Social destructionism: Psychosis and the limits of dialogue

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Abstract: Some words have the power to define what is real. This article introduces a comprehensive view of mental illness as an inner conflict with those words. We suggest that individuals are sometimes unable to assimilate the narratives most human beings live by because the social realities they portray are abstract, incoherent and conflicting. We do this through a constructive criticism of Open Dialogue, an innovative, celebrated approach to mental health care that resembles family therapy. Open Dialogue is important due to its situated focus on human relationships. However, the approach adheres to the metaphysical narrative of social constructionism, which we argue is but another form of rationalism that competes with the rationalism of the biomedical model. Both approaches effectively disregard embodied experience, individual decision-making and the sciences of behaviour because they have a basis in societal norms. We illustrate our case through the psychosis stories gathered in a unique, minimally edited book, which we contrast with case examples of Open Dialogue. Our analysis shows that epistemic and therapeutic value should not be seen as opposites. Questioning our most fundamental assumptions reveals that the person in crisis has a lot to say about life's biggest questions, and opens the door to a genuinely open dialogue.

Keywords: morality, psychiatry, Open Dialogue, decision-making, family, rationalism, social realities

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My problem is that I am not able to live in this Commonly Agreed world of destructive madness

—Lotta, hospitalized for psychosis (Korvenniemi, 2013)

1. Introduction

The world of psychiatry continues to be divided, roughly speaking, between two attitudes: discriminating against some people for their illness and accepting them for their health. This dichotomy resembles the old debate between nature and nurture, mind and body, or reason and emotion. Academically, it resembles the divide between the natural and social sciences, or between what could be termed atomistic and holistic views in other fields and subfields (e.g. cognitive vs. psychoanalytic psychology, classical vs. relational narratives in psychoanalysis, analytical vs. continental philosophy). Politics and the family also become a battlefield for individualistic versus egalitarian attitudes. These clashes essentially occur because individuals or groups have opposing values, which are related to their different criteria for knowledge and reality (Maanmieli, 2018). Yet this social (or anti-social) phenomenon is intrinsic to the linguistic fabric of societies (Maanmieli, 2019). We find identity in narratives that put us at odds with others or limit our mutual understanding because they outline different worldviews (Maanmieli, K. & Maanmieli, 2019). In this age-old situation, there emerges a third group of people whose quasi-narratives are not understood or followed by anyone, and who are today generally hospitalized.

Many have pointed at the traditional clinical setting as a factor that reinforces psychoses, thereby causing powerlessness, objectification, mortification and stigma (e.g. Cullberg, 2014; Rosenhan, 1973). The narrative that one knows or is able to know what is *wrong* with these people becomes more powerful than the curiosity to find out what they are trying to say. This theoretical position may be called rationalism: the view that meaning is natural, accessible by the individual, and therefore that something does not work properly with the minds of some. Other approaches reject this position, as do the present authors, and move away from the biomedical model. In particular, the model known as Open Dialogue (OD) is now regarded as one of the most effective clinical practices. OD has fundamentally changed the way in which the afflicted person is received. It consists of meetings arranged at the onset of crisis, in which relatives, workers and others close to the client are given an "equal voice" (Haarakangas, 2008; Seikkula, Aaltonen, & Alakare, 2001).

Open Dialogue is a promising avenue due to its attention to our most important

relationships and the improvements it makes on the work of narrative and family therapists. However, these efforts rely on the alternative position of social constructionism: the view that meaning is in nurture, the product of interactions within what is commonly known as society, and therefore that there is nothing right or wrong in the previous rationalistic sense. In this case, the content of expression is dismissed when it does not fit into a process of "meaning making", and the psychotic individual is seen as alienated from a certain communicative practice. This is an equally problematic narrative or metanarrative. Its emphasis on dialogue is said to be embodied but ignores the immediate ecological context in which informed decisions are actually made by individuals. Indeed, the results of OD are generally limited, and there is little reason to expect this to change in the current theoretical paradigm.[1]

