

In the Rooms vs Around the Rooms

Deep Dives · The Recovery Files

From Peripheral Presence to Active Participation

3 Readings

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In this workbook

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Each reading is followed by its check-in questions and exercises, in the same order as the app. Your scored results are shown in the app.

PART 1 OF 3 · READING

The Two Circles: Understanding Peripheral vs Engaged Presence

Picture two concentric circles. The outer circle represents "around the rooms"—physical presence without emotional engagement. The inner circle represents "in the rooms"—genuine participation, authentic connection, and active membership in the recovery community.

Both circles exist in the same physical space. Both attend the same meetings, sit in the same chairs, hear the same messages. But the experience and the outcomes are entirely different.

****Around the Rooms:****

People who are "around the rooms" show up, but they don't participate. They sit in the back. They arrive late, leave early, or both. They don't share, don't exchange phone numbers, don't socialize before or after. They keep their recovery at arm's length—doing the minimum required to maintain the appearance of engagement without the risk of actual connection.

This is not a moral failing. It's a protective pattern. Around the rooms feels safer—you can claim you're "doing recovery" without the vulnerability of being truly seen. You can avoid the discomfort of authentic sharing. You can maintain the illusion of control.

But around the rooms is also lonely. It's passive. And over time, it becomes insufficient to sustain recovery through the inevitable challenges, triggers, and life stressors that will come.

****In the Rooms:****

People who are "in the rooms" are active participants. They arrive early, stay late. They share honestly about their struggles and victories. They build relationships with others in recovery. They exchange phone numbers and actually use them. They volunteer for commitments. They sponsor or get sponsored. They show up not just physically, but emotionally, mentally, and spiritually.

In the rooms doesn't mean being perfect at recovery or never struggling. It means being present, honest, and engaged with the process and the people. It means treating recovery community as real community rather than a service you're consuming.

The distinction matters because recovery outcomes are dramatically different between these two circles. Research on mutual support groups consistently shows that active participation (sharing, connecting, volunteering, sponsoring) predicts better long-term outcomes than passive attendance.

****Why the Difference?:****

Recovery is fundamentally relational. Addiction is a disease of isolation and disconnection. You cannot heal isolation with more isolation. Showing up physically while remaining emotionally distant is still a form of isolation—you're in a room full of people, but you're alone.

In the rooms requires risk. It requires vulnerability. It requires the courage to be seen, to be known, to be imperfect in front of others. But that risk is also the path to the connection, the

belonging, and the accountability that make sustained recovery possible.

The question isn't whether you should move from around to in—it's what's keeping you on the periphery, and what would it take to cross that boundary.

Reflection Questions

1. Honestly assess: Are you currently around the rooms or in the rooms? What evidence supports your answer?

2. What does being "around" protect you from? What does it cost you?

3. What would "in the rooms" specifically look like for you? What would change about your recovery participation?

CHECK YOURSELF · CHECK-IN 1 OF 4

Physical Presence Patterns

Scale: 1 = Not at all · 2 = A little · 3 = Somewhat · 4 = Quite a bit · 5 = Very much

1. I attend meetings but sit in the back and leave quickly

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. I arrive late and/or leave early to minimize interaction time

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. I position myself where I won't be called on or noticed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. I check my phone or mentally disengage during meetings

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. I attend the minimum meetings required but no more

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

6. I treat meetings as a checkbox obligation rather than genuine engagement

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

CHECK YOURSELF · CHECK-IN 2 OF 4**Connection & Participation**

Scale: 1 = Not at all · 2 = A little · 3 = Somewhat · 4 = Quite a bit · 5 = Very much

1. I rarely share in meetings, even when I have something to say
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
2. I don't have recovery friends I connect with outside of meetings
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
3. I haven't exchanged phone numbers with anyone or I don't use the numbers I have
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
4. I decline social invitations related to recovery (coffee, dinner, events)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
5. I keep my sharing surface-level and avoid real vulnerability
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
6. I don't have a sponsor or I rarely contact the one I have
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
7. I view others in recovery as acquaintances, not real connections
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

YOUR EXERCISE**Current Presence Assessment****Current Presence Assessment**

1. Describe your typical meeting experience. Where do you sit? When do you arrive and leave? Do you talk to anyone before or after?

2. How often do you share in meetings? When you do share, how honest and vulnerable are you?

3. Do you have recovery friendships—people you connect with outside of meetings? How many? How deep are those connections?

