

Pain Resolving in Addiction and Recovery: A Grounded Theory Study

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Abstract

The aim of this study is to develop a classic grounded theory about how addicts resolve their pain during addiction and recovery. Interviews and observations were analyzed and secondary analyses were carried out. Pain emerged as the main concern with pain resolving as the emergent pattern of behavior through which they deal with this concern. Pain resolving is a two-stage basic social psychological process of becoming where their identity is formed based on how they resolve their pain. This process of becoming is progressive over time. These two stages are instantaneous pain relieving and honesting. Trapped in instantaneous pain relieving leads an addict to become a worthless person while continuous life-long implementing of honesting brings the addict towards becoming a fully functioning person. Instantaneous pain relieving and honesting account for the patterns of behavior in resolving pain when an addict is in addiction and during the recovering process respectively.

Keywords: pain, addiction, recovery, obsessing, instant pain relieving, vicious cycling.

Introduction

Theories of addiction are models that explain the causes of addiction and its obsessions. By using these models, addiction could be understood and thus treatment and interventions could be implemented to help addicts.

An accepted model currently used in explaining addiction is the medical model. The medical model of addiction views addiction as a progressive disease with symptoms characterized by an individual's loss of control over the addiction and the progression of the disease that leads to death (Miller, 2005). It also views that addiction could not be cured; however, it could be managed in the long term throughout an individual's life. It allows the individual to be medically cared for without any moral judgment.

The medical model has also evidenced that addiction is

a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors (American Society of Addiction Medicine [ASAM], 2011, para. 1).

Brain scans have shown that there are abnormalities in the individual's brain and the brain improves when the individual abstains from drugs (National Institute on Drug Abuse [NIDA], 2014). These findings are very encouraging.

The medical model of addiction has conceptualized addiction with scientific and clinical evidence; it is useful in understanding addiction and thus able to guide treatments and interventions in addiction recovery. Nevertheless, a social psychological study grounded in data on how addicts continue to resolve their main concerns in addiction and recovery would be beneficial to contribute to the existing body of knowledge on addiction.

Purpose of the Study

The purpose of this study is to develop a substantive grounded theory (Glaser & Strauss, 1967) theory that explains how addicts continue to resolve their main concerns during their addiction and recovery. Grounded theory study is not to produce factual, detailed descriptions of data, but an integrated set of related concepts identifying a main concern for participants, as well as the latent pattern underlying how they continually work to resolve their main concern (Glaser, 1998). It focuses on conceptual abstraction and not conceptual description (Glaser, 2001). It is not to be assessed, judged, and evaluated in terms of descriptive accuracy and prediction of a phenomenon of interest. By staying close to the process of theoretical sampling and constant comparison, an emergent theory relevant to the participants studied will result (Glaser & Strauss, 1967). Thus, the theory generated in this study can be evaluated in terms of its close adherence to the methodology, its relevance to the participants, and its modifiability in light of newly uncovered data (Glaser, 1978).

Glaser (1978) emphasized conceptualization abstract of time, place, and people. A theory discovered with the grounded theory method should be easy to be used outside the substantive area where it was generated through the generation of a formal grounded theory.

Research Questions

In accordance with grounded theory methodology, the two main research questions guiding this study were as follows: (1) What is the main concern of addicts during their addiction and recovery? (2) How do they go about addressing or resolving this main concern? (Glaser, 1998). The conceptual abstraction of the latent pattern underlying the behavior of participants in addressing or resolving their main concern forms the theory of the substantive area.

Methodology

The methodological procedures delineated in grounded theory, as proposed by Glaser and Strauss (1967), are rigorous. Simultaneous and iterative process of data collection, coding, and constant comparative analysis are carried out to generate a theory. These procedures are highly systematic and consistent. By employing these procedures, the researcher stays close to the data. Thus, the theory emerges from the data. It has grab, fit, and relevance (Glaser, 1978) to study participants.

Glaser (1998) advised that pre-conceptions about the study are to be suspended to allow the theory to emerge. The researcher's pet theories are obstacles to generating a grounded theory. Researchers are strongly asked to trust in emergence and not to "force" a theory on the data. The theory must fit the data to generate a theory properly grounded in data.

