# Conceptualization of mental constructs in clients attending reality orientation therapy

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***Abstract***

Researches show that the number of mental problems, anxiety and depression and also the number of psychiatric hospitalizations is increasing. Suicide rate is increasing, and so are other destructive forms of manifestation of personal distress, especially alcohol abuse and violent behavior. Other dangerous behaviors are also present – use of illegal drugs, non-chemical forms of addiction, but it has been particularly noted the increase of excessive use of the computer by the young population, who carries without a doubt its part of the burden brought by the crisis.

Besides studying the factors, which influence an individual's mental health, the article highlights the forms of manifestation of distress and searches for answers to the immanent socio-humanistic question, how can an individual maintain or get mental health despite the situation in

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***Keywords:*** *modern society, mental health,reality therapy, choice theory, mental problems*

***Povzetek*****:**

Raziskave kažejo, da narašča število psihičnih težav, anksioznosti in depresije ter število psihiatričnih hospitalizacij. Samomorilnost je v porastu, prav tako tudi druge destruktivne oblike manifestiranja osebnih stisk, predvsem prekomerno uživanje alkohola in nasilna ravnanja. Prisotna so druga tvegana vedenja – uporaba prepovedanih drog, nekemične oblike zasvojenosti, zlasti se beleži porast prekomerne uporabe računalnika pri mlajši populaciji, ki brez dvoma nosi svoj delež bremena krize.

Poleg proučevanja dejavnikov, ki vplivajo na duševno zdravje posameznika, pričujoči prispevek osvetljuje načine manifestiranja stiske ter išče odgovore na imanentno družboslovno-humanistično vprašanje, kako lahko posameznik ohrani oz. si povrne duševno zdravje navkljub razmeram v družbi.

***Ključne besede:*** *sodobna družba, duševno zdravje, realitetna terapija, teorija izbire*

**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, VidichandManning 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, Sallisand

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 mental 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 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.

## 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.

## 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 mental 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 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 (Mesec, 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 mental crises, the characteristics of an individual's consideration and activity, and the larger socio-cultural context of mental 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 andCorbinova, 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.

## Concluding conceptualization

The discussed material was full of implicit theories (*'theories in use'*bySchon), 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.

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.'

1. *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.

2. *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.

3. *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.

4. *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.

5. *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.'

1. *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.

2. *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.

3. *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).

4. *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.

5. *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.

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

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 mental crises* is also connected to the socio-cultural environment. The intertwinement 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 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 womens' 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 mental 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, marrital 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 etal., 2006) establish that the social network and relationships work as factors of chances or protective factors for the formation and development of mental problems.

The English scientists Brown and Harris (1989) indicated as causes of mental problems disappointment in the family, conjugal fights, change of place or working place, illness or death of a family member financial problems or loss of a certain social role– these kinds of occurrences are present in 30% of precedent mental illnesses. In the process, it came into view that the type of event does not determine the later illness as much as the meaning given to it by the person affected, and its subjective modification. The research showed that women who have a strong, confident mutual relationship with their husband, relative or friend are less susceptible to depression as the women who did not received that type of support in their relationships.

The importance of relationships for mental health is emphasized by the research about Slovenians' mental health condition, which showed that the individuals with mental health problems have smaller networks of emotional support that those without problems. Reports of smaller emotional support networks also came from individuals who in the last month felt strongly limited because of their emotional problems in comparison to the individuals who did not have these kind of problems,

and also those who reported that they control their life worse than those who have a feeling of controlling their life. The data statistically also show that the individuals with smaller social networks report more often about feelings of sadness, bad mood, depression, as well as suicidal thoughts (Kamin et. al. 2009: 85).

Violence is a distinctly destructive controlling behavior immanent in Slovenia. The results of a research carried out within the research project Analysis of family violence in Slovenia, in the period between 2004 and 2006, show that the victims of domestic violence in Slovenia (and also elsewhere) are manely women, children and older family members. The occurrence of violence against women in a domestic environment is increasing in the last decade, and the violence against women and children ending in their deaths is also increasing. For a woman in Slovenia the most dangerous place is her home and the most dangerous person is her partner. At the same time, the fact that the level of awareness, especially of violence against women, is low and the level of social tolerance to domestic violence is high, is very alarming (Sedmak et.al. 2006: 6).