As an embodied perspective suggests, psychosis is probably best understood by those who have experienced it themselves. By encouraging people to tell us about their psychoses, instead of dismissing them as unintelligible, both clients and researchers can benefit. Apart from OD and its precursor, the Need-Adapted Approach, there has been an increased appreciation of the perspective of clinical service users here in Finland. The greater efforts to collect their stories, the training of "experts from experience", and their use for the development of health services as well as for research are good examples (Koulutetut kokemusasiantuntijat ry.2018; Beresford & Salo, 2008). Our present analysis uses the special, written accounts of people who have been able to reflect freely on their past crises and periods in hospital. Writing provides a means for safe expression that sheds light on the fundamental problem we have described in this introduction. Our material includes the five psychosis stories in the book *Toisen maailman kartalla* [On another world map] (Korvenniemi, 2013). These stories tell the memories and insights of five people under the pseudonyms of Lotta, Ville, Pirkko, Helena and Antero, all of whom were diagnosed with

[1] For example, OD seems to reduce the incidence of psychosis and the need for medication over time, but not to reduce suicide rates (Bergström et al., 2018; Seikkula, Alakare, & Aaltonen, 2001; Seikkula, 2002; Seikkula & Alakare, 2004). Its results have recently been criticized for their bias and lack of empirical rigor (Freeman, Tribe, Stott, & Pilling, 2018). In view of its popularity, the lack of implementation of OD in other regions (Finland included) also seems paradoxical. Our personal communications with OD team members, however, suggest that there is a political or moral dimension to their approach that clashes with the predominant one. For instance, in a popular documentary on Open Dialogue, Markku Sutela comments, "[Open Dialogue is not about] the treatment system per se ... [It is] a political thing" (Mackler, 2014).

psychosis and eventually recovered. In our translations, we have tried to retain all the idiosyncratic use of capital letters and any unclear or awkward phrasing. This unique, minimally edited work was put together by asking the writers about their experience and the reasons that led to it. We have obtained this information personally from the editor, as well as permission to analyze these texts on behalf of the writers.

2. Meaning-making vs. decision-making

It is widely acknowledged that our bodily emotions or feelings play a key role in decision-making as well as in social cognition (Lerner, Li, Valdesolo, & Kassam, 2015). These individual abilities, however, become compromised when one is expected to live by stories that set standards for reality. It is our general contention that such stories are essentially moral (Maanmieli, 2018; Maanmieli, K. & Maanmieli, 2019). Nobody can choose what is absolutely impossible, just as it is often "impossible" to choose what is morally objectionable (Phillips & Cushman, 2017). When psychosis strikes, the self can be seen to lie disembodied and lacking in those abilities, floating in the interpersonal void between the family system and the health care system. A decision has to be made as to where the person will end up. These decisions involve narratives such as that patients should respect doctors, or that parents should care for their children. OD bridges the gap by immediately arranging a meeting. This is a decision in itself, made by a coordinated group of people on the basis of another narrative. During the meetings, however, the focus on "embodied dialogue" conceals the context of action, in which decisions still have to be made by team members and clients alike:

> Team members respond as fully embodied persons, with a genuine interest in what each person in the room has to say, *avoiding any suggestion that someone may have said something* wrong … First, the mother announced that she did not want a family meeting, because she was afraid that speaking about old and sensitive memories would make Matt become psychotic. Indeed, while speaking about some emotionally loaded issue, Matt all of a sudden did start to speak about his specific stories, which could be seen as psychotic. When this happened, *I asked him if I had said something wrong* for him to speak about those issues. And then I asked if it was possible to go on with the subject we had opened with. Mostly Matt

> answered that we did not say anything wrong and allowed us to go further. Step by step, Matt's psychotic speak episodes decreased and on the whole stopped. (Seikkula, 2011, our emphasis)