The data gathered for this study consist of interviews and observations of recovering addicts and clinicians, and secondary analysis of personal stories from recovering addicts contained in 12-step fellowship printed and online literature of the Alcoholic anonymous (AA) (2001), Narcotics Anonymous (NA) (2008), Marijuana Anonymous (MA) (2001), Gamblers Anonymous (GA) (2007), Sex Addicts Anonymous (SAA) (2005), Co-dependents Anonymous (CODA) (2009), Al-Anon Support Group (Al-anon) (n.d.), Overeaters Anonymous (OA) (n.d., 2013, 2016), Emotions Anonymous (EA) (n.d.), and Emotional Health Anonymous (EHA) (2012) fellowships. Data of personal stories from a diverse group of fellowship were sampled because data show that addicts have multiple addictive and obsessive behaviors. An addict attends different fellowships to overcome specific problems helped by a respective 12-step fellowship.

Interview and observation data were collected directly from the participants by being in their recovery program. Participants were from two sites: (1) a private addiction recovery center that uses 12-steps as the main recovery program, and (2) a public mandatory addiction recovery center that has a 12-steps component as part of its program. Clinical meetings and group sessions were attended to obtain observation data. Individual participants were interviewed to get more clarification of behaviors and comments made during those sessions. Where applicable, when a participant was not able to provide clarification of his or her comments and behavior due to his or her language inability and/or refusal to comment, an experienced participant was sought via email to acquire the needed clarification. These email communications and field notes from the interviews and observations were coded and analyzed using the constant comparison method. The experienced participant who was sought had also proposed a study of 12-step fellowship literatures because they contain data that could answer many of the researcher's interview questions. By using secondary data, i.e., personal stories of addicts contained in the literature, the researcher could complete the study as he found that it was increasingly challenging to acquire more data from participants who are limited by their openness and lacked experience in recovery to provide diverse and extensive data for the study.

These personal stories were collected by the fellowships to share pertinent experiences of addiction and recovery to other people who want to embark on the recovery journey. Thus, these stories are good resource for data to generate a theory. These stories were coded and compared with the interview and observation data. Generally, these stories have two parts. The first part is the story of the recovering addict's addiction and the latter, his or her recovery journey. To date, these stories have not been analyzed using the grounded theory methodological procedures and thus, the stories provide vast opportunities for theorizing. The data from the personal stories helped to achieve theoretical completion. Statements made in these stories were useful to illustrate concepts contained in the theory.

Through theoretical sampling, constant comparison of data, and theoretical saturation, the main category of Pain Resolving and its sub-categories and properties

emerged. The theory is to be judged by its outcome (Glaser, 1998) and evaluated based on fit, workability, relevance, and modifiability.

A Theory of Pain Resolving

Pain is the main concern by most addicts during their addiction and recovery. They experience pain pervasively during their addiction and recovery. They resolve this main concern by pain resolving. As the core category, pain resolving has two sub-categories: (1) instantaneous pain relieving and (2) honesting. While addicts engage in instantaneous pain relieving to resolve pain in addiction, honesting is implemented as a strategy by them in the recovering process to resolve pain.

The next section of this paper discusses the following concepts: pain (as the main concern of the addict), pain resolving (the core category, as how the main concern is resolved), instantaneous pain relieving, honesting, and recovering process.

Pain as the main concern of addicts

Pain is the overall distress that addicts experience in addiction and the recovery process. It includes emotional pain and physical and mental distress.

Pain is largely emotional. Emotional pain is an emotional distressful feeling that the addict encounter as a result of painful experiences in life. It is the "human psychological suffering" (Khantzian, 2003, para. 1) that the addict come across in life. These painful experiences are events of (1) abandonment, (2) rejection, (3) loss, (4) non-approval, (5) betrayal, (6) humiliation, (7) abuse, aggression, and punishment, (8) enforcement of rigid social expectations and beliefs, (9) enmeshment, and (10) controlling. These painful experiences are events caused by others. When these painful experiences are predominantly caused by an addict's parents and family members during his or her childhood, these events are non-nurturing and traumatic to the addict. An addict shares that by the age of 17 years, he was a victim of emotional, physical and sexual abuse, spiritual neglect, enmeshment with his mother and severe abandonment (CODA, 2012, p.372).

