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THE RELATIONAL ESSENCE OF NATURAL RECOVERY: NATURAL RECOVERY AS RELATIONAL PRACTICE

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Response to Reviewers:	Thank you for your helpful suggestions and comments. In response to the reviewers' comments, we have made the following edits: In response to reviewer #2 p. 5 we want (not wants) p. 5 no comma needed after perspective p. 11 it is confusing to have COUNTRY to identify two different countries. If you want to hide the country names, it would be better to use COUNTRY 1 and COUNTRY 2 where appropriate. p. 16 delete "that" in that compromised. We also conducted a very careful read to catch grammar mistakes and awkward

	wording. Thank you!

RUNNING TITLE: NATURAL RECOVERY AS A RELATIONAL PRACTICE

THE RELATIONAL ESSENCE OF NATURAL RECOVERY: NATURAL RECOVERY AS RELATIONAL PRACTICE

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Abstract

This article offers a relational practice view to conceptualize natural recovery from addiction concerns. Through the lens of a social practice framework the processes of natural recovery are seen as specific relational trajectories or transformative pathways involving relationships between humans, non-humans, communities, and philosophies, rather than as a process of symptom elimination. We argue that this kind of conceptualization of recovery acknowledges the many people who manage to recover without treatment or professional help, known as natural recovery. In addiction practices, we can see the dominance of pathologizing interpersonal patterns (PIPs) that maintain the addictive process. Over the course of recovery, we can see the dominance of healing interpersonal patterns (HIPs) that support the recovery process. To utilize this understanding as practitioners, we need to help nourish the platforms where the healing interactional patterns in daily life might be supported and maintained. While this reduces power from the position of "expert" in the biomedical model, it also provides more optimism, as members of the social network we can directly contribute to those healing interpersonal patterns - by the way we relate to, support, and engage with other people.

Keywords: Recovery, natural recovery, relational recovery social practice theory, addiction

Background

This article offers a relational practice view to conceptualize natural recovery from addiction concerns. The basic premise is that through the lens of a social practice framework (e.g., Nicolini, 2013; Schatzki, 2012; Shove, Pantzar, & Watson, 2012) the processes of natural recovery are seen as specific relational trajectories or transformative pathways involving relationships between humans, non-humans, communities, philosophies and so forth, rather than as a process of symptom elimination. We argue that this kind of conceptualization of recovery acknowledges the many people who manage to recover without treatment or professional help, known as natural recovery (Camargo-Borges & Nepustil, 2014; Ness, Borg, Semb, & Davidson, 2014).

In this article, we use first-person narratives of individuals who talk about the crucial role of relationships in helping them in their recovery processes. Traditional approaches (Davidson, Borg, Marin, Topor, Borg, Mezzina, & Sells, 2005; Slade, 2009; Topor, Borg, Mezzina, Sells, Marin, & Davidson, 2006) typically ascribe support networks and relationships in a supportive role to recovery, while still viewing the recovery process as an inherently personal process. In contrast, we introduce an approach that positions recovery as relational in principle. The identities, including the identity of a "person-in-recovery" are products of relational processes. This is notion also supported by Price-Robertson, Obradovic, and Morgan (2016) in their relational recovery approach.

By focusing on natural recovery and informal support (i.e., provided by family, friends, interest groups, etc.), we do not deny the importance of more formal, institutionalized support such as rehabilitation centers, therapeutic communities, Alcoholics Anonymous, etc. Addiction professionals and mutual help groups are often an important, or even necessary, part of many individuals' recovery network, particularly where they lack other helping and trusting relationships. However, we challenge the biomedical model of treatment (Volkow,

Koob, & McLellan, 2016; Wampold & Imel, 2015) that puts the helper into the role of "expert" who has the tools for correcting the life of individuals who struggle with mental health and addiction problems. On the contrary, we view individuals struggling with addiction as the experts, who use their situation and social networks as resources in their recovery efforts.

Recovery and Natural Recovery

Recovery has been described in different ways in the literature. Most commonly, recovery has been described as a clinical outcome (by the professionals), often referred to as recovery *from* (Davidson, 2003). In this way, an individual has fully recovered and no longer has any symptoms of addiction. Another notion is recovery as a process (by the service users), where people find ways to live with their problems and societal barriers, also referred to as recovery *in* (Davidson, 2003).