The previous example illustrates the unacknowledged importance of morality and decision-making in OD. Seikkula breaks his own rule by suggesting that someone (himself) has said something wrong. This implies that anything that causes such "meaningless" response in Matt must be objectionable, which neutralizes Matt's communicative intention. Indeed, Seikkula's intention is to continue with the dialogue he and the others consider meaningful, while the decision to continue is delegated to Matt. But who is really making this decision? Seikkula's apologetic request for permission does not alter the message that Matt's reaction has aborted the dialogical process and that there might be something wrong with it. Crucially, such a message is in agreement with the mother's warnings about Matt's "psychosis", for which he had spent 25 years in hospital up to that point (Seikkula, 2011).

Other examples in the OD literature express a greater interest in the client. For example, there is the idea of creating new language for the "not yet spoken" (Seikkula, 2002). This idea can be contrasted with the translation (into the same language) of what has actually been spoken. Indeed, the aim seems to be to reinterpret, to *create* an acceptable voice for the client. This involves shifting the dialogue to the socially competent team, for example, about what they did to trigger the psychotic response (Seikkula et al., 2001; Seikkula, 2011). The dialogue becomes a discussion about the client in front of the client. The team will also openly deliberate and decide on medication and hospitalization, though this is confused in the literature by using the passive voice. The fact that such deliberation includes everyone present and considers their opinion does not change the locus of authority.

Hence, the context of action reveals two attitudes: that of making decisions directly (e.g. by the doctor who diagnoses), or indirectly by invoking others and even the client. They are attitudes of actively or passively, selfishly or selflessly, dealing with something that is wrong with people. This seems to entail a distancing from embodied reality, unlike Seikkula claims:

> In the type of family therapy that focuses on generating dialogues this means shifting the focus from the *content* of narratives to the unfolding feelings in the present moment when narratives are told. (Seikkula, 2011, emphasis in original)

Matt's case shows how those unfolding feelings are actually disregarded, because their *content* brings wrongness to the dialogue. (Seikkula refers to this content as "his specific stories" and "those issues" above.) That is, in spite of a disposition to listen, OD is gripped by an underlying narrative of local values that can make certain feelings valid and others invalid. Correspondingly, Matt's previous hospitalization can be seen as a result of the active appeal to the narrative that he is psychotic, which involves directly deciding for him.

Interestingly, this dichotomy reproduces itself within the subfield. There are "leading" versus "following" approaches to these meetings, or "narrative and solution-focused" versus "conversational" styles, as Seikkula (2011) states quoting Lowe (2005). There are also monological dialogues that "reject" the utterances of others versus dialogical dialogues that accept them (Seikkula, 2002). However, these appear to be merely active and passive ways of leading a process of acceptable meaning-making. Indeed, narratives are not only stories that build an identity and sense of belonging. Narratives are stories that convey understanding (Velleman, 2003). They are important for human societies because understanding leads to making the kind of decisions that are the point of morality (Maanmieli, 2018).

3. Therapeutic and epistemic importance of psychosis stories

From a social constructionist perspective, the client with psychosis experiences a "terrifying alienation from shared, communicative practices" (Seikkula & Olson, 2003). However, the view that shared, communicative practices are a basis for reality is not necessarily the client's. Psychosis becomes a source of ontological anxiety for the dialogical therapist by definition, which is likely projected onto the client. The client cannot help but sense defensiveness around him or her. The resulting frustration, anger and sadness turn against the self. This affects mental health even if psychotic episodes recede, which are perhaps fueled by a fear of engulfment (Laing, 1960). It is difficult for everyone present to avoid these pressures in a context such as OD precisely because of their embodied dimension. Hence, writing or other means of indirect communication are helpful, because they deal directly with the symbolic nature of the problem.