These painful experiences cause addicts to undergo emotional pain in the form of feelings of worthlessness throughout their life. These feelings are interconnected and consist of (1) feelings of inadequacy where they feel that they are not good enough, less than or different when compared with others; (2) feelings of un-belongingness where addicts feel that they are unable to fit in, unaccepted, unwanted, un-validated, un-respected and unloved by others; (3) feelings of insecurity where they feel unsafe and unprotected; (4) feelings of emptiness where they feel isolated, bored, alone, lifeless and purposeless; (5) feelings of low self-esteem where self-esteem is the "relational value in other's eyes" (Leary, 1999, p. 34); (6) feelings of hopelessness where they feel useless and desperate. Manifested from these feelings are (7) painful emotions. Common painful emotions are shame, fear, guilt, anger, resentment, anxiety, and depression. They experience an overlapping combination of these feelings and emotions when experiencing the painful experiences in their life and they strive to resolve these feelings. An addict shares: "I felt alone, worthless, hopeless and desperate. I ached for relief" (NA, 2008, p. 354).

While pain is largely emotional, substantial parts of the pain that the addict experiences are physical and mental distress. Physical and mental distress include hurting, diseasing, disabling, and debilitating physical and mental conditions that an addict experiences; they are physical and mental disabilities and diseases that include psychiatric illnesses listed on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, American Psychiatric Association, APA, 2013). These physical and mental disabilities and diseases may arise early or later in the addict's life or as a result of the addict engaging in instantaneous pain relieving. An addict shares: "Towards the end of my using, I was suffering from short-term memory loss, shortness of breath and headaches" (MA, 2001, p. 154). An addict shares: "The depression didn't go away. Instead it got much worse. I heard voices and saw people who weren't there The medical team said I was severely depressed and schizophrenic" (NA, 2008, p. 357). Addicts who experience physical and mental distress encounter physical pain along with emotional pain.

Pain resolving

Pain resolving is a basic social psychological process of becoming where the identity of addicts is formed based on the how they resolve their pain. This process of becoming is progressive over time as addicts resolve their pain and is consists of two inter-related stages: (1) instantaneous pain relieving through vicious cycling in gaining instant (immediate but temporary) pain relief in the form medication, reward, sense of worth and escape from the pain by obsessing over a combination of instant pain relievers. Engaging in instantaneous pain relieving is a natural tendency by addicts; and (2) honesting where addicts resolve their pain by facing it when they are in the recovering process. Honesting is a binary strategy where addicts are being honest by relating and belonging to their trusted-others. It is a long-term resolution for their pain; they free themselves progressively from instantaneous pain relieving. Progressing into this stage also means that the addict has embarked on the recovering process.

Instantaneous pain relieving and honesting account for the patterns of behavior in resolving pain when addicts are in addiction and recovering process respectively.

In Stage One, engaging in instantaneous pain relieving, addicts progressively become worthless people who increasingly (1) lose their freedom and are trapped in a vicious cycle; (2) experience pain in the form feelings of worthlessness especially hopelessness and desperation pervasively in their lives, (3) lose their will and purpose to live except for obsessing over a combination of instant pain relievers, finally choosing or ending-up dying to resolve their pain; (4) under-developed in maturity as pain is instant relieved rather than faced; (5) perceived by others as immature and socially rejected as he not able to "engage with the world from a place of worthiness" (Brown, 2012, p. 37) and is "disengaged from active participation in normal social networks" (Bigus, 1996, p. 15) as time passes.

In Stage Two, addicts are progressively becoming a fully-functioning person who gradually (1) "able to experience all of his feelings" (Rogers, 1963, p. 22) of pain; (2) uses pain as a catalyst for his or her continued development and maturity; (3) is empowered to live the good life; and (4) is perceived by others as mature and socially respected as they progress over time in implementing honesting in the recovering process as a long term resolution for their pain thereby freeing themselves from instantaneous pain relieving. The good life is a process of movement and not a fixed

state where it involves an increasing (1) openness to experience, (2) tendency to live fully in each moment, and (3) trust in themselves to arrive at the most satisfying behavior in each situation (Rogers, 1961).

Although there are many addicts who are trapped in instantaneous pain relieving, addicts progress to honesting when they experience a moment of clarity that arises when they hit bottom in their life and experience intense pain in the form of worthlessness, hopelessness, and desperation. They realize that instantaneous pain relieving did not work to resolve their pain but only bring them more pain. Thus, they implement honesting. An addict (MA, 2001) says:

The day finally came when I had a moment of clarity. I hope I never forget that day. I couldn't take it any more. I was sick and tired of being sick and tired. I just wanted the pain of everyday life to stop! I wanted my life to be so much more, but I had no idea how to achieve it. I cried out to my Higher Power that night to help me. (p. 148)

Instantaneous pain relieving

When addicts are engaging in instantaneous pain relieving they are vicious cycling in gaining instant (immediate but temporary) pain relief by obsessing over a combination of instant pain relievers. When addicts obsess over an instant pain reliever, they fixate on, crave for, pursue, and use the instant pain reliever. They preoccupy themselves with the instant pain reliever in extremes compulsively and impulsively, and disregard the adverse consequences of more pain that arise from continuing to obsess over the instant pain reliever (Smith and Seymour in Coombs, 2004; Coombs, 2004; Smith, & Seymour, 2004; and Carnes, Murray, & Charpentier, 2004).