Natural recovery, or the process of overcoming problems without formal help, has many other names (natural recovery, spontaneous recovery, spontaneous remission, unassisted recovery, unassisted recovery, etc.) and has been documented with various mental health problems including eating disorders (Vandereycken, 2012; Woods, 2004), depression (Whiteford et al., 2012), and social anxiety disorder (Vriends, Bolt, & Kunz, 2014). In the substance use and addiction field, there are many studies not only confirming the existence of the phenomenon (Biernacki, 1986; Burman, 1997; Cloud & Granfield, 2001; Granfield & Cloud, 2001; Hodgins & el-Guebaly, 2000; Robins, Helzer, & Davis, 1975; Sobell, Cunningham, & Sobell, 1996; Sobell, Ellingstad, & Sobell, 2000; Waldorf, 1983; Waldorf & Biernacki, 1979), but also providing estimates of rates which are unexpectedly high. For example, the U.S. National Epidemiological Survey on Alcohol and Related Conditions (NESARC) surveyed individuals from the general population (total n = 43,093) and concluded that 24.4% of people who met the DSM-IV criteria for alcohol dependence, two

years' prior, were abstainers or non-dependent drinkers in the time of the interview, without having ever received any kind of treatment (Dawson, 2005). From the same study, it can be concluded that 72.4% of all people who recovered from alcohol dependence, managed to do it without formal intervention (Dawson, 2005; Rumpf, 2016, personal communication). Similarly, Sobell, Cunningham, and Sobell (1996) analyzed two large, general population surveys in Canada and found that most individuals (76% and 78%) overcame alcohol problems naturally (i.e., without formal help).

Natural recovery from alcohol problems has been most commonly researched (Carballo et al., 2007; Sobell, Ellingstad, & Sobell, 2000). Unfortunately, large survey data of natural recovery from illicit drugs are less available because national surveys often do not contain questions on severity of problems with illicit drugs (Klingemann et al., 2012), and more importantly, questions on natural recovery are not usually asked. However, several smaller-scale studies demonstrated the phenomenon. In an early study of Vietnam veterans, Robins (1975) found 80% of people addicted to narcotics in Vietnam overcame their addiction after coming to the US, while only 2% received some form of treatment. Similarly, Biernacki (1986) detailed the processes of natural recovery of 101 heroin addicts.

While natural recovery in behavioral addictions has not been studied widely, Thege et al. (2015) examined the natural course of excessive behaviors including exercise, sexual behavior, shopping, online chatting, video gaming, and eating. They found that in most cases, problems were transient, people overcame them, and only a small proportion used professional help. Individuals who cited problems with eating and exercising sought formal help most often, though, more than half resolved their problems without treatment.

The stability of natural recovery over time has also been researched. Rumpf et al. (2009) found a cohort of 144 naturally recovered individuals who fulfilled the criteria for alcohol dependence 12 months prior. They re-interviewed these individuals 24 months later

and found that 92.3% of them showed stable remission – again, without formal treatment. Based on their meta-analyses of the natural recovery studies from 1999 to 2005, Carballo et al. (2007) contend that there is no reason to believe that the stability of self-changers would be lower that of the treatment attenders. In fact, we might argue that individuals who recover naturally would have higher rates of stability, because they were able to do so using their own existing relational resources and through relational practices.

The studies and findings about natural recovery challenge the notion of addiction as an illness or disorder, which has also been challenged by scholars from a variety of disciplines (Gergen, 2009; Lewis, 2015; McNamee, 2015; Reinarman, 2005; Whitaker, 2002). Even neuroscience, a domain typically aligned with the disease model, has developed new perspectives on this issue. For example, having recovered from addiction himself, neuroscientist Marc Lewis (2015) argued that changes in the brain during addiction (and recovery) have more to do with learning, than disease. He wrote, *"*The many addicts who end up quitting do so uniquely and inventively, through effort and insight. Thus quitting is best seen as further development, not 'recovery' from a disease" (Lewis, 2015, p. xii).

