**Empowering Families and Networks Struggling with Substance Use and Addictions through an Open Dialogue Approach**

**Abstract**

The purpose of this chapter is to introduce an open dialogue (OD) approach as a postmodern practice in the field of substance use and addiction. First, OD’s origins and development in the area of first-episode psychosis are outlined. Second, family intervention programmes, harm reduction psychotherapy, and motivational interviewing are described as existing approaches in the field of substance use and addiction that share some similarities with OD. Third, a socio-material network perspective for working creatively with clients is offered to enrich OD practice. Tangible examples are offered in how an OD approach can be used to work with clients and their network to invite the voices of every member in the network, move beyond the individual to consider the material aspects of the substance/behavior, entire network, everyday practices, and interactional patterns. Finally, a real case vignette from an innovative counseling program is utilized to illustrate how an OD approach has been used in practice to help couples and families manage substance use and addiction struggles.

**Open dialogue: Empowering the network**

OD is inherently postmodern (Anderson, 2012; Gergen, 2001). In rejection of a single “truth” or preferred objective reality, OD privileges multiplicity of voices, known as polyphony, where each voice is respected, and the team strives to hear all voices (Seikkula & Trimble, 2005). Instead of a focus on dysfunction, assessment, or diagnosis, the OD approach begins with a “not-knowing” stance (Anderson, 2012), where the intention is to create knowledge together in the dialogic space. Those engaged in OD strive to understand and honor the stories (as “truth”) of all members of the network, in a responsive, dialogic manner. Together, network members are negotiating knowledge and finding their way forward in the present moment: “new words ⁄ new language develops especially in the answers that [participants] give to each other in response to the questions, concerns, and worries that are expressed in the session” (Seikkula et al., 2012, p. 668).

The OD facilitators engage in reflective talks in the session, sharing their thoughts, ideas, and reflections openly with each other, while family and network are listening and commenting afterwards. The OD facilitators privilege local knowledge and the daily life practices and understandings of the OD participants. In the OD approach, the practitioners strive to include anyone and everyone in the network (and we propose all practices and materials) as every individual is in relationship with and to one another.

According to Shotter (2003), instead of seeking "representational-referential understandings" to "get the picture", the practitioners support the whole network to bring "relationally-responsive understandings" that "call us to respond in different ways" (p. 13). For example, the facilitators are curious what are the feelings of the network members at the present moment and also share their feelings - what touched or moved them. In this way, the OD conversations are inherently transformative, for all involved, including the facilitators. It is understood that “the act of observing and engaging with others during therapy, the helpers are inevitably changed by the process” (Taylor et al., 2022, p. 1).

**Origins and development of open dialogue**

OD is an approach to mental health care that emerged from various philosophies, practices, and methods including reflective processes, need-adapted treatment, and Bakhtinian notion of dialogue (Seikkula et al., 2006). The OD approach was developed in 1980’s by a multidisciplinary team in the Keropudas psychiatric hospital in Finland that started experimenting with a new style of working with individuals experiencing first-episode psychosis. One of the very innovative elements of the treatment were network meetings that include family and close others in the individual’s social network who are present from the very beginning of the treatment, as well as members of the staff (at least two). A second aspect is that the team is mobile, and the meetings can take place in patients’ own homes. Perhaps most importantly, the main focus is on creating a dialogical space, which typically involves slowing down the process, creating a feeling of trust and safety, making all the voices heard including the “problematic” voices that are often an important part of the psychotic episode. All of these elements are rather unique in managing crisis situations connected with psychotic episodes and goes in line with the postmodern view in psychotherapy that sees the symptoms as relational and dialogic in nature (Hoffman, 2007).

Since the 1990’s, three pivotal research studies were conducted with follow-ups that showed very promising results regarding the treatment outcomes of patients who were in this type of care (Bergström et al., 2018; Lehtinen et al., 2000; Seikkula et al., 2006). Seikkula et al. (2006) reported, out of 72 patients only 17% were using antipsychotic medication after 5 years, the average of hospital days per patient was 31, and 81% of all patients returned to a normal job or school. Based on these results, OD attracted world-wide attention, especially in psychiatric services for first-episode psychosis.