Instant pain relief is gained in the form of immediate (1) medication for the pain, (2) reward, (3) a sense of self-worth, and (4) an escape from the pain.

It is natural tendency for addicts to engage often in instantaneous pain relieving to resolve their pain as the obsessing over instant pain relievers "is often more subtle and serendipitous" (Suh, 2008, p. 29).

In this section, vicious cycling, obsessing over a combination of instant pain relievers, and instant pain relief are discussed.

Vicious cycling

When an addict is vicious cycling in gaining instant (immediate but temporary) pain relief, the following circular trajectories are observed (1) reprising of pain, (2) amplifying causal looping between obsessing over a combination of instant pain relievers and pain, (3) downward spiraling, and (4) intergenerational and social transmitting.

Reprising of pain arises because painful experiences are re-enacted when addicts obsess over a combination of instant pain relievers. Their lives revolve around their painful experiences, pain, and obsessing over a combination of instant pain relievers to gain instant relief in the form of temporary and immediate medication, reward, sense of worth, and escape from their pain. An addict states: "Day after day the same sad reality of living with a disease that wanted to kill me, and torture for those who had the misfortune to be part of my life" (NA, 2008, p. 327).

Amplifying causal looping between obsessing over a combination of instant pain relievers and pain is observed when the wearing-out of the immediate but temporary effect of the obsessing over instant pain relievers leads addicts to amplified pain. An addict shares: "you see, it was very short time after started using, that alcohol and drugs quit doing what they did in the beginning. The fear had returned, only much worse than before" (NA, 2008, p. 129). Thus, addicts have to continue obsessing over a combination of instant pain relievers in an increased fashion to relieve their amplified pain. The increased obsessing characterizes tolerance where addicts "require increasing amounts [of instant pain relievers] to achieve the desired effect" (Coombs, 2004, p. xiii).

An addict shares as follows: "My feelings of anger, resentment, and hatred fueled by justification for using more and more" (NA, 2008, p. 209).

Downward spiraling consists of the deterioration of addicts as time passes where they gradually lose attributes that they value in life and the control of their lives. When they lose these attributes, they lose those that determine their self-esteem. Relationships and acceptance of others is a major esteemed attribute among others. An alcoholic shares: "I went from being a solid A student to nearly flunking out of school, from being anointed a class leader to being shunned as a pariah" (AA, 2001, p. 424).

In losing control of their lives, they fail to control their obsessing over instant pain relievers and end up being controlled by their obsessing behaviors. They live in an illusion of control where control is a paradox. A marijuana addict (MA, 2001) describes his experience as follows:

At the end, I was smoking to stop the craving. Even though smoking pot wasn't fun, I couldn't stop. I've heard that one of the meanings of the word addiction is slavery, and I was truly a slave to marijuana. (p. 117)

Losing attributes that they value in life and the control of their lives cause addicts to experience more pain in the form of worthlessness especially hopelessness and desperation that lead them to lose their will to live.

Intergenerational and social transmitting occurs through learning where addicts develop their obsessing over instant pain relievers by modelling, exposing, and responding to others' obsessions over instant pain relievers and the painful experiences that are caused by other people on them throughout their lives. Such "other people" are those with whom addicts have close, intimate, and social contact. An addict shares: "I grew up the oldest child in an alcoholic family" (CODA, 2012, p. 273). Another addict (CODA, 2012) shares as follows:

I learned it was more important to please my parents than to express my feelings I was subjected to systematic beatings, public humiliation, unmerciful criticisms and constant intimidation. I grew up in confusion and terror, tension and fear became a way of life. (p. 545)

In turn, due to their obsessing over instant pain relievers, addicts enact painful events and pain of people around them (especially their children and family members).