Kenneth Gergen (2009) is another critic of the medical model of mental problems, and a major proponent of social constructionist thinking. He challenged the notion that so-called mental problems are individual problems. For him, there is no such thing as aggression, love, or pain as such. Instead, these vocabularies derive from our relational processes, and without such processes these concepts would not have any meaning. Thus, he suggested a focus on relational processes rather than individual and personal processes (Gergen, 2009). Applied to so-called "mental problems" (and addiction), we might divert from individual assessments of the identified problems to interest in the relational practices that precede, construct, and are shaped by these problems.

In her recent work, Sheila McNamee (2015) built on Gergen's notion of "relational being" with her notion of "radical presence" as a way of being a therapist. If we (as therapists) want to take seriously the presumption that we can never find a "real" and "true" individual description of someone's behaviour or problems, we need to move towards " . . . a fully reflective form of existence where attention is directed to what we are making together as we engage" (p. 9). Being radically present means that we step out of our cannonical understanding and forms of practice, and engage in co-constructing generative and responsive alternatives to recovery.

Where do these ideas bring us in thinking about recovery? From the perspective we are taking, we cannot think and talk about recovery "from" something. If we see the processes of developing "mental problems" and addictions as relational, with no clear beginning or ending, then we need to see the same in the processes of recovery. However, this does not mean abandoning all existing notions of recovery. There is a clear line of contextual and social orientation in current recovery literature (Borg, 2007; Price-Robertson et al., 2016; Tew, 2008; Topor et al., 2011). These authors maintain there are many everyday life aspects that are central parts of the recovery processes, such as helpful relationships, supporting environments, services, and systems of care (Topor et al., 2011). Ordinary environments and activities emerge as the most common and recommended arenas for recovery, rather than formal mental health or addiction service settings (Borg & Davidson, 2008; Davidson, 2003; Krupa, 2004; Tew et al., 2012). These arenas give meaning and offer people "normal" contexts to engage in recovery practices and reclaim their status of being citizens, as everyone else.

Another more personally orientated line in the literature views recovery as a personal process, thus accepting that the aim and direction of care ought to be defined at the personal level, where the central actor in the recovery process is the person him-or herself (Davidson,

2001, 2003; Strauss, 1996; Topor, 2001). In this line of thinking, a deep understanding and respect for the individual's thoughts, experiences, and points of view in the recovery process is emphasized (Topor et al., 2011).

From a relational perspective, neither of these notions of recovery is false (Price-Robertson et al., 2016). In fact, understanding the complex social relationships and system context of recovery processes, while also appreciating the central role of the individual as the main actor in these processes, is more complementary than contradictory. In addition, the ideas of relational being and radical presence take us one step further. When we concentrate more on the subtle, here-and-now interactions and everyday practices, the boundaries between the "illness" and "recovery" will start to blur dramatically.

A Relational Practice Perspective

A relational, recovery oriented practice perspective invites us to "consider and describe addiction processes over time, especially when considering how addiction manifests in relationships and daily life" (Graham, Young, Valach, & Wood, 2008, p. 122). This means viewing addiction and recovery "across the contexts of their family, work, school, psychotherapy sessions . . . [pointing to the] significance of grounding a theory of individuals in structures of social [or relational] practice" (Dreier, 1999, p. 5). From a relational practice perspective, we can see how the various activities and practices of an individual function to stabilize or destabilize addiction practices. For the purposes of this article, we define relational practices as the recurrent relational interactions that people engage in, filling his or her daily life. We use Karl Tomm's interpersonal patterns (Tomm, St. George, Wulff, & Strong, 2014) as a heuristic for understanding recovery as a relational practice.

In the field of Family Therapy, Karl Tomm developed a conceptual approach to understanding mental health concerns through relational, interpersonal patterns. According to Tomm (1991), all human relationships consist of a multitude of reciprocal or circular

interactions including Pathologizing Interpersonal Patterns (PIPs) and Healing Interpersonal Patterns (HIPs). These interpersonal patterns are coupled interactional invitations that create relational stabilities.