The therapeutic effects of writing have been well documented (Daiute & Buteau, 2002; Graybeal, Sexton, & Pennebaker, 2002; Lepore & Smyth, 2002). On the other hand, writing as a form of therapy is a relatively new idea. Poetry therapy, in particular, takes the pressure away from

the need to create a traditional or coherent narrative (Mazza, 2016). Writing can also be communal, without requiring that participants be "fully embodied" (cf. Seikkula, 2011). One of the present authors (née Kähmi) has researched poetry therapy's effectiveness in supporting people diagnosed with psychosis (Kähmi, 2013; Kähmi, 2015a; Kähmi, 2015b). Writing about psychosis this way can bring relief *and* order to a chaotic memory of unclear fragments. Often the results are mature and insightful, as can be seen in our main source (Korvenniemi, 2013).

The writing may proceed with ease because the story can be left patchy and incoherent. In this sense, psychosis works as a protective fog against painful facts. One of the male storytellers, Antero, expresses his awareness of this after bouts of depression and drug abuse precipitated the crisis:

> I dozed and I feared. I remember that especially: my incommensurable fear. I don't think I feared so much death or what might happen to me, straitjackets, treatments or stigma. I feared remembering! (p. 167)

Antero's piece is dialogical. He recreates his discussions with the nurses at the hospital, deliberates and allows for uncertainty:

> I notice that I am patching up my story with a bunch of question marks. There are no comprehensive answers, so luckily there are questions. If they ran out, I wouldn't be writing this. (p. 161)

Moral or religious themes often surface at the onset of crisis. Pirkko was studying in an English university, far from her family of origin, when she was hospitalized for psychosis. A daily encounter with the hospital's cook brought a deep realization:

> Suddenly, I realize: "Though I walk through a dark valley of death, I will fear no harm…" The Bible! And dad and mum… I flood with tears. Rose takes me into her round-safe hug. *A fragile spider web starts to grow under my feet*. (p. 70, our emphasis)

These are feelings of existential despair, of being held by nothing but by a spider web. Pirkko's recovery begins when she allows earlier feelings to surface and begins to process them. The experience of psychosis is no doubt linked to an anxiety about the family, which the hospitalized

person sees as yet another repressive institution. Again, this anxiety is typically interpreted either as pathological or as a need for acceptance. However, psychosis can also be seen in the light of family pressures that are very common. Consider, for example, the increasing number of people who live alone or fear having children (DiDomizio, 2015; Jamieson & Simpson, 2013; O'Sullivan, 2015), or Germany's struggles to regulate both motherhood and the freedom of parents to change gender (Butcher, 2018), or how different kinship and arranged-marriage systems have formed the basis of human societies from time immemorial (Allen, Callan, Dunbar, & James, 2011; Walker, Hill, Flinn, & Ellsworth, 2011). Psychosis uncovers a lack of human connection and trust that most of us overlook because it is inherent in language (Maanmieli, 2019).

4. The failed father

The story of the male who is either psychotic or depressed and suicidal is all too common in Finland. OD case examples sometimes describe how these afflictions replace the previous psychotic symptoms. Seikkula's (2011) second example features Jaakko, a husband and father with marital problems who had lost his own father four years earlier. In the meeting, Seikkula attempts to bring up the memory of Jaakko's dead father, though this is again said passively: "*Father's* voice was invited to the dialogue in the first session" (Seikkula, 2011, our emphasis). The lack of grammatical reference to whose father was invited is important. It is difficult to elicit a personal memory when what is invoked is a role or a moral identity, not a real person, not a situated individual in all his complexity. Indeed, the exchange with Jaakko shows his reticent agreement with the positive bias of the therapist. This creates a narrative of compassion against Jaakko's reporting that *his own* father was absent or difficult to handle (see Maanmieli, 2019).