There have been attempts to bring the OD approach beyond the treatment of psychosis to other domains such as childcare (Clement & McKenny, 2019) and migrant families (Sundvall & Wallsten, 2021), however, this development is just beginning. The same is true for substance use, addiction, and recovery - the main focus of this chapter. One of the authors of this chapter is a part of a team expanding the OD approach, by organizing OD network meetings for families who struggle with addiction issues (Author1, 2021). We share this experience as a case vignette later in this chapter.

**Similar approaches to OD in the field substance use, addiction, and recovery**

Involving significant others (Ariss & Fairbairn, 2020) or social network members (Copello et al., 2006) in an addiction treatment and recovery is not new. However, most of the time it is viewed as a supplement to individually oriented care (Author 1, & Author2 XXX). We also make a clear distinction between OD network meetings and network or family-oriented intervention models that are focused on engaging or sustaining the “identified patient” or “substance user” within the treatment system by mobilizing the family network (Landau et al., 2000; Szapocznik et al., 1988). In the OD approach, there is no specific intention such as getting the substance user into treatment, complying with treatment, or staying abstinent in recovery.  Furthermore, while family-, significant other-, or network-focused *interventions* tend to be manualized, OD network meetings avoid pre-planned, manualized, formal interventions, in favor of present-oriented, collaborative, co-constructed open dialogical interchange.

In the OD network meeting, the only emphasis is on dialogue in the present moment. No single perspective (i.e., “treatment is necessary for them”) is regarded as more true or more useful than others. Eliciting and listening to the different perspectives is the main job of the network meeting facilitators. The facilitators also support the dialogue between the different perspectives by various means such as by reflective talks with each other while the family listens and is invited to reflect and comment afterwards. In other words, “drug and addiction issues” can be relevant and important at the beginning and can bring a lot of worries and concerns, but later on, other issues can take the lead - relationship issues, family secrets and traumas, feelings that were not spoken about, etc. The focus of the conversation moves as meanings are being transformed in the dialogue. The OD facilitator does not bring any particular perspective that should be considered “more true” than the others.

In terms of philosophical and ethical underpinnings, it seems that the OD approach has more commonalities with the harm reduction movement than with family intervention models. To start with, both harm reduction and OD put a great emphasis on human rights. In case of harm reduction, it means that drug users are approached as a vulnerable population that often lacks access to ways and tools of reducing drug-related harms (Ezard, 2001). Similarly, OD with its relational perspective and focusing on polyphony (making all the voices be heard) is well suited for preventing coercion and other forms of human rights violations as well as preventing stigmatization (Von Peter et al., 2019, 2021).

Harm Reduction Psychotherapy (Denning, 2010; Tatarsky, 2007) has many common features with OD, with its emphases on the meaning of problematic behavior, taking a non-judgmental stance, and the primacy of therapeutic alliance. The problematic behavior is being discussed, sometimes in many details, but not with the intention of diagnostics or evaluating the severity of the dysfunction, but to inquire into the meanings and possible changes. This is a similar approach to how the original OD team regarded psychiatric symptoms as, for example, hallucinations. They developed a great sensitivity for the content of hallucinations, such as different voices that are, in traditional psychiatry, regarded as pathological symptoms. Seikkula et al. (2006) stated that great attention should be given to these “symptoms” because they express something meaningful and important that has not yet gained words.