Using an example of substance abuse in a family context, there are a variety of PIPs and HIPs common to the individuals and family, some of which might be more in line with (or encourage) substance use, and some which might be directing away from use. For example, a common PIP between a parent and substance-abusing teenager might be: the parent's correcting and controlling behaviours invite the teen's responses of protesting and rebelling (Mudry, Strong, & Chang, 2014). In this example, the parent might be attempting to control the teen's drug use by refusing to allow his/her child to socialize with friends, which might invite the teen to rebel by sneaking out of the house to go to a party and use. From a relational practice perspective, as the PIP is performed and repeated, it stabilizes the relational practice - as the parent is more correcting and controlling, the teen engages in more protesting and rebelling.

In contrast, an example of HIP might be: parent supporting inner control invites a response such as making better choices. If the parent was to provide guidance and opportunities for the teen to make good choices, the teen might learn to make better choices and engage in less substance use. This HIP is an opportunity for a more preferred stability, where the parent and teen perform healthy, recovery-oriented relational practices – encouraging recovery. If, as Tomm (1991) suggests, all relationships have a multitude of both PIPs and HIPs present, there would be a variety of interactional patterns, some of which would be more supportive of addiction practices, and some of which would be more supportive of recovery practices. Using this logic, in the cases where natural recovery occurs "spontaneously," the individual may simply have more stabilized HIPs comprising his or her

daily life, than PIPs. In this way, recovery "from" an addiction would be a matter of encouraging and supporting the already present HIPs to replace addiction-oriented PIPs.

Next, we use real case examples to illustrate how natural recovery can be viewed as relational practices. First, AUTHOR1 provides examples of two relational moments viewed as qualitative shifts that initiate transformational pathways away from long-term crystal meth use. Second, AUTHOR2 provides examples of how everyday recovery oriented practices are sustained and stabilized in relationships with others. We extend the heuristic of HIPs and PIPs to include interactional patterns between individuals and their relational practices. We close by providing implications for practice - providing ideas of how therapists might support clients in establishing new HIPs and amplifying the HIPs already present in their lives.

Case Studies

These case studies are drawn from data from dissertations of AUTHOR1 and AUTHOR2. Details on methodology used in each study can be found in AUTHOR1 (2016) and AUTHOR2 (2016) .

Relational Moments of Recovering Meth Users

Natural recovery was my (AUTHOR1's) specific focus in a PhD dissertation aimed at understanding the process of quitting methamphetamine use without formal help (AUTHOR1, 2016). Each of my 19 participants was using methamphetamine regularly (more than twice/ week) for at least one year and managed to quit without any formal help. At the time of our interview, they were not using crystal meth at least five years. While I was not specially targeting the interactional patterns, there were many moments within the interviews that underline the relational essence of recovery. I will share two small stories showing transformational moments described by Miloš and Magda. They both were living in PLACE at the time of our interview and the interviews were translated for the English edition of my

book (AUTHOR1, 2016). I met Magda after she responded to a media advertisement about my research, Miloš was refered to me by my friend who knew of my study.

From anger to trust, from lack of concern to care. Miloš´ described his life as having two major negative turning points from childhood to adulthood. The first was his mother dying when he was 15 years old, the second was when his marriage ended. He described not being able to find a balance between his family life and his "career" as a meth user. He actually described it as a career:

> *And I'd say that after that year I had the feeling that I'd actually accepted it. I'm a junkie, I'm not the only one on earth, so what. Some people go to work, some are drivers, and, just so, I'm a junkie. I told myself, why become the stereotype bloke going to and from work just to lie on a couch in front of a telly? I only live once, so I better enjoy it.*

Throughout his career as a meth user, there was one person from his previous life that was almost always on his mind, his daughter. During his meth use, he didn't see her, he did not even know where she and her mother were, because he and his ex-wife were still angry with one another. He was not in touch with anyone from his or her family – he said that he didn't care about family since he started to have his own *"amazing new life."* His family had *"written him off,"* and his father even changed the lock on his house. The relevant PIP described by Miloš might be viewed as: Anger expressed by his ex-wife, father, and others inviting Miloš distancing from family and engaging in the subculture of meth users and producers.