On the other hand, the stories of Ville and Antero (Korvenniemi, 2013) emerge from an absence of such tensions between society and individual. They provide information. They are not stories of compassion, but of martyrdom and dishonor, of failure to defend a selfish cause:

> I relate the actual beginning of my father's alcoholism to the moment his mother died and dad sat at the kitchen table drinking his sorrows away. Dad's alcoholism brought my family psychological violence. When he drank he would pick fights with my teenage sister. He would call my mother a whore. (p. 33)

When Ville was twelve, his parents divorced. This ended a period of great distress and was a relief for him, who could feel close to his mother again. During his teenage years, he began to feel depressed. Ville experienced his eventual fall into psychosis as driven by pressures surrounding his job and military service, something he believed he had failed. He saw military service as a kind of masculinity test that he could not pass. His psychoses involved religious delusions, such as becoming an angel who could walk into traffic.

Antero also describes himself as unable to step into a husband's shoes following Father's disappearance. He believes in the Christian God (the Father). His delusions include chasing a princess in Versailles and an obsession with death. Antero seeks individuality and escape in drinking, but still sees himself as heir to a fatherly responsibility and curse. In a maelstrom of inadequacy and shame, all the men seem to be erased and die around the mother figure:

> I caused a *ridiculous amount* of pain and fear to both my wife and other family members, most of all my father and my mother, who had lost my father and her brother to suicide and alcohol. (p. 160) ... My father *fell from a train* and died when I was twenty-three. He was twice my age himself; as old as I am now. My male relatives have committed *an inconceivable amount of suicides*, drank themselves to death, directly or indirectly. (p. 171, our emphasis)

The form of expression is important here, particularly exaggerations such as "an inconceivable amount of suicides" and its contrast with the case of his father, who supposedly fell from a train. An editor who did not question the common narrative of loss would see the text as unfit. Perhaps this is why we were unable to find similar books in the literature. But psychosis stories begin to make sense when one sees the person as writing about societal roles that are unintelligent and oppressive, not about real people and their ethical sense. The afflicted person becomes a troubled mimic, a kind of serious satirist who is detached from the common narrative, unable to assimilate it, protesting its predictability, and yet unable to confidently deviate from it due to the fear of saying something wrong. The meaninglessness of psychotic expression in general might be the intense embodiment of such a paradoxical feeling.

5. The failed mother

Seikkula et al. (2001) features the case of Siiri, a girl who spoke of powerful, external threats of collective violence. Siiri's rejection of her father eventually uncovers a marital conflict, the latter's alcoholism, depression and suicidality. Both mother and father are invited to the meetings through the years. Decisions become difficult to make in the group regarding whether to leave the child with one or the other. Siiri's condition seems to improve but this brings episodes of aggression toward a male doctor, her father and family. Her parents end up buying a bigger residence in order to move in together and accommodate Siiri, as she finds a boyfriend whom she plans to marry. The case of Simone (Seikkula et al., 2006), who sees Jesus and the saints walking around, also concerns a conflict between father and daughter that surfaces at the meetings. The situation is eventually "resolved" when the girl goes travelling abroad, falls in love, and has a baby. Simone returns to her homeland and limits her visits home in order to minimize contact with her father.

In contrast, Helena writes about two psychotic episodes after giving birth, as well as their background (Korvenniemi, 2013). Her husband had always wanted children, whereas she was of the opinion that independence came first and that the mother role is overemphasized. (This helps illustrate that the two conflicting attitudes are independent of biological gender.) Her story can therefore be seen as an eventual surrender to her corresponding role. Like Antero and Ville, Helena's psychoses came with feelings of inadequacy in the eyes of her family. She was hospitalized and had paranoid delusions in which her husband was part of a collective scheme that spied on her and threatened to take the infant into custody.