Motivational interviewing (MI; Miller & Rollnick, 2002), a widely and globally used approach in addiction counseling that is generally regarded as evidence-based and effective (Bischof, Bischof & Rumpf, 2021) also has some striking similarities with OD. For example, the non-judgmental stance of the helper, respect, curiosity, and compassion are basic features of both approaches. For MI, establishing trust with people who are often in a position of being judged by general society, is a very important part of the interview. MI has developed closely with the harm reduction movement and diverted from the abstinence-based approaches in the sense that every change that leads to reduced harm is welcomed, whether it is safer use of the drug, lower doses, or not driving a car while using. Similarly, OD development has been largely influenced by the insider perspective, such as the peer movement and hearing voices network (Hopfenbeck, 2015) that stresses that symptoms such as hearing voices or paranoia are not a pathological production of the brain, but rather expressions of the body that carry meaning that can be grasped and listened to by the help of other members of the network and the OD facilitators.

**Sociomaterial networks: Possibilities for OD**

While addiction counselling commonly focuses on the substance and the individual in recovery, an OD perspective invites practitioners to think beyond just the individual and their use or behaviour, to the individual as situated and part of a larger network. The clinicians might invite family members, friends, neighbors, health practitioners, and/or anyone else who might feature in the individual’s life. In this way we invite other voices to contribute to the joint co-creation of meaning. Later, in the case vignette, we show how this can be seen in practice.

Drawing from a socio-material network practice perspective (Author2, 2021), we propose it useful to also include non-human agents, such as the substance or activity (i.e. pornography, online gambling, shopping) itself as a “member” of the network. In thinking about recovery from a socio-material network perspective, we consider the social, affective, and material (Duff, 2011) aspects relevant to the daily life of the individual. From an Actor Network Theory perspective (Latour, 2005), socio-material elements have relational agency in the substance use or addictive practice (Duff, 2012), often creating pleasurable, embodied, affective experiences that invite continuation. In addition to the substance or behavior, other important aspects could include objects important to using (e.g., pipe, syringe, rolling papers) or associated with using (alcohol along with cannabis for example), particular contexts (e.g., music festivals; Dilkes-Frayne, 2016; Duff, 2012) or places (e.g., areas of town, bars; Dilkes-Frayne, 2014; Duff, 2012) that come together to comprise the practice. In addition to practices associated with using, the individual is connected to and part of other social practices including work, social, and family – all practices in a larger “network” (Latour, 2005) of practices. A challenging day at work might invite some practices, while spending time with family or particular friends might invite other practices. Each of these practices are interdependently connected in a network, influencing, and being influenced by other practices (Kemmis et al., 2012).

Using a socio-material network perspective, there could be several areas to consider: the substance use or behavioral practice itself, including its socio-material elements, the practices associated with using, and practices of daily life that might be more supportive or “enabling” (Duff, 2011) of recovery. Team members might inquire how the network might support everyday practices and encourage “atmospheres of recovery” (Duff, 2015). Using an OD approach, we invite others in to support recovery in ways that are specific to the individual and their network – which could include peer wellness groups, supporting family relationships, connecting with other social supports, and fostering and inviting hope and belief. Rather than on the substance, attention might be better placed on the everyday “enabling places” (Duff, 2012) and practices that are promotive of wellness and care. This is an opportunity to foster relational wellness and mobilize relational resources (Author et al., 2019).

In OD network meetings, each member’s voice is invited to share and participate in the dialogical interchange. By inviting the “voice” of the substance or the particular habit, the network might imagine the concrete role the substance / habit plays in the network, and its relationship to the individual in recovery, as well as others in the network. Inviting others’ perspectives, goals, and wishes does a few important things. First, it shifts the focus from the substance and the person in recovery to other members in the network. Oftentimes, in recovery there is an intense gaze placed on the “problem” individual or “problematic” substance use. Often, we hear “you need to focus on your recovery” or “you need to put your recovery first,” which sometimes also becomes the mission and focus on well-meaning, good-intentioned friends and family.  Some substance users might find this unhelpful or experience this as pressure or imposition. In contrast, focusing on relationships between people or on others in the network opens space for the individual in recovery to engage in preferred ways of being. Inviting others in the network to focus on their own hopes and goals allows them to ensure their own health and wellbeing.