4. On a scale of 1-10, how "in the rooms" are you currently? What would it take to move that number up by 2 points?

PART 2 OF 3 · READING

The Neuroscience of Connection in Recovery

The human brain is wired for connection. This is not metaphor—it's biology. Research in social neuroscience demonstrates that our brains contain dedicated neural circuitry for processing social connection, and that activation of this circuitry is essential for both physical and mental health.

Dr. Matthew Lieberman's research at UCLA has shown that social pain (rejection, exclusion, isolation) activates the same neural regions as physical pain—the dorsal anterior cingulate cortex and the anterior insula. The brain doesn't distinguish between physical and social pain. When you're isolated, your brain experiences it as a threat to survival.

For people in recovery, this has specific implications. Addiction itself is neurobiologically an isolation disorder—it hijacks the brain's reward system and makes the substance the primary source of dopamine, gradually eroding the motivation to seek connection with others. Recovery requires reversing this process—rewiring the brain to find reward, safety, and meaning in human connection rather than in substances.

****The Oxytocin Connection:****

When you engage authentically with others—when you share vulnerably, receive support, offer support to someone else—your brain releases oxytocin. This neurochemical does several things simultaneously: it reduces stress (by dampening the HPA axis), increases feelings of trust and bonding, and activates the brain's reward circuitry.

In other words, authentic connection literally feels rewarding at a neurological level. The brain is designed to seek it, just as it's designed to seek food, safety, and other survival necessities.

But here's the catch: peripheral presence doesn't activate this system. Sitting silently in the back of a meeting, listening without sharing, attending without connecting—this produces minimal oxytocin release. Your brain doesn't interpret passive attendance as genuine social connection.

****Why Vulnerability Matters:****

Research on self-disclosure shows that the act of sharing personal, emotionally vulnerable information activates the brain's reward system. Vulnerability is not just psychologically beneficial—it's neurochemically rewarding. When you share honestly in a meeting and receive acceptance rather than judgment, your brain gets flooded with positive neurochemical feedback.

Over time, with repeated experiences of vulnerability leading to connection rather than rejection, your brain rewires. The fear circuitry (amygdala activation in response to social risk) gradually quiets. The reward circuitry strengthens. Sharing becomes easier. Connection becomes more natural.

****The Default Mode Network:****

When you're isolated and ruminating—around the rooms but not in—your brain's default mode network is hyperactive. This network is associated with self-referential thinking, often in a negative, ruminative pattern. "I'm different. I don't belong. People wouldn't understand. I'm too

broken for real connection."

Active engagement interrupts this pattern. When you're genuinely connecting with others, the default mode network quiets and the social cognition network activates. The focus shifts from internal rumination to external attunement. The shame-and-isolation loop gets disrupted at a neural level.

The bottom line: your brain needs genuine connection to sustain recovery. Around the rooms doesn't provide it. In the rooms does.

Reflection Questions

1. Has your brain been receiving the neurochemical benefits of genuine connection, or have you been in isolation mode even while attending meetings?

2. When was the last time you experienced the "reward" of authentic sharing or connection in recovery? What did that feel like?

3. What would need to shift for your brain to start associating recovery community with reward and safety rather than threat?

CHECK YOURSELF · CHECK-IN 3 OF 4

Emotional Engagement

Scale: 1 = Not at all · 2 = A little · 3 = Somewhat · 4 = Quite a bit · 5 = Very much

1. I can identify with others' stories and feel genuine connection to their experiences

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. I feel emotionally moved or impacted by what I hear in meetings

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. I care about the people in my recovery community beyond surface level

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. I celebrate others' milestones and feel genuinely happy for their progress

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. I feel a sense of belonging when I'm in recovery spaces

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

6. I miss meetings when I can't attend—I feel the absence of community

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

PART 3 OF 3 · READING

The Crossing: Moving From Around to In

The transition from around the rooms to in the rooms is not a single moment—it's a series of micro-decisions and small actions that, over time, shift your position from observer to participant, from isolated to connected.

****What the Crossing Requires:****

1. ****Deciding You Want It****

The first step is recognizing that around isn't enough. Maybe you've noticed that your recovery feels fragile. Maybe you've relapsed and realized isolation was part of the chain. Maybe you're just tired of feeling alone in a room full of people. The crossing begins when you acknowledge: I need more than I'm getting. I need to move closer.

2. ****Identifying What's Keeping You Out****

Fear. Shame. Pride. Perfectionism. Past hurt. Comparison. Social anxiety. Trauma responses. Everyone's barriers are different, but they're all rooted in one core belief: "It's not safe to be fully seen here."