Helena relates how on a one-day leave from the hospital, they travel to her parents' village on the other side of Finland for the baby's name-giving party, despite her poor mental state at the time. There she bonds with her equally afflicted mother:

> We left to my parents place in the north … All the time I was sure that the whole village (!) was against us and we would soon be arrested. I even feared my family members, who spoke rudely and grossly. *The only one who felt safe was my demented mother. I immediately thought that she understood everything I said and that she was totally sane, only unable to speak.* I identified with her very much because I still had difficulties to get my words out. … In a way, I saw something safe and familiar in my relatives, my acquaintances, and especially in my old

> home, as if the world had not actually gone upside down. … On the journey back I thought my husband would leave me in the freezing cold with the baby and the car but no keys … and that *he would get a ride with my sister*, who was soon driving past. I didn't even think that the baby had to be fed and the nappies changed. (our emphasis, p. 116)

Helena's paradoxical account points at society as an oppressive conspiracy enforcing the motherly value of care, yet filled with hypocrisy and betrayal. She is not supposed to relate this explicitly, which might also apply to her silent mother, or to everyone else for that matter. This might explain why she still perceives all these people as safe. In the end, she longs for a happy family and blames herself for her inability to defend a selfless cause:

> Since I was small, I had been independent and willful, and rarely stopped to listen to my considerate and selfless mother's advice (p. 100) … I was happy and proud of our relationship, of our joint parenthood and family, which didn´t even exist yet two years ago. (p. 121, our emphasis)

6. The failed child

The only person in the book who does not write about feelings of self-blame is Lotta, who describes herself as a shaman (Korvenniemi, 2013). Lotta scrupulously denounces society's hypocrisies with overconfidence. As she hides in her own mythical world, she displays an extreme sensitivity to what is illogical and abusive of the weakest:

> Nothing could stop me if someone offended my sense of justice. When the flipper machine punished me for a TILT, though I HAD TO tilt because the ball was stuck, I went through the whole chain of command of the hotel in order to get my money back. I didn't get it, and *I realized that I was wrong only because I was a child*, nor would I be able to do anything no matter how morally right I was. Still I had to pretend that good and bad are something moral and not just something easy and rewarding. This kind of pretending caused me more anxiety than the thing itself. I have still not recovered from this at 43, and it is still just as depressingly true. (pp.

21–22, our emphasis)

We believe that this overconfidence indicates an awareness of the previous conflict of narratives. It is the voice of a child who is misunderstood and frustrated by common parental attitudes, which she criticizes but still depends upon. Lotta's writing enhances the caricaturing that surfaced in the stories of Antero and Helena. She is aware of her different selves, of the characters who reproduce such conflict on the abstract, societal level. One is "Uncle Taxpayer" (the selfish father, the drugs-prescribing doctor):

> When the activists arrange a demonstration in Finland, Uncle Taxpayer retorts that couldn't those spoiled brats go somewhere where you will really be afraid of the police. When a Finnish activist is shot in Mexico, where he has gone to help the Indians, Uncle Taxpayer sneers at the idiot who goes there to get killed—fucking hippy. (p. 24)

Then there is "Aunt Dreary" (the selfless mother, the dialogical therapist):

> Aunt Dreary has both a bitter and a self-complacent expression. For Aunt Dreary, you have to do things because you should do things. If you don't want to do something that you don't feel like, you still have to do it because Others Have To. (p. 19)

And "Black Warrior" (the unruly child, the antagonistic client):

> Black Warrior protects me from the Mucous Being … Black Warrior is a mercenary, a pirate, *an amoral adventurer*. Devil may care. Happy go lucky … I'd rather reign in Hell than serve in Heaven. (p. 25, our emphasis)

This unruly character rejects the other two dominant, parental ones. It is the last defense against her true, embodied self, who lies deep down, disowned and despised as a slimy, failed child:

> The Mucous Being is the side of me that I hate and makes me all slimy and incomprehensible. The Mucous Being is intelligent and sensitive. It is a euphemism for the fact that the Mucous Being is not good enough to do the right things with the right people in real life. The Mucous Being is just as valuable as

> other people, only different. That's what they say. The Mucous Being grieves and cries, stays out, thinks in too complicated ways, sees things that do not exist for other people. … The Mucous Being is a statistical anomaly that should not exist. The Mucous Being aches and cannot stand madness and badness. The Mucous Being doesn't know how to pretend that everything is fine when it isn't. The Mucous Being doesn't know how to be brutal or lying, although brutality and lying are vitally important features of survivors and winners. (p. 25)