Second, network conversations can invite others to examine their role in the network in terms of how they are helpful or hindering in recovery or preferred ways of living. By listening to others’ experiences, they could come up with new ways of being that are more facilitative of recovery. Conversations might bring forth opportunities for new trajectories towards recovery and living and being in ways that are at odds with engaging in unhelpful or dis-preferred behaviors (Author et al., 2018). For example, time spent together doing an enjoyable activity, such as going for a walk, time in nature, or exploring a new area of the city, could crowd out or replace opportunities to use or engage in behaviors they might want to replace.

Third, members might consider how their interactional patterns (Tomm, 1991; Tomm et al., 2014) with other network members are healing or pathologizing and in alignment with recovery and wellbeing. According to Tomm (1991), all relationships have numerous reciprocal or circular interactions including Pathologizing Interpersonal Patterns (PIPs) and Healing Interpersonal Patterns (HIPs). These HIPs and PIPs are coupled interactional invitations that create relational stabilities that might be important in substance use and recovery. For example, a common PIP between a parent and youth who uses substances might be: parent’s correcting and controlling behaviors coupled with (inviting) the youth protesting and rebelling (and potentially using more; Author et al., 2014). The good-intentioned parent might be attempting to protect and control the youth’s substance use by preventing their child from socializing with friends, which might invite the youth to rebel by sneaking out of the house to go to a party and use (Author et al., 2014). As this PIP is repeated, the relational practice stabilizes. As the parent becomes more controlling, the youth engages in more protesting and rebelling. In contrast, an example of a HIP might be: parent supporting inner control coupled with (invites) the youth making safer choices. The parent might provide some guidance, support, and opportunities to engage in healthy practices (e.g., socializing with friends with less substance use), the youth might construct those opportunities more often. Through repetition, this HIP could develop a preferred stability, where the parent and youth engage in healthy, recovery-oriented relational practices. Another common PIP relevant to substance use is checking for evidence of use coupled with evading and hiding. This PIP is associated with reduced trust and increased anxiety for everyone involved. An alternative might be allowing the other to make choices coupled with space to make recovery-oriented choices. As Tomm et al. (2014) suggest, all relationships have a multitude of both PIPs and HIPs, some of which would be supportive of recovery or wellbeing-oriented practices. In OD conversations, network members might describe the relational patterns that are supportive of recovery and those that are preventing them from engaging in healthy ways of being.

**Case Vignette**

We offer a case vignette that originates from a therapeutic practice of one of the authors (Author 1) who is a member of the Community Team Narativ, in Brno, Czech Republic[[1]](#footnote-1). This team uses the OD approach as the main therapeutic modality, similarly to the Peer-Supported Open Dialogue (POD) model (Hopfenbeck, 2015). When addressing drug and addiction issues, there is always one person with lived experience with addiction (recovery coach) present at the meeting.

By this example, we show that using an OD approach brings other emphases and possibilities to support recovery in a way that is very compatible with the aforementioned philosophies: relational approaches (e.g., Gergen, 2009; Kemmis et al., 2012) and socio-material network perspective (e.g., Duff, 2015; Latour, 2005).

**Telephone interview: Organizing the first meeting**

The first contact is made by Iveta (54) who is the mother of Natalie, a 23 year-old woman who has been using methamphetamine for the last 3-4 years. Author1, as the current contact person of the team, listens carefully to what Iveta is saying but does not ask any additional questions regarding the “problem situation.” His main intention at this point of time is to organize the first meeting - and so he asks questions to find out where, when, and who is going to meet. Iveta and Natalie live separately, as does Natalie’s father (Jakub). Iveta states that she would prefer to come alone with Natalie for the first meeting. Even though Author1 offers to meet in their home, the team's therapy room is chosen by Iveta. The date and time are proposed and Author1 says he will be there with one of his colleagues. Following the phone call, Author1 uses a WhatsApp group to ask who would join him in working with this new family. Therapist2 responds that she is available.