Instant pain relief

Obsessing over a combination of instant pain relievers provide relief to addicts in the form of medication for the pain. When pain is medicated, it is numbed, deprived, coped, ameliorated, compensated and made tolerable (Khantzian, 2003; Suh, Ruffins, Robin, Albanese & Khantzian; 2008, Khantzian & Albanese, 2008; Carnes, Murray & Charpentier, 2004; & Coombs, 2004). An addict shares: "If I get rejected, left out, treated as second best, or am not wanted in some way, the pain can become acute. I used to medicate this pain with drugs" (NA, 2008, p. 221).

Instant pain relief in the form of reward is the savoring of excitement, pleasure and achievement. A marijuana addict shares: "I thought it was delicious. My head felt light and I began to giggle" (MA, 2001, p. 189). Another addict shares:

Relief came at the ripe old age of sixteen in the form of alcohol at a dance. Immediately my fear of girls was gone. My two left feet disappeared, and I knew exactly when and where to lay my newfound wisdom of people. (NA, 2008, p. 136)

Instant pain relief also comes in the form of sense of self-worth that is false; it consists of a false sense of adequacy, belongingness, security, self-esteem, wholeness and purpose, and hope. An addict clarifies:

I felt more confident, more popular, and less worried about what people think of me. My inhibitions melted away and I felt I could be who I wanted to be, that I fit into the world and somehow belonged. Music sounded better and women were more attracted to me. (MA, 2001, p. 127)

And finally, instant pain relief is in the form of escape from pain. Here, escape is a negative reinforcement to respond to an on-going state of distress (Duncan in Achalu, 2002). An addict shares: "I didn't want to deal with those feelings that had come up. I felt too vulnerable, and once again I was looking for a way out" (SAA, 2005, p. 219).

Obsessing over a combination of instant pain relievers

Instant pain relievers are "objects of obsession" (NA, 2008, p. 270) to addicts. As objects of obsessions they are "entities that are capable of stimulating a person" (Alavi, Jannatifard, Eslami, Alaghemandan, & Setare, 2011, p. 290).

The combination of instant pain relievers that addicts obsess over are interconnected and they are (1) addictive substances, (2) activity, (3) people and relationships, (4) self-importance, (5) perfection, (6) irrationality (7) denial, (8) deception, (9) avoidance, (10) aggression, (11) fantasy, (12) control, and (13) death.

The obsessing over a combination of instant pain relievers is self-organizing where its mix grows and adjusts gradually over time according to level of pain experienced by the addict. It portrays the multiple addictions that addicts have. An addict shares that her life is consists of many addictions and self-destructive behaviors that forms her multi-faceted addiction (CODA, 2012).

The self-organizing nature of obsessing over a combination of instant pain relievers is brought to life where the addict takes on the interconnected processes of experimenting and taking risks in adding and substituting the obsessing over an instant pain reliever to experience instant relief as pain level changes. The instant pain relievers that were added and substituted could be of similar or different types.

When the addict is experimenting and taking risks in adding, he or she is (1) simultaneously increasing (Carnes, Murray, & Charpentier, 2004) the obsessing over two

or more instant pain relievers, (2) combining, (3) intensifying i.e. accelerating, augmenting or refining, (4) masking, and (5) mediating (Carnes, Murray, & Charpentier, 2004) the obsessing over one instant pain reliever with another one, and (6) ritualizing (Carnes, Murray, & Charpentier, 2004) the obsessing over one or more instant pain relievers as a prelude to another one.

However, when the addict experimenting and taking risks is substituting, the addict is (1) replacing, (2) disinhibiting or lowering the inhibition of, or (3) inhibiting or deterring (Carnes, Murray, & Charpentier, 2004) obsessing over one instant pain reliever with another one.

Experimenting and taking risks in adding and substituting are acts of reinforcement where the addict obsesses over one instant pain reliever and reinforces the obsession over an instant pain reliever of a similar or different type. The functional analysis (Ramnero, & Torneke, 2008) of this reinforcement is that when the addict experiences pain as the antecedent (A), he or she obsesses over an instant pain reliever as a behavioral (B) response; the consequence (C) of this behavior is temporary pain relief. When the pain returns and often amplified with other painful experiences, this pain, in turn, will be an antecedent for the behavior of obsessing over another or similar instant pain reliever. This process repeats; with each repetition, the obsession over a combination of instant pain relievers grows and adjusts; pain increases thus leading the addict to vicious cycle.