The work is identifying your specific barriers and understanding that they are protective mechanisms—your brain trying to keep you safe based on past experience. They're not character flaws. They're patterns that made sense once but may no longer serve you.

3. ****Starting Small****

You don't have to go from silent observer to meeting chair overnight. The crossing happens in increments.

Micro-actions for moving in:

- Arrive 5 minutes early, stay 5 minutes late
- Make eye contact and say hello to one person
- Introduce yourself to someone new
- Share once this week, even if it's brief
- Ask for someone's phone number
- Accept an invitation to coffee
- Volunteer for a simple meeting commitment (making coffee, greeting newcomers)
- Reach out to someone between meetings

Each of these actions is a small crossing. Each one rewires your brain's social circuitry a little more.

4. ****Practicing Imperfect Authenticity****

In the rooms doesn't require you to be perfectly articulate, to have everything figured out, or to share your deepest trauma on day one. It requires showing up as you actually are—struggling, uncertain, imperfect, human.

The people most deeply "in" the rooms are not the ones who have perfect recovery. They're the ones who show up honestly with whatever they're carrying that day.

5. ****Building Reciprocal Relationships****

Around the rooms treats recovery as a service you're consuming. In the rooms recognizes recovery as a community you're co-creating. This means not just receiving support but offering it. Checking in on someone who shared something hard. Welcoming a newcomer. Sharing your experience with someone who needs to hear it.

The crossing is complete when you stop seeing yourself as separate from the community and start seeing yourself as part of it. When "they" becomes "we." When the rooms feel like home rather than obligation.

****What Changes:****

When you cross from around to in, several things shift:

Your recovery becomes less fragile. You have multiple connection points rather than relying on solitary willpower.

Your sense of belonging increases. You're not just a person who attends recovery—you're a member of a community.

Your honesty deepens. When you feel safe, you share what you're actually struggling with rather than performing a version of recovery.

Your growth accelerates. In the rooms, you're exposed to new perspectives, new tools, new ways of thinking about recovery and life.

Your service becomes natural. You stop asking "What can I get from recovery?" and start asking "What can I give?"

The crossing is not a one-time event. You will drift back toward the periphery sometimes—during stress, shame, or complacency. The work is noticing the drift and choosing to move back in.

Reflection Questions

1. What specific barrier is keeping you from moving more "in the rooms"? Fear? Shame? Pride? Past hurt? Something else?

2. Choose three micro-actions from the list. Which ones feel doable this week? What would it take to actually do them?

3. Imagine yourself fully "in the rooms"—actively participating, connected, engaged. What does your recovery look like? How does it feel different from now?

4. Who is someone currently "in the rooms" that you admire? What do they do differently that you could model?

CHECK YOURSELF · CHECK-IN 4 OF 4

Barriers to Connection

Scale: 1 = Not at all · 2 = A little · 3 = Somewhat · 4 = Quite a bit · 5 = Very much

1. Fear of judgment keeps me from being fully honest

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. I don't feel "recovery enough" to fully participate

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. I compare myself to others and feel like I don't measure up

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. Past rejection or criticism in recovery spaces makes me guarded

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. I don't trust that people actually want to connect with me

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

6. I fear being seen as needy, broken, or too much if I'm authentic

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

7. Shame about my past keeps me from showing up fully

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

YOUR EXERCISE

Barrier Identification & Analysis

Barrier Identification & Analysis

1. What specific fear keeps you from sharing more openly in meetings?

2. What past experience (in recovery or elsewhere) taught you that vulnerability is unsafe?

3. How does shame show up as a barrier to connection? What does it tell you about yourself?

4. What does pride tell you about needing people vs being self-sufficient?

5. If these barriers disappeared tomorrow, what would you do differently in your recovery community?

YOUR EXERCISE

Micro-Actions for Connection

Micro-Actions for Connection

1. This week, I will arrive ____ minutes early to meetings and use that time to ____.

2. I will introduce myself to one new person and ____.

3. I will share at least once this week about ____.

4. I will exchange phone numbers with ____ and follow up within 48 hours.

5. I will volunteer for this meeting commitment: ____.

6. After completing these actions, how did they feel? What shifted?

YOUR EXERCISE

30-Day In the Rooms Action Plan

30-Day In the Rooms Action Plan

1. My specific goal for the next 30 days is to move from ____ (current state) to ____ (desired state).

2. The three most important actions I will take are:

3. The biggest barrier I anticipate is _____. My plan to navigate it is _____.

4. I will know I'm succeeding when _____.

5. My accountability partner for this plan is _____. I will check in with them weekly.

6. After 30 days, I will assess my progress by _____.