*Author’s commentary*

*We can see that the socio-material network perspective is present from the very beginning as the participation and physical space of the meeting is the primary focus of the conversation. These issues are discussed very carefully so that the family feels as safe as possible and leads the decision-making process.*

**First meeting: Creating safe space for everyone including the habit**

Author1 and Therapist2 greet Iveta and Natalie in a large therapy room. Natalie is very nervous and does not want to talk at all. Author1 and Therapist2 introduce themselves, and then Author1 and Iveta start to recap what they already talked about by phone.

Iveta shares her worries about Natalie and her great despair after finding out that she is “a junkie.” Author1 wants to clarify this and asks a matter-of-fact question about the meaning of the word “junkie” for Iveta. She says it is mostly the use of crystal meth that makes Natalie “a junkie.” Author1 then turns to Natalie and asks if she wouldn´t mind telling a bit about the use itself. Natalie says it is OK because mother knows everything.

Therapist2 joins the conversation and shares about herself - that previously, she regularly used crystal meth for almost ten years. When Natalie describes her patterns of use, Therapist2 asks matter-of-fact questions and shares how some of her patterns and habits were different but also confirms Natalie’s experiences, specifically the positive aspects of the crystal meth use. She concretely asks Natalie, “how is the drug beneficial to you?” Iveta and Author1 only listen. Natalie is describing her everyday use of the drug by sniffing. She measures the doses very precisely and mostly she uses with her boyfriend. In recent weeks, she also started to take breaks from using (i.e., when she is about to see her mum).

In final reflection, Natalie says that the meeting was a great relief for her. She said that it was the first time when someone was really curious about the actual way of using without judging it. Iveta said that “she expected more,” but that at least she has a small hope.

*Author's commentary*

*In this meeting, we wanted to stress how the substance / habit (as it’s own separate socio-material actant) can be separated from the person and become part of the network with its own agency. Instead of the idea of “junkie” that places the problem into the individual, the facilitators propose (by questions and through self-experience) to talk simply about the use of meth. The curiosity around patterns of use expresses the interest in the specific and unique relationship Natalie has with the substance and how it is associated with other relationships.*

**Second meeting: Eliciting new perspectives of the situation**

For the second meeting, both Natalie and Iveta arrive in a good mood, smiling and joking. Natalie managed to “get off” the substance and has been 6 days without using. She feels good but she is also afraid that it will not last long because she already had such attempts that never lasted long before. Author1 and Therapist2 want to get to know more about both of their lives in a wider context. Iveta talks about when Natalie was a baby and how she grew up. Natalie listens carefully and adds some of her memories. When the talk turns to the period of time when Iveta was in the process of divorce (Natalie was around 12) with Natalie’s father, both of them get more serious. Iveta states that she failed in the process of separation. Natalie cries. After a while, Author1 asks whether she can imagine that her father is at the meeting too and Natalie answers that she would like to invite him. Iveta welcomes the idea, but also says that she would not join the meeting if her ex-husband is there.

*Author's commentary*

*If we regard addiction as a response to life difficulties (Denning, 2009) rather than as an individual deficiency, we are inclined to inquire about the issues and situations that called for such a response. In other words, we are curious to hear about the circumstances that made habitual use of a drug an attractive way of coping. In the second meeting, this kind of inquiry revealed an important period of time for both Natalie and Iveta and at the same time, inviting father started to seem to be a very interesting option.*

**Third meeting: Shifts in the network (including the habit)**

Natalie comes with Iveta for the next meeting again. When Therapist2 opens the door, she can see that Natalie is sitting on the stairs, crying. She comes to her and hugs her. Meanwhile, Iveta comes in and Author1 shakes her hand. Therapist2 makes sure that Natalie wants to attend to the meeting and they come in together. Although it seems that Natalie might not be able to talk, she does so after a few minutes. She states that her father couldn't make it this time but wants to attend next time.