Miloš described a transformative moment that sparked a new HIP towards recovery. He recalled an incident when he and a friend went to see a meth producer to buy drugs to consume and sell (he was also a dealer). They randomly met Miloš´ sister-in-law on their way, and she asked him, *"why don´t you go and see your kid?"* His daughter happened to be

staying with her, while his ex-wife was in PLACE with her new boyfriend. He described what followed:

> *And that was the turning point, I told the mate, I'm not coming with you. And he said, look, I'm not gonna say a word, I'm not gonna persuade you otherwise, but listen, if I see you in two weeks with your daughter doing the same stuff you're doing now, I'm gonna beat the shit out of you. And that was the turning point right then and there, I didn't go with him, and took a bus to [a town] instead, and spent the night there. I hadn't seen my daughter for maybe two whole years, and she woke up, it was eleven at night, jumped around my neck and shouted, daddy, daddy. I sobbed like a child. I reckon that was the turning point.*

Following that moment, Miloš started to see his daughter regularly and never touched crystal meth again. He built a new life, with new relationships, and now works as an outreach worker for injection drug users. The moment, where he met his sister-in-law, began a transformation from anger and distrust to a concern and trust in the relationships. His sister-in-law's question, "why don´t you go and see your kid?" was not only an offer, but also hope for Miloš. The invitation to see his family, followed by the immediate acceptance and love expressed by his daughter, formed a HIP: Acceptance and love from family inviting commitment and responsibility from Miloš. His actions that followed served as a message for his ex-wife's family that he cared, even if they previously thought he didn't. The trust was not built in one day, or in one month, it actually took years, but this was the first step changing the interpersonal pattern and new relational practices. Miloš and his family took a transformational pathway from Anger and distancing towards acceptance and commitment, later changing to trust and care.

From fear to shame, from shame to sharing, from silence to action. Magda was born in an Arabian country as a child of a COUNTRY1 mother and Arabic father. They

moved to COUNTRY2 when she was six years old, but she regularly went back to her country of origin for long periods of time, because her father continued to work there. Magda described beginning to use drugs as a way to help her reconnect with her peers in COUNTRY2. She said: *"I had the feeling that everyone had gone mad – I was a few months away and all of my friends were taking some drugs!"* She tried ecstasy and found it fun, increasing her enjoyment of spending time with her COUNTRY2 peers.

Methamphetamine use came along with a new boyfriend, who was a regular meth user and always had meth with him. With this new boydfriend, Magda used meth almost daily, over two years. Her parents were unaware, though her mother noticed some changes in her daughter. Magda insisted that it was nothing, and mother was scared that her husband would react strongly. Therefore, the mother stayed silent, which we could understand as a part of the PIP: Fear and silence inviting shame and denial. However, one day, Magda's mother found injection paraphernalia and meth, and she decided to act. She called her husband abroad, whom immediately changed his flight and was returned home. Magda described a transformational moment with her father:

> *I was sitting in my room and he said: "we will help you. I will pay for the best hospital, or some treatment facility or . . . I will help you." I couldn't believe it, that he'd tell me anything like that, that he wouldn't shout at me instead, and that made me feel ashamed all the more. Maybe, had he shouted at me or slapped me, I'd tell myself, well, what of it? I think I felt shamed by how good he was to me.*

Magda was deeply touched by this conversation, and her shame was apparent in her inner dialogue. While at the time, she still insisted that it was not her paraphernalia and that she did not use any drugs, her parents were no longer silent. Her parents were very concerned, and they consistently spoke to their daughter, trying to be with her as much as possible, and slowly Magda started to talk and openly share about her secret life. Here, a HIP started to

form: Open sharing inviting new ideas and possibilities. Magda's parents made the decision that they would move as a whole family to the father's country of origin. For Magda, it was an opportunity to build a whole new life. Now, more than 10 years after quitting illicit drug use, Magda is a high school teacher and a new mother of two children.

Viewing Magda's story from the perspective of interactional patterns, we can observe moving from fear and silence that led to shame and denial, towards sharing and new ideas, and eventually towards trust and action.

Natural Recovery Practices in Everyday Life

I (AUTHOR2) came into natural recovery data somewhat unintentionally. My dissertation research focused on the practices involved in sustaining and interrupting excessive behaviours (EBs; eating, Internet use, and gambling; AUTHOR, 2016). I interviewed 22 participants (pseudonyms used here) who were concerned with their own or a loved one's engagement in one or more of these behaviours. During these interviews, I found that individuals were already engaged in natural recovery practices, which I view as HIP-ish practices. What follows are some brief examples of how participants engaged natural recovery practices (in a HIP-like fashion) to reduce their gambling, eating, or Internet use. These recovery practices include: changing people and places invites new practices; keeping busy with other relational practices, preventing EB practices; supporting partner invites preferred practices; motivation to spend time with pets invites reduced motivation to gamble.