This addict (NA, 2008) shares:

As I got older, my feelings of discomfort and isolation kept getting stronger. My ability to belong was a source of some of my most painful feelings. I couldn't find anyone to feel comfortable and close with. I did anything to get attention or approval from others. Sometimes I was loud and active; at times I was very quiet, I kept looking for a place to belong.... I started smoking cigarettes when I was sixteen and kept wanting to try new things. While I was attending college, I decided to get married to fill the hole that I felt inside me. In my second year of marriage, my daughter was born. My feelings of loneliness followed me into adulthood. I kept looking for new things to fill my emptiness. Every time I found something new I thought it would fix me. However, anything that I tried kept my interest only for a short while and eventually led to more problems and headaches. On the surface I seemed to have a good comfortable life, but on the inside I was ready to explode. I found drugs when I was twenty-eight. (p. 368)

Honesting

Honesting is a binary life-long and lifestyle-based strategy that most addicts carry out to face pain when they are in the recovering process as a long-term resolution for their pain; it frees themselves progressively from instantaneous pain relieving. Facing pain includes embracing, moving and living through it and taking a moment at a time to allow it to pass. An addict shares: "the only way to live is to walk through fear" (NA, 2008, p. 324). Addicts consciously and continuously work on themselves to implement honesting in their recovering process because it is natural tendency to engage into instantaneous pain relieving when they experience pain.

Honesting involves addicts being honest by relating and belonging to trusted-others. By relating and belonging to trusted-others, the addict is empowered in being honest. An addict shares: "I am empowered" (CODA, 2012, p. 248). This empowerment is in the form of support, guidance, belongingness, hope, and sanity.

Trusted-others are interconnected external trustworthy entities with whom addicts trust in being honest. They are a trusted person, group, and personal Higher Power. An addict shares: "I needed to trust something outside of me" (NA, 2008, p. 387). A trusted person is an individual that has the experience and expertise in empowering the addict in being honest. A trusted group consists of people who collectively empower the addict to be honest. They often consist of people who implement honesting and are in the recovering process themselves. A trusted personal Higher Power is a spiritual entity that is considered greater and better than the addicts based on their personal understanding. Many addicts commonly understand their personal Higher Power as a deity, while some addicts may regard spirituality, or extend their trusted group that embodies this spirituality as their personal Higher Power.

Trusted-others have specific characteristics that make them able to empower the addict in being honest. These characteristics are as follows: (1) love, and compassion which is a "deliberate commitment to pursue the welfare and best interest" (Miller & Rollnick, 2012, p. 43) of the addict; (2) unconditional acceptance which is the basic and warm acceptance (Rogers, 1957) towards the addict, (3) peace and joy that the addict wants, (4) more superior ability (that is knowledge and skills) than the addict and experience with which the addict could identify, and (5) honesty, which is genuineness and accuracy in representation (Rogers, 1957) to help the addict.

In this section, being honest, and relating and belonging to trusted-others are discussed.

Being honest

Being honest is a continuous process of capturing a moment at a time to gain clarity and be real with the empowerment of trusted-others.

In gaining clarity, addicts obtain a moment of clarity in the form of insight that their pain is largely due to their own obsessing over a combination of instant pain relievers with the empowerment of their trusted-others. An addict (NA, 2008) shares how a trusted-other empowers him in capturing his moment of clarity:

Our next meeting was very productive. He asked me: 'What are your feelings from the work you have done?' I said: 'I am not only just a drug addict. I have an addictive personality. My sexual life has the same symptoms of addiction as when I use drugs'. (p. 346)

Gaining clarity can be sudden or gradual. An addict (NA, 2008) shares:

Some people experience recovery like a lightning bolt: a sudden flash of understanding and clarity, an immediate lifting of desire to use. The effect of the program on me was more like rain or wind, gradually eroding my false beliefs. (p. 289)

When addicts are being real, they are empowered (1) to express themselves authentically, (2) to admit and accept the painful truths in their life, and (3) to take action and responsibility by their trusted-others.

In being real, addicts are empowered to express themselves authentically when they share their feelings openly with their trusted-others. An addict shares: "I was dumped, and instead of dwelling on the rejection, I took inventory. I shared and shared" (MA, 2010, p. 363). They are being themselves as they do not need to hide their feelings. It is "to be that self which one truly is" (Kierkegaard in Rogers, 1961, p. 166).