Iveta joins the conversation saying that she was hesitating a lot whether to come because she doubts the usefulness of the therapy. After a while, Natalie shares that last week, she had such a terrible craving that she used again, two days after the last visit. She did not tell her mum until today, just before the visit. Iveta starts to raise her voice, getting angry with such proclamations as: “How should I trust you?” “Why should I keep paying for you, the apartment, the food!?” After a while, Author1 asks Iveta to wait a bit so that he could hear more from Natalie. He asks Natalie to share more about the situation.

Natalie starts with saying that she split with her boyfriend which was new information, even for her mum. It was after a big quarrel with her boyfriend, when he left, she started to have the terrible craving. At first, she thought she would be able to cope, but then she just went to buy the meth. However, the effects were not what she expected, so she went to see some friends, had some meth with them, and attended a big party. After the party, she went home, and she did not continue using. Her mum, again, started to raise her voice, stating that she cannot understand how she can go to have fun at a party when she (her mum) is in despair, doesn't know what to do, and has terrible fear about her.

When the situation escalated, Author1 proposed to take “a break” to use this situation for the sake of therapy. He proposed that he and Therapist2 would have a reflective talk in front of Natalie and Iveta about what they are experiencing. Natalie and Iveta agreed. Therapist2 and Author1 primarily share their feelings of sorrow for Natalie’s breakup with her boyfriend and also reflect the strong feelings expressed by Iveta’s loud voice. They also emphasized that this time, there was something new. Although Natalie previously said that after every break, when she begins using, she continues uncontrollably for many days, this time, she discontinued the next day. They were appreciating this and emphasizing this as an important change in the pattern of use. When Natalie heard this, she smiled a bit and was visibly energized. She said that she also thought this way, that she is experiencing something new. Iveta started to be very curious, and at the end of the session, she said that this perspective was very new and interesting for her.

After this meeting, Therapist2 also starts to see Natalie individually as a recovery coach. This was offered at the network meeting and Natalie happily accepted. (For the individual session, they met in a park and went to a local café together.)

*Author's commentary*

*When we adopt the network perspective, we can experience more shifts and transformations than in an individual one. In this case, it was not only the separation with her boyfriend, but also the change in the pattern/practice when Natalie discontinued after only 2 days of using, which she never did before. In this way, she stood up and resisted the pull of meth. The facilitators’ appreciation was not meant as a technique of positive re-framing but as an authentic reflection. Such a reflection is generated by a sincere interest in relationships, not only between humans but all members of the socio-material network, including habits. By highlighting a change in the practice, Natalie can see how her relationship to the habit has shifted (i.e., reducing the power and agency of the habit).*

**Fourth meeting: Establishing new understandings and connections**

Natalie attends with her father, Jakub. He said that he and his new partner support Natalie, but that they also have a strong “opinion” that she should go to inpatient treatment. Natalie explained to him her stance that she really wants to completely stop using, but, after last experience, she never wants to go to inpatient treatment again. She also asked Therapist2 and Author1 to support her opinion that inpatient treatment is not the only option. Therapist2 talked about her own experience and Author1 shared some research data that generally confirmed this, but both were clear that they don´t know what would work best for Natalie.

Natalie also shared quite a lot about her current life and many things were new to Jakub. They had an interchange about why they are not seeing each other: while Natalie thought it was because her father does not want to see her, Jakub thought that it was Natalie who does not want to come.

*Author's commentary*

*Inviting other members of the network and planning who will be present only for the next meeting is one of the specific features of collaborative-dialogic perspective (Anderson, 2012) that has been developing in synchronization with OD. Decisions around participation is always collaboratively decided with the family. And, even if specific members cannot be present for various reasons, their perspective can always be presented by imagining (i.e., if your mum was here, what would she say in response to this discussion of inpatient treatment?). In this example, inpatient treatment is an example of “place” Natalie no longer wants to include in her network.*

**Fifth meeting: The body as the co-creator of HIPs**

For the fifth meeting, both Iveta and Natalie came to the session in quite a good mood and joking. However, Iveta started to talk about her anger when she found out that Natalie had another “relapse.” This time it was better, though, because Natalie at least wrote a message to her mother “I have terrible craving” shortly before she used the drug and stopped communicating. There was a big difference this time. Previously, Natalie never let her mother know that she was going to use. In reflecting upon the situation, Iveta appreciated this difference, even though she also wanted to express the anger she feels.

