recognition and taking into consideration a person's world of qualities are necessary
328 for the search of more effective ways of appeasing needs, which represents the creation of a life of quality and
329 the improvement of health. 15 b) The orientation towards choosing more effective behaviors and deliberations
330 When a client learns how to remove the external control from his life, he starts to change his actual unsatisfying
331 relations. The change in the perception and understanding of his own actions and the actions of others enables
332 him a more effective appeasing of the basic psychical needs and the reassuming of control over his own life. The
333 client's key cognition is that he can control and also change only his own actions not the actions of others.

334 13 c) Care for an (equilibrated) appeasing of psychical needs

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

338 14 d) Taking care of relations and/or establishing new ones

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

342 e) The meaning of the relation therapist-client.

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

349 15 VI.

350 16 Final Statements And Interpretation

351 The analysis of the material confirms the concept of sexually conditional and socio-culturally acceptable behaviors
352 of manifesting psychical crises.

353 Men and women adjust psychical distress to a specific socio-cultural environment and to sexually acceptable
354 behavioral patterns. 16 The mental health problems of women are closely linked to her social role, they are a
355 network of past educational patterns and consolidate external expectations. Mental pain is manifested by forms
356 that are attributed to women and are the consequence of socialization and later life experiences connected to
357 it. Women express personal dissatisfaction within the accorded sexual roles and a determined cultural context.
358 The form of mental pain manifestation are the result of the 'woman's' socialization. Women express personal
359 dissatisfaction with a silent, inconspicuous 'woman's' behavior ??Podgornik, 2012: 6).

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

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

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

374 Their social roles do not deviate essentially from the ones defined based on a biologic function. Women
375 realize the role of a family and home guardian and educator while men preserve the role of a family provider
376 and representative in the public sphere and in comparison to women they benefit of a superior position. The
377 convictions and actions of the clients reflect a traditional course of socialization, favoring of social roles regarding
378 the 17 biologic gender. Their sexual identity is the result of commonly adopted norms and values of the culture
379 that they belong to. They act appropriately in socially acceptable roles in view of the gender. The qualities in
380 the domain of womens' social gender are tenderness, sensibility, excessive sentimentality, passivity, willingness
381 to subordinate, while in the domain of the male social gender are rationality, aggressiveness, emotional stability
382 and activity. This represents itself as an additional burdening in the manifestation of psychical crises. If the
383 behavior does not suit the qualities connected to the gender, they experience a bigger stigmatization -the case of
384 a depressed man and an alcoholized woman.

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

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

398 The reason why we perceive a great part of reality (life situations) differently than others is situated in the
399 personal world, in the construct of the world of qualities, which is proper to each person, and in the construct
400 of individual differences. The showed therapeutic processes take into consideration the individual choices of
401 behavior, chosen by individuals with different biological endowments in different environments, that have the key
402 influence on a different development of a personality, besides the biologic differences and different environments

17 CONCLUSION

403 in which individuals live. By that, the individuals develop specific world of qualities that again influences the
404 diversity of individuals ??Lojk, 1999: 19).

405 The choice theory defines the construct of holistic behavior as a simultaneous activity of four components:
406 activity, thinking, feeling and physiology (ibid: 80). Although by choosing the holistic behavior all four
407 components still function, a person has a direct control over his activities and his thinking, while feeling and
408 physiology depend on the two of them (ibid: 81-82). That is why the holistic behavior (mentally and physically),
409 even if it is that unusual and pathological, of a disease (except when it is caused by a proved organic pathology)
410 in the organismic sense is always intentional ??Lojk and Lojk, 2011: 313).

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

425 The reality therapy, substantiated by the choice theory that we established as the contextual and interpretative
426 theory of the present article, belongs among the psychotherapeutic approaches with a constructivist and
427 systematic background.

428 We conclude the attempt to form theoretic concepts with the relationship therapist-client, which represents
429 the expedient and purpose in the reality therapy. The client (and the therapist) senses in the most genuine
430 relationships, how the subject-object relationship 19 changes into the subject-subject relationship. In the
431 therapist-client relationship we are not concerned with the question of 'transfer' and 'contra transfer' as a process
432 that in psychoanalysis enables the client to comprehend, and as a process that a psychoanalytic should be
433 conscious of in order to avoid eventual problems in the relationship between him and the client. The reality
434 therapy believes that a responsible personal connection between the therapist and the client is the best, the
435 fastest and frequently also the only way for the client to learn how to develop his relationships with the people
436 he needs ??Lojk, 1999: 9).

437 VII.

438 17 Conclusion

439 The paradigmatic move was performed in dealing with problems with mental health based on a dialogue between
440 anthropology, sociology and psychotherapy, which enables us to see a person and to consider them as a holistic
441 being, with all their physical, psychical, social and mental extensions and their position in a socio-cultural
442 environment.

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

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

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

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

463 In the democratization of individualization it is about searching for a person's chance to successfully form
464 and realize their life story by being conscious of the free choice, liberated from the restraints that determined

465 their life style in the past. A person is the one that creates the nucleus of every human action with their own
466 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.



Figure 1:

467

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