Changing people and places invites new practices. Participants reported that they reduced their opportunity to engage in gambling, eating, or Internet use which invited less engagement in those behaviours (i.e., HIP). Reduced opportunity was often intentional, but also sometimes unintentional. For example, Caitlin described how her partner's ability to gamble was reduced because the pub where he gambled closed. Caitlin explained,

We don't have the same life even, because that pub we always go to is shut down, the guy we'd always go with is gone. Um, so we're kind of like we would frequent the pubs now just as much as we would but the main place where all of this stuff [i.e., gambling] would really occur is not in our vicinity anymore.

According to Caitlin, her partner was less likely to gamble because the people and the places important to gambling were no longer accessible.

Participants also reduced their opportunity and likelihood of engaging in EBs by involving other people. For example, interacting with family members was key for participants who lived at home. In terms of Internet use, Brittany stated, "*maybe staying more like in the general area of the house. Like not in my room [with my laptop] but like actually maybe staying in the living room actually interacting with other members in my family*." Kendra, who struggled with eating particular foods, recruited her mother to reduce opportunities to eat. She explained,

So my mom has actually started, at my request, hiding certain foods from me like nuts and dry fruit because if I can't see it, I won't eat it. If I don't know where it is, I won't eat it.

When opportunities were reduced to engage in eating, Internet use, and gambling, participants were less likely to engage those behaviours. Changing the relational context (people and places) where EBs are normally practiced was facilitative in reducing opportunities to engage in EBs. Here, a HIP-like pattern might be: Changing people and places invites new (Non-EB) practices.

Keeping busy with other relational practices, preventing EB practices. Perhaps not surprisingly, participants kept busy with other activities, which prevented them from spending time online, eating excessively, or gambling. Various forms of exercise were commonly mentioned, as well as volunteering, going to movies, walking around the mall,

spending time outdoors, and spending time with others. Some participants talked about recruiting others for distraction or support. Kendra reported,

> *I usually go and bug my mom to do something . . . I'll just ask her if she needs help with anything . . . if we're at home and it's late at night or something we'll play games. We'll usually play rummy, we'll get a deck of cards and play rummy. She'll rub my shoulders sometimes if I'm really stressed out, so that helps too. That brings me down.*

Participants also described how they needed to recognize when to recruit others. Beth described the importance of self-awareness in recognizing when to ask for help,

> *I'm not enough to get myself out of that rut, I need to engage other people to help me . . . I'll like pull myself out and like "that, that's enough, let's go get outside and do something," right? But I will engage my supports. Each time, each time I'm going down into that rut I can engage my supports earlier and earlier cuz I start to recognize that I'm getting there earlier and earlier.*

In these examples, participants kept busy with other practices and people, which helped them avoid EB practices. The HIP might be: Keeping busy with other relational practices, preventing EB practices.

Supporting partner invites preferred practices. Participants often described utilizing the support from others in their recovery practices. Support of partners was described as helpful during recovery processes. Gus described,

> *my wife's support has helped. She has supported me through the entire horror story. . . she didn't get angry, she didn't, she didn't, (pause) I felt horrible enough about myself at the time, if she had beat me, you know when you're standing this tall it doesn't take much for somebody to beat you over the head with a 4-foot-long stick.*

In a different way, Megan explained how she supported her partner from a distance, in their long distance relationship,

A couple of weeks ago he called me and said "Oh I'm really feeling stressed out." I was like "Oh ok, thanks for letting me know, how are you going to cope with that?" He said "Well I feel like I might wanna watch pornography but maybe I'll go for a run." So like his awareness of that and like that's a really good idea. I mean I support that idea . . .The greatest thing for me is that, that he feels comfortable enough to include me in that and realize, "Ok, I might be upset but so much more less than if you lie to me about it."

Megan and Gus described examples of a HIP-like pattern: Supporting partner to engage in preferred practices invites engaging in preferred practices.

