A SOCIOLOGICAL UNDERSTANDING OF PEER-LED SUPPORT GROUPS ON UNIVERSITY CAMPUSES

by

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This research takes an inductive look into the ways in which participants in peer-led support groups on university campuses, specifically those geared towards recovery from mental health conditions, interact socially with each other. Using data from open-ended surveys and interviews, I explored how individuals learn to interact in these supportive environments, as well as how language, norms, and personal identity impact their experiences. University students are at a life stage filled with change, and they experience drinking and party culture differently from most other communities. Previous research on peer-led support groups has primarily focused on the efficacy and measurable outcomes of support groups (Pointon-Haas et al. 2024; Pistrang, Barker, and Humphreys 2008), but this research broadens the understanding of these mutual aid groups and assists in identifying the complex factors that contribute to whether these groups are helpful, and in what ways they allow for recovery and connection. I found that recovery is a process where both individuals and groups work together to form a shared understanding of what recovery looks like for them. Through finding one's own path through recovery, discussions around norms and violations, navigating different identities, and creating relationships with peers and staff, peer-led support groups develop a common idea of recovery.

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Introduction

In late 18th century France, psychologists started to approach mental health care through a more individualized lens and in the mid-1800s, the first peer-led support group was formed. It was a British organization called the Lunatic Friends' Society which was rooted in advocacy for former asylum patients (Shalaby & Agyapong 2020). In an age of increasing mental health awareness, communication via the Internet, and an emerging culture of empathy, peer-led support groups continue to be a key resource for those in recovery. Today, individuals can participate in support groups for topics ranging from grief to weight loss to addiction recovery. Although many groups are led by a trained professional, like a therapist or social worker, mutual aid support groups are led by a peer: someone who is dealing with the same issue as others in the group. This connection with the other members of the group places group facilitators on a more even level with the other group participants.

This research looked inductively into the ways in which participants of peer-led support groups, specifically those geared towards recovery from a mental illness or addiction, interact with each other. Although qualitative methods have often been used to analyze recovery resources and broad experiences, there is little information on how peer-led support groups specifically create meaning and establish relationships within the group. My research utilized a survey and interviews to focus on the ways in which group participants interact with each other and how dialogues, norms, and environments affect their experience. Furthermore, I analyzed how one's social positioning outside of the group compares to and complicates their position within the group. For example, if someone is talked over or minimized by others within a support group, they may have similar experiences in their daily life.

Data collection involved a survey distributed to over 100 university collegiate recovery programs (CRPs), which are university programs that offer recovery spaces on college campuses and are "designed to provide an educational opportunity alongside recovery supports" (ARHE 2026). I then conducted follow-up interviews with survey participants who provided contact information. Interviews with group members centered around their experiences in the group and how they interacted with their peers.

Previous research on peer-led support groups has primarily focused on its efficacy and measurable outcomes. This research broadens the understanding of these mutual aid groups and aids in identifying the complex factors that contribute to whether these groups are helpful and they ways in which they allow peers to build a shared understanding of recovery.

Theories that aid in the explanation of these processes include symbolic interactionism, and dramaturgy, specifically the concept of the looking glass self. These theories contribute to our understanding of how we view our place in society and the world at large. Social constructs, like race, gender, and class, as well as social processes are shaped by our interactions with others. Furthermore, our actions are only given meaning through the responses of others, which we internalize and learn through the process of socialization. For example, when individuals are perpetuating unwanted behaviors in a group, they may not be aware these behaviors are perceived negatively if others simply mimic the wanted behavior instead of correcting their peers. I also focused on how one creates meaning through intimate, interpersonal interactions. Communities attribute meaning to facial expressions or social roles and use that understanding to create a narrative around daily interactions (Halasz and Kaufman 2023). Groups, including support groups, create their own shared meanings that dictate how they interact with others and within the broader world.

This research aimed to answer the following questions: 1) What are the ways in which the structure of peer-led support groups and CRPs impact how support group participants interact? 2) How do support group participants' individual identities affect their interactions? 3) How do different dialogues, language, and norms affect group members' experiences? I found that recovery is both an individual and communal process as groups work to form a common idea of what it looks like within their group. Through finding one's own path through recovery, discussion norms and violations, navigating different identities, and creating relationships with peers and staff, peer-led support groups develop a shared understanding of what recovery means to them.

Literature Review

Defining Peer-led Groups and their Leaders

Although my research will use the term "peer-led," other research may consider these groups to be "mutual-aid," "mutual support," "self-help groups," or generally "support groups" (Pistrang, Barker, and Humphreys 2008). The definition of these groups is difficult to narrow down, but one key aspect is that control "rests with its members rather than an outside agency; and mutual, peer support is provided within the group" (Chaudhary, Avis, and Munn-Giddings 2013). These groups are egalitarian and are managed by group members. With this precedent, 'peer-led recovery support groups' are groups in which peers who experience the same condition participate in dialogue to foster narrative and emotional conversation with the goal of advancing in their recovery. These groups may have a designated facilitator, but there is no hierarchical power, and the facilitator also has personal experience coping with the focus issue of the group.