7. Social destructionism

According to the Finnish Encyclopedia of Health (Huttunen, 2017), people with a susceptibility to schizophrenia present a different response pattern of the central nervous system, which causes their special sensitivity to traumatic events, stressful situations and contradictory speech. On the other hand, irrationality or incoherence are typically listed as psychotic symptoms. These stresses are not unfamiliar to any of us, especially when one is faced with issues of morality or existence. Some evolutionary theorists indeed see madness as a result of the cognitive stresses that characterize our complex sociality (Brüne, 2004; Burns, 2007). Here we would like to address the logic of statements about the nature of knowledge or reality.

Consider the statement "meanings are relative". This statement cannot be absolutely true, due to its own meaning: if the meaning of "meanings are relative" is relative, then some meanings are absolute. Certainly, the statement itself conveys an absolute truth, as does the opposite statement "meanings are absolute". These kinds of statements encapsulate the false dichotomy we have tried to illustrate in the previous sections, and which we may now rephrase as the view that meanings are absolute versus relative. Because these are both absolute claims, they are merely two sides of the same linguistic phenomenon, which we would simply call rationalism: The *active* rationalist affirms the absoluteness of meaning, whereas the *passive* rationalist (the social constructionist) retreats to the relativity of meaning. This dichotomy has clear consequences for behavior. For example, the assertions "you are a whore!" (moral) or "this child is psychotic" (epistemic) typically accompany the selfish making of decisions (e.g. a man punishes his wife; the child is hospitalized) and are an appeal to absoluteness in meaning. Correspondingly, the denial of those assertions accompanies the selfless making of decisions (e.g. the wife accepts her jealous

husband; a family therapy process begins around the child) and is an (absolute) appeal to relativity in meaning.

From the doubt of Descartes to the suicidality of Wittgenstein, rationalism has severe existential consequences. Social constructionists in particular maintain that reality, in full or in part, is the product of interactions among people, that referents are created and developed through an ongoing dialogue between minds. Let us consider how this contention applies to itself as a supposedly meaningful message conveyed to the reader through writing, in this case. This is immediately enlightening about what might be happening with psychotic individuals who cannot participate in such dialogue. Namely, if reality is socially constructed, then this includes the reality in which someone states that reality is socially constructed. The opposing contention that reality is *not* socially constructed would be equally valid as long as it is the product of dialogue. Researchers, therapists or psychiatrists are left with no means to arrive at a reasonably objective, working definition of mind, individual or psychosis, let alone the authority to diagnose somebody as delusional or their discourse as meaningless. Yet those who adhere to such a view inevitably use these words with a sense of objectivity.

There is an element of objectivity or grounding in ordinary reality that is, of course, unavoidable. When using the term "mind" or "consciousnesses", one willingly or unwillingly appeals to a fundamental separation between biological individuals. In Jaakko Seikkula's words: "Seeing our consciousnesses as intersubjective abandons the frame of seeing individuals as subjects of their lives, in the sense that the coordinating centre of our actions exists within the individual." However, this proposal is inconsistent with such physical separation. It betrays our instinctive knowledge that each individual has control over their own actions, that is, our appeal to such control in ordinary interactions. It betrays the proposal's own appeal to the reader's ability to decide whether to agree and act accordingly, for example, by setting up their own dialogical treatments.