Motivation to spend time with pets invites reduced motivation to gamble. Pets were frequently mentioned as helpful in recovery, often in terms of distraction in the form of walking the dogs. However, for others, pets were also seen as a motivation. Gus described,

I go straight home [after work], we actually we bought two dogs a year ago . . . knowing that they're at home and they're so excited . . . it's been helpful it, it's I don't wanna sit at the casino . . . they stand at the door and they're so excited . . . So those two little faces when you come home, um, I can't wait to get off work to go home and . . . so I would recommend it to anybody that is trying to battle those addictions.

For Gus, a HIP-like pattern involving his dogs might be: Motivation to spend time with pets invites reduced motivation to gamble.

In each of the above examples, participants described small HIP-like practices that they engaged in naturally, which facilitated recovery. These recovery practices include: changing people and places, inviting new practices; keeping busy with other relational practices, preventing EB practices; supporting partner, inviting preferred practices; and motivation to spend time with pets inviting reduced motivation to gamble. Encouraging and supporting HIP-like practices helped to overshadow or crowed out the PIPs, which was

facilitative of recovery processes. Individuals engaged new small practices involving people and places in their daily life, which supported their recovery from EBs in their daily life.

Implications for Practice

> If treatment as we currently understand it does not seem more effective than natural healing processes, then we need to understand those healing processes. (Vaillant, 1980, p.18)

Nearly 40 years ago, George Vaillant (1980) made an invitation to understand and study natural healing processes. Using a lens of relational practice, we have attempted to take up Vaillant's invitation. By studying these natural recovery processes and trying to understand them through the lens of relational practice, we can learn about treatment, rehabilitation, and perhaps most importantly, supporting the recovery of loved ones, friends, and people in our community.

As demonstrated in the case examples above, the important moments (Magda and Miloš) in recovery often come spontaneously, unexpectedly, and as such it is not possible to plan for or expect them. However, it may be possible to prepare for them. Since these moments are always relational, people require relationships comprised of love, care, and trust so that these moments might have a chance to occur. While Miloš' sister-in-law seemed to show up almost by chance, her care and trust inspired her to say, "why don't you come to see your daughter?" Similarly, while Magda's father was not often available, in this important moment, he was able to be there as a loving, caring father and support her recovery.

Similarly, in the natural recovery practice examples shared by AUTHOR2, participants engaged others (loved ones, family members, pets) to support them in engaging in preferred practices in their everyday life. Our daily life is comprised of various practices and activities, that involve other people, therefore it makes sense that recovery practices do as well.

These examples are in contradiction to the common belief that close others need to distance themselves from the person who is abusing substances or behaviours. The relational approach we are taking invites a stance that the people around the person struggling need to stay connected to him or her, so that the transformational moments can occur (Hari, 2015; McNamee, 2015). However, this does not mean that loved ones should support engagement in destructive activities. Rather, as family therapist and social worker Dean Wolf puts it, the main challenge for loved ones is to "separate themselves from the addictive process while remaining connected to their loved one in more productive ways" (D. Wolf, personal communication, August 15, 2016).

Professionals such as psychotherapists, social workers, and counsellors, may see themselves primarily as members of the user's social network. As such, the professional can establish an open, trusting relationship, where the user can share and reflect upon the shifts and trajectories whenever they are ready to move towards change. The professionals cannot impose the change, they can only establish a strong connection and invite productive dialogue. Another role for the professional is facilitator of the relational processes that surround the user. This way of working is close Speck and Attneave's (1973) social network intervention, which requires that the professional is an active member of the network, working mostly in the natural environment (where everyday life occurs), rather than an office. The role of the professional may involve organising and facilitating family or social network meetings, where relational moments could occur or where connections are re-established so that these moments will have a better chance to re-occur later.

Professionals can also support clients in exploring, developing, and expanding recovery oriented HIPs, such as how they might reduce opportunities to use, engage in other activities, and access support from others. Professionals can map out (on paper), the client's HIPs and PIPs to identify opportunities to develop and expand upon HIPs in their daily life.