One reason that professionally trained facilitators are not always the preferred option for group leadership is that they can act like "a dog with a bone" (Mowat 2007). As opposed to being a space primarily for sharing experiences and emotions, professional support group leaders have their own expectations for a group's productivity (Mowat 2007). This hierarchy can ensure mutual respect and maintain a level of order, but it also may lead the group away from what members feel is most important for them to talk about. Additionally, professional and peer leaders may define a 'successful' group differently. Professional facilitators have reported frustration about not being able to help, while peers may be more concerned about whether participants are "sharing and caring" (Medvene, Wituk, and Luke 1999). Self-help group leaders don't need to be confined to only professional or peer roles; they can also be 'dual-status'. When asked about their motivations for leading a support group, 55% of the leaders surveyed in one

study said they were “feeling a need, or enjoying helping, or teaching others” (Medvene et al. 1999). Both single and dual-status leaders described a sense of satisfaction from helping others, as well as through their own self-disclosure (Medvene et al. 1999). This vulnerability also serves the function of eliciting trust from the participants, as they see the group leader as someone who understands their situations.

Considerations of Group Participation

As of now, there are mixed results on the clinical effectiveness of peer-led support groups, however there are still numerous factors why one would elect to participate in a support group, especially one led by others dealing with a shared condition. For example, Davison, Pennebaker, and Dickerson (2000) found that sources of anxiety and embarrassment can affect why some are more likely to participate. Anxiety is often a key part of why individuals seek treatment from group settings. Additionally, conditions that may be considered more embarrassing or socially stigmatizing, as opposed to more normalized conditions like heart disease, positively impact group involvement (Davison, Pennebaker, and Dickerson 2000).

Peer-led support groups also rely on a unique network of peer connections and social capital. Social capital is the positive impact of interpersonal relationships in “facilitating trust, cooperation, and collective support” (Jason et al. 2020). The relationships formed within peer-led support groups can reshape our social experiences, while offering tangible support from others in that reformulation. One key factor in why individuals choose to stay within a particular recovery group is whether they are welcomed by the current group members (Jason et al. 2020). These interactions are crucial in forming social capital and reaping the benefits of peer-led groups. Additionally, peer-organized support groups provide spaces for those who find it difficult to ‘do being ordinary’ to connect with others experiencing the same condition (Hitzler 2024). Group

participants can address a shared topic, which may cause anxiety or embarrassment, in a safe space without needing to commit to a societally dictated idea of normal.

One reason why people choose to participate in peer support groups is because they are dealing with a condition viewed as "embarrassing, socially stigmatizing, or disfiguring" (Davison et al. 2000). Support groups act as a private environment where all participants hold a negotiated understanding of how living with a specific condition looks like. The stigma is lessened when all members in the group are in the same social position. We base our sense of self off of how we perceive others to view us – a concept described by the 'looking-glass self' (Vejar 2024). In peer-led support groups, when an individual feels like they are regarded as an equal, they perceive themselves as one, as well. However, especially for disorders that create competition and comparison between individuals, like eating disorders, being in an environment with others experiencing a similar condition can exacerbate these issues. Self-esteem, mood, and the type of relationship with someone in a group can impact whether one draws upward comparisons – comparing oneself to someone deemed superior –, downward comparisons – comparing oneself to someone deemed inferior–, or lateral comparisons–compared to a perceived equal (Barta, Wolberg, and Andalibi 2023). Lateral comparisons may draw on specific aspects of a shared experience, and as peer support groups include individuals with a variety of experiences, they are prime for upward and downward comparisons (Barta et al. 2023). Simply put, comparisons within the support group environment may cause feelings of isolation, however, they can still ultimately improve one's mental health through creating community and belonging (SAMHSA 2026). Furthermore, despite feelings of social marginalization, there is likely a "more complex interaction of illness, individual differences, and cultural norms" at play in group participation (Davison et al. 2000).

Identity and Support Groups

One's identity, including race, gender, and justice involvement, can impact support groups' effectiveness and dynamics. In a study by Majer, Plaza, and Jason (2016) on a pro-abstinence group composed of formerly incarcerated individuals, they found that participating in the group led to acquiring the coping skills modeled by peers. Pro-social relationships with people who are abstinent or recovering can contribute to shifting one's peer relationships and aid in long-term recovery (Majer, Plaza, and Jason 2016). Socioeconomic and other demographic factors can heavily influence one's health outcomes, and if they face stigma when seeking treatment, it can discourage them from changing their patterns (Alegria et al. 2010). One's identity can contribute to whether they join a support group, the relationships they form with others, and how they are perceived by others in the group.

Gender can affect how members of a support group interact with others, both in the group and the greater world. When compared to women, men are less likely to seek medical or psychological help, while still experiencing higher levels of alcohol/substance use disorders (SUDs) (Keohane and Richardson 2018). Particularly those who adhere to normative values of masculinity, like toughness and assertiveness, are less likely to talk with others about their difficulties (Bryde Christensen et al. 2023). There is a common perception among men that therapy is "just talking," contributing to the divide of femininity as passive and masculinity as active (Bryde Christensen et al. 2023). The reality is that individual therapy can include learning skills and coping mechanisms, while groups have the added benefit of creating community through shared experiences (Gray et al. 2005). Additionally, the unspoken gestures as well as the