In a certain moment of the consultation, it became clear that Natalie is going through something hard. Author1 asked her how she was feeling and she said “not very good . . .” and after a pause she added: “I have a terrible craving.” She started to become restless, was crying uncontrollably, and said that she had trouble breathing. First, Author1 asked if her mum had any ideas of something to comfort her, but Iveta felt helpless. She said that in past, she would hug her, but nowadays Natalie hates when she touches her - which Natalie confirmed. Therapist2 then went closely to Natalie and slowly put her arm around her shoulder. Therapist2 also found a piece of chocolate and offered it to her. In one moment, when Natalie gave a sign that she would like to move, Author1 helped her and walked with her shortly around the room. Everyone in the room was trying to find out something that would help a bit. Natalie said openly that she is considering going out and look for the drug. But slowly, with the effort of everyone, the situation was getting better, and at the end, Natalie felt relief and even smiled.

The session ended by reflecting upon the difficult situation - Natalie was trying to realize what helped her and the most important lesson for her was that she only needed to wait a bit - and then the crisis diminishes over time.

*Author's commentary*

*We could see how the healing interactional patterns are reflected and even developed in this meeting. Firstly, Natalie and Iveta reflect upon the situation when Natalie “relapsed.” This time, Natalie shared her feeling of having “terrible craving” and Iveta appreciated this, as she had a small sign about was going on before Natalie switched off her phone. Natalie sharing her craving invited Iveta appreciating and trusting Natalie to share. The situation of actual crisis (i.e., the strong craving) could also be regarded as a way of creating new pattern. Iveta could observe how both Author1 and Therapist2 were struggling with finding a suitable way of responding to such a crisis (caring presence of others) and Natalie had an experience that such a terrible bodily state of mind can be managed with time, in the caring presence of others and without the substance. The HIP could be described as Caring presence invited managing uncomfortable craving. Finally, we could also see the described interaction in the meeting as giving space to the voice of Natalie´s body.  HIP: giving space for the voice of Natalie’s body invited Natalie’s body sharing voice (e.g., sharing physiological discomfort and crisis). Key socio-material actants in this meeting include meth encouraging a craving, describing her use of her phone, giving physical space for Natalie, and chocolate. Each play a role in the socio-material network of Natalie’s use.*

**Closing commentary**

The purpose of this chapter was to introduce a postmodern approach to working with issues of substance use, addiction, and recovery. First, we showed how the OD network meetings, initially developed for working with psychosis crisis, can be introduced in this field. Second, we offered a relational, socio-material perspective as a way to also include the non-human agents such as substances, habits, or physical places in the network. Third, using a case vignette, we highlighted some typical elements of OD network meetings that are also compatible with the socio-material network theory. The network perspective is present from the first contact (often by phone) when the responsibility of the therapist who receives the call is to organize a meeting where not only the person in the center of concern, but also significant others are present. It is always decided collaboratively with the clients who will be present at the next meeting. The participation of new members is always welcomed because they can bring new perspectives and new meanings can be established. The facilitators are very attentive not only to shifts in the human relationships but also to new patterns of use or changes in the habitual behavior. The bodily experiences and habits themselves are also invited as important voices in the present moment of the meetings.

We are very aware that the experience with using OD approach with working with substance use and addiction is rather anecdotical and we cannot yet refer to any research or evaluation that for its use. However, based on promising results of OD in working with psychosis, we see it as very important to start using this approach creatively in other domains and other populations. We hope that readers of this chapter would join us in our effort of bringing the postmodern ideas into the field of substance use, addiction, and recovery.

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