We interpret and establish the complete material, from the viewpoint of pathogenesis and salutogenesis, through the espoused theory — the choice theory, *on the construct of interpersonal relationships, the construct of basic needs and the motivational construct*. Regarding the

studied material, the choice of a creative destructive behavior is explicitly connected to a person's problems in his interpersonal relationships or unappeased needs (for love, appurtenance, attention, value…) in relationships that are important to him. The therapeutic process, whose objective is for the client to take over the control over his life, is orientated consequently to the amelioration of existing relationships or the formation of more satisfying relationships. We also did not expose the meaning of the relationship, we did not install it among other factors, which induce the evolution of mental crises, but we wanted to singly examine and show how unsatisfying interpersonal relationships or the lack of relationships can considerably influence the evolution of mental health problems.

The reorganized behavior – the manifestation of mental health problems and other forms of destructive physiology (autoimmune and other psychosomatic illnesses) are explained by the choice theory with the use and/or share of external control. Besides the choice theory, which differs from the neo-behavioral theories according to the theological explanation of human personality, the biologic perceptional control theory of William T. Powers (2005) with a systematic-cybernetic model also explains the behavior of live organisms with naturalteleology;. Based on cybernetic experiments of second order[2], by understanding the

[2]Second order cybernetics studies systems that study systems, while first order cybernetics studies is the attitude of a person towards the system, and it

human behavior, Powers defined the variables that a person can control. To supervise or control does not mean reacting to stimuli, as explained in the behaviorism theory, which between a stimulus and a reaction inserts also the processes in the organism and by that explains the diversity of the individuals' behaviors. The control theory and the choice theory explain the gap in the causative-consecutive reaction with the expedience of the behavior of human beings. So the stimulus does not define the behavior, it just passes the information (in the reality therapy – where and how to satisfy the basic needs), but it cannot determine the choice of behavior (by considering the holistic behavior neither the feelings nor the physiological processes) or any other type of constraint. The behavior in a person's autonomy is in accordance with the goal he wants to reach. For the organism, the activity outside itself it does not represent a stimulus, which can trigger its reaction, but an interferences, controlled by the organism. The explanation that people are responding beings is the basis of the *external control psychology*, as Glasser names a group of destructive behaviors, based on the false belief that it is possible to control another person's behavior. With the mass usage of traditional psychology, Glasser connects numerous unhappy relationships and of course persons, who cannot satisfy their basic needs in unsatisfying relationships. In opposition to the external control theory,

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does not originate from the phenomenological viewpoint of understanding the systematic theory of oneself.

the *internal control theory* or the theory of personal freedom (Glasser) urges that a man consciously chooses his most complex behavior connected to a personal system of values (images in the quality world). Consequently he can also choose connective behaviors that enable him to establish and maintain satisfying relationships within which he will be able to satisfy more successfully his psychical needs.

From the viewpoint of the internal control theory, the *'illness' theory* also explains an illness in the light of the reality therapy that a client's symptomatic behavior is not caused by pathologic organic changes, but it is about the client's unhappiness which manifests itself through the chosen symptomatology. He perceives unhappiness ad loneliness, the lack of relationships or life in unsatisfying relationships. The client's dissatisfaction originates from his comprehension that other people or external circumstances cause him suffering, which is why he perceives himself as a victim, without any power of influence to make better choices. He tries to regain control over his life with constraint and belief behaviors, by changing other persons' behavior even when they are not willing to do so. The client tries to change a person's behavior and adapt it to his desires and needs through behaviors like criticizing, accusing, complaining, whining, bribing, extorting, threatening, punishing, etc., the sort of behaviors that not only make a person change his behavior, but they also have a destructive effect on the relationship and they destroy it.

## Conclusion

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 viewwe 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 mental 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 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.

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