They are empowered to admit and accept the painful truths in their life because they do it in the presence of their trusted-others. An addict shares: "I went to a meeting in the morning and shared directly about my recent experience, and exposed the dark secrets of my shame to the light of recovery before a group of men" (NA, 2008, p. 354). Addicts admit and accept the painful truth in their lives especially their imperfections, inability to control to obtain their desired outcomes, and "the label" (Bigus, 1996, p. 17) of an addict. Acceptance is important in instituting change. Carl Rogers stated: "The curious paradox is that when I accept myself just as I am, then I can change" ("Revisiting Carl Rogers Theory of Personality", 2015, para. 1).

Addicts are empowered to take action and act responsibility. They take action by allowing themselves to be vulnerable, where vulnerability is "uncertainty, risk and emotional exposure" (Brown, 2012, p. 40); they take risks to be honest with the empowerment of their trusted-others. Next, they are empowered to take responsibility for their actions by making amends by apologizing and correcting his future behavior with the empowerment of their trusted-others. When they make amends, they mend their relationships with others. An addict (NA, 2008) shares how he was guided to make amends to mend his relationships with her family members:

I quickly went over my Ninth Step work with my sponsor so that I would be able to make amends to my mother, stepfather, brother, and sister-in-law all in one week. They all said the only amends I could make for them was to stay clean. (p. 280)

Relating and belonging to trusted-others

Relating and belonging to trusted-others consists of the following interconnected actions: (1) seeking help, (2) learning from trusted-others, (3) letting-go in their presence, (4) getting involved, and (5) staying open (which includes staying open-minded, aware, present, spontaneous, willing, humble, reachable and teachable) with trusted-others. These actions are social processes that benefit the addict (Timko, Halvorson, Kong, & Moos, 2015). A cyclic trust process can be observed when the addict is relating and belonging to trusted others.

The cyclic trust process in relating and belonging to trusted-others

When relating and belonging to trusted-others, most addicts go through a cyclic trust process that develops, progresses, and repeats as time passes. The process repeats when addicts relate and belong to new trusted-others in being honest to resolve their pain. The cyclic trust process has four inter-related stages: Denying, Accepting, Discovering, and Trusting.

At the denying stage, addicts resist and doubt the relevance of the trusted-others to their recovery. An addict shares: "it was hard for me to see how they applied to my situation. I was terminally unique" (CODA, 2012, p. 538). Another addict shares: "These people were not like me How could I relate to them?" (NA, 2008, p. 300). Addicts most often resist in relating and belonging to their personal Higher Power. This resistance is due to their (1) self-will or the illusion that they are in control, (2) blame of the Higher Power for causing their pain, (3) the belief that the Higher Power is judgmental and punishing, or (4) not believing in a Higher Power. The addict's trusted person or group helps him to relate and belong with his personal Higher Power which is his ultimate empower-er. An addict (CODA, 2012) shares: "My sponsor was wise in guiding me toward reliance on my permanent sponsor, God" (p. 419).

Next, at the accepting stage, addicts accept the relevance of the trusted-other out of no other choice. An addict shares: "This was not the place for me to step back in and try to figure out the 'hows' of God's work" (CODA, 2012, p. 541). They decide to accept the trusted-other as they are in a lot of pain. An addict shares: "I felt extreme emotion. I didn't want to go back but I knew I had to" (CODA, 2012, p. 513). Another addict shares: "I was hurting so much I was willing to do anything" (NA, 2008, p. 321).

At the discovering stage, addicts search, find-out, and experience the relevance of the trusted other with their recovery. An addict shares: "I started to hear, and started to have some hope, and started to laugh, and started to understand a little bit, and started to want to live" (NA, 2008, p. 328).

Finally, at the trusting stage, they build and have faith in the trusted-other because they are gaining their life and peace in through the empowerment of the trusted-other. An addict (NA, 2008):

For the same reason I didn't panic like I used to. Instead I took a deep breath and looked for a new position in the corporation. Out of the blue I was offered a better position. The miracle of that ordeal was not the last-minute job offer but the calm response so unusual for me. It was the first sign of my growing faith. (p. 268)

Recovering Process

By implementing honesting, the addicts are grounded in reality and thus are recovering. An addict shares: "I have to stay honest, for that's the way I stay clean" (NA, 2008, p.133).

Recovering is a two-fold, life-long progress-based process where addicts take a moment at a time, staying clean and going beyond. Recovering is asymptotic and a continuous process where addicts could only do the best they could at any point of time. Thus, they focus on progress and not a perfect outcome. An addict shares: "there is no end to the process, so there's no need to hurry" (NA, 2008, p. 288).