Seikkula's statement appears to be no proposal for an embodied interaction, but one that is eminently abstract and metaphysical. It leaves us with no means to tell where the coordinating center of our actions is. Perhaps the statement could be rephrased for consistency: "Seeing consciousness as subjective mistakenly abandons the frame of seeing the group/society as a subject of its own life, in the sense that the coordinating center of our actions exists within the group/society." These alternative statements echo the old Christian paradox whereby one can be

condemned to eternal damnation by God unless one has control of one's will, but one is anyway predestined by God, whose omniscience would otherwise be imperfect. Indeed, the difference is only one of locating will versus consciousness in the individual, while replacing the group/society with God. Is there an individual consciousness and will, or is this a threat to an omniscient, deterministic God? (Maanmieli, 2019) Perhaps not surprisingly, this relationship between ontology and morality forms part of the insights of one of the writers in Korvenniemi (2013): "If I now here prohibit your idea of psychosis, will you then call me psychotic?" (p. 170) Antero's aphorism expresses the power struggle between his social constructionist prohibition on absolute meanings and the rationalist affirmation of them (i.e. that he is psychotic), which is its antagonistic source. It expresses the moral character of such a linguistic conflict, where prohibitions on ideas amount to prohibitions on behavior. As the Gospel of John reads: "In the beginning was the Word, and the Word was with God, and the Word was God". Essentially, these are insurmountable puzzles for the individual, and a destructive basis for sociality.

8. Conclusion

In this article, we have tried to elucidate the link between the abstract and the personal that is characteristic of mental illness. There are fundamental limitations in the understanding and treatment of mental illness that have much common with the object of study, namely, their moral dimension. Morality conditions our theoretical views by making them metaphysical or rationalistic. We tend to theorize in the same way as we think about how the world should be, in competition with others. This cognitive tendency creates the false dichotomies of "rationalism" versus "social constructionism" or "intuitionism", or "individual" versus "society", or "reason" versus "emotion". These dichotomies can be seen clearly when adopting a perspective that is consistent with biology, the behavioral sciences, and the everyday reality in which we interact and make decisions (Maanmieli, 2019). Morality manifests itself in the active form of demanding individual decisions, and in the passive form of precluding individual decisions. This power struggle characterizes our linguistic, abstract sociality, from the family to our greater institutions (Maanmieli, 2018; Maanmieli, K. & Maanmieli, 2019).

In the spirit of Open Dialogue, one can see not only the crisis group but an entire society as a dialogical entity that involves families. The institutional practices that make these meetings

possible, its "micropolitics" (Seikkula & Olson, 2003), are enacted by decision-making individuals who are themselves sensitive to the issues raised by the person in crisis. The greater political context could not exist without functioning families that produce functioning citizens who engage in metaphysical conflicts that are viewed as normal. OD aims to preserve this ostensible social order by attempting to reduce the number of people who, essentially, experience an understandable alienation. A good outcome means that the client is able to work, possibly meet someone and have their own family. However, what can be the consequences of not looking beyond society?

Some of the biggest sociological changes happening today affect the family. Researchers do not know what is producing these sociological changes, whereas they do know that families quarrel. We believe that the nature of this conflict can be elucidated by taking the accounts of the person in crisis more seriously. In turn, this will elucidate the nature of mental illness and its relation to society, which has the potential to overcome the old impasse of psychiatry. We call for a self-aware approach that abandons our moralistic, conflicting need to achieve certainty in meaning and behavior within closed, abstract contexts such as family or country. Such an approach would have a grounded, personal element that can already be seen in the efforts of Open Dialogue, but which must extend beyond the clinical context and into our personal lives, much in the way the Internet does today. It would also have the element of safety that is characteristic of writing and other artistic therapies. All this can be summarized by quoting Antero again:

> Psychosis is deep shit. But you can get inside me, or at least deeper into me, simply through this surface. Look into my eyes, shake hands and talk. Treat me humanely, like humans do. You *construct* this idea of me—you have a right to that—and then you do it. (p. 172, our emphasis)

It seems likely that the mentally ill feel the destruction that comes with our social constructions more clearly and deeply than do the rest of us. They take it more seriously. They cannot live with it or express it clearly. The psychotic then becomes a sort of inadequate child, whose body and cryptic expressions expose a universal social absurdity. This poses a huge challenge for everyone. Yet these stresses are a gateway for communication about the things that really matter to us all.

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