Professionals may also adopt an advocacy role. Access and opportunities for alternative, preferred practices and support are important, particularly for individuals who have lost connection to their community or lack the financial resources to access opportunities such as recreation, fitness, and hobbies. Advocating for access to recreational facilities and reducing financial barriers would be beneficial. For example, the City of Calgary (Alberta, Canada) has a "Fair Entry" program, which provides subsidized programs and services based on low-income. Exploring options already present (such as the one above), and advocating for potential new options for free or inexpensive activities might be warranted.

Recovery communities. On a less formal level, inviting, welcoming, and supporting people to engage in family and community activities is vital for reducing societal stigma faced and experienced by those recovering. In Norway, a project has been initiated called *Recovery Communities* (Johnson & Wilhelmsen, 2014). Recovery Communities are meeting places and arenas for dialogue for people with experience with, or related to, mental health and addiction challenges. Participants of recovery communities might include relatives, professionals, or other stakeholders (managers, politicians etc.). They are implemented as open evening events (public meetings) that invite dialogue around specific themes among participants related to social and personal recovery. The themes are linked to improved processes and coping, as well as focus on improving municipal services. The goal of Recovery Communities are: (a) to strengthen people's opportunities to participate in the local community and establish a good, meaningful life, and (b) further develop health and welfare provision in the municipalities so that they are accessible, flexible, collaborative, and provide support in a way the individual wants. Activities and strategies for Recovery Communities are developed in dialogue and cooperation between the participants. Recovery Communities are comprised of citizens of the municipality who want to develop mental health and substance abuse programs and develop a more generous community (Johnson & Wilhelmsen, 2014).

In this way, both practitioners and the people who come to the Recovery Communities create the tone and agenda for collaboration. A strong relational collaboration is evident by how the professional fosters the person's integrity and dignity throughout the process of collaboration. Thus, people who come for help are viewed as what they are - people with autonomy and preferences, and looking for "a quick fix," to be "repaired," or "treated" by professionals.

In this collaboration process, the professionals and citizens explore and discover together what the individual wants, what he or she can do to better his/her situation, and see possibilities to how it can be achieved practically. Therefore, it creates space for the autonomy of members of recovery communities, as they are active participants in their own lives, and with their own relationships. They are viewed as individuals with the skills and resources needed to be able to make their own choices, take responsibility, have desires and intentions, and exercise judgment in their actions. They can be an ordinary person - and fellow human being (Ness, 2016).

Implications for Research

Research on natural recovery is in its infancy. Further research is needed to understand, promote, and better support natural recovery efforts. How are natural recovery practices explained in detail in first-person accounts? What facilitates and hinders natural recovery? What is the current prevalence of natural recovery within the field if mental health and addiction? What are professionals views, attitudes, and explanations of natural recovery? How do formal health systems support relational recovery efforts?

Continuing on a relational path, future research could focus much more on the role of other people and social interactions in the process of natural recovery. If we can see the whole recovery process as relational, are there some specific configurations that promote natural recovery and others that block it? What are the relational sources for natural recovery on the

level of intimate relationships, families, communities or, even more broadly, the whole society?

Conclusion

Our aim in this article was to offer a relational practice view to conceptualize natural recovery from addiction concerns. Through the lens of a social practice framework (e.g., Nicolini, 2013; Schatzki, 2012; Shove, Pantzar, & Watson, 2012) we wanted to illustrate the processes of natural recovery as specific, relational trajectories or transformative pathways involving relationships between humans, non-humans, communities, philosophies - rather than as a process of symptom elimination. We wanted to emphasize the inherently relational processes of recovery, and with case examples show how it is visible in people who engage in the recovery process without institutional help, with the use of their own resources. We used a relational practice framework to understand the transformation that occurs when someone stops engaging in substance abuse or excessive behaviour practices. In addiction practices, we can see the dominance of pathologizing interpersonal patterns (PIPs) that maintain the addictive process. Over the course of recovery, in turn, we can see the dominance of healing interpersonal patterns (HIPs) that support the recovery process. To utilize this understanding as practitioners, we need to help nourish the platforms where the healing interactional patterns in daily life might be supported and maintained. While this reduces power from the position of "expert" in the biomedical model, it also provides more optimism, as members of the social network we can directly contribute to those healing interpersonal patterns - by the way we relate to, support, and engage with other people.

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