Staying clean and going beyond are interrelated process steps; they reinforce each other.

In staying clean, addicts make a choice to abstain from obsessing over their combination of instant pain reliever, and maintain their abstinence. Recovery is not a matter of cutting down, but a matter of stopping all together (Bigus, 1996) the obsessing over instant pain relievers. An addict shares: "What keeps us clean is the choice that each of us makes not to pick up and to live this way of life to the best of our ability" (NA, 2008, p. 276). Thus, addicts gain clean time and find their obsession over instant pain relievers diminish as time passes with the progress of their implementation of honesting. An addict shares: "I have not used, binged, purged, or self-mutilated for the fifteen years I have been in NA. I have not, since that early suicide attempt, heard voices" (NA, 2008, p. 363).

Going beyond consists of (1) continuously working on self, (2) gaining life and peace, (3) being grateful, and (4) impacting others. They are interconnected. However, they are distinguished as follows:

In continuously working on self, addicts work on their development (which includes personal growth, transformation, maturity, and self-discovery) by implementing honesting in all facets of their life to discover what they lack thus leading them to learn new professional, intrapersonal, and interpersonal skills to resolve their issues and heal themselves. An addict shares: "I have discovered so much about myself" (NA, 2008, p. 238).

In gaining life, they gain attributes that they value in life that determine their self-esteem. Relationships and acceptance of others is a major attribute among others that they gain. An addict shares: "I had earned the respect of my fellow NA members and the community. I even had a soul mate, a wonderful lady who was clean in NA. I was living life" (NA, 2008, p. 257). Addicts gain relationships by acquiring new relationships, regaining lost ones, and accepting that some relationships could not be regained.

Most of all they gain peace while still facing pain. Peace is the feeling of "worthiness" (Brown, 2012, p. 65)—an accurate sense of adequacy, security, belongingness, wholeness and purpose, and hope. Peace is experienced and expressed spiritually, intrinsically and extrinsically. An addict shares: "Given the reality that I will face severe illness each day, and still being able to stay clean, that's an incredible miracle! Spiritually, I'm in a state of grace" (NA, 2008, p. 260).

In being grateful, addicts are thankful for gaining life and peace from the empowerment to be honest that they gained from relating and belonging to their trusted-others. An addict (NA, 2008) shares:

I'm alive because of NA has blessed me with a clean life. Recovery makes it possible for me to treasure the moments when I have a serene heart, and to be grateful for the miracles, large and small, happening around me. (p. 260)

Being grateful, the addict impacts others by taking on the role of a trusted-other and giving back to other addicts and other people outside of the community of addicts. An addict shares about that he is able to give back to his daughter because he received it from his fellowship (NA, 2008, p. 388). By impacting others, addicts participate in a virtuous cycle where they benefit not only the life of others but also their own when they benefit others.

However, when addicts are in the recovering process, regressing and relapsing are common. Bigus (1996) observed that "recovery plans are usually doomed to failure" (p. 19). When addicts regress and relapse, they re-engage in instantaneous pain relieving. Regressing and relapsing happen for the following interconnected reasons: (1) addicts experience pain, (2) recovering is not prioritized by addicts, and (3) stopping to work on themselves by implementing honesting because of complacency is not prioritized. Most addicts return to honesting to return to the recovering process.

Limitation of Study

Data collected are from rehabilitation centers that have the 12-steps as the main ingredient or a component in their recovery program, and from secondary data available

from printed and online literature from 12-steps fellowships. Data from participants and secondary data from non 12-steps groups or organizations, such as therapeutic communities (TC's), sober houses, half-way houses, and other self-help groups such as the SMART Recovery (Self-management for Addiction Recovery) group, were not included in this study due to constraints of time, availability, and the researcher's knowledge about the organization.

Implication of Study

This grounded theory on substance addiction and recovery can be used by addicts to understand themselves better with the assistance of a mental health professional. Mental health professionals could focus on the main concerns that matters to addicts easily with the concepts that were generated from this theory. These concepts serve as guideposts for mental health professionals in treating addicts. Misdirection of issues by mental health professionals during treatment and interventions could be reduced and avoided.

Conclusion

Together with the medical or disease model, this grounded theory on pain resolving can be used to implement intervention programs for addicts. Mental health professionals will be able to focus on the main concerns and issues of addicts with guidance of this grounded theory thus reducing and avoiding misdirection of issues in treatment and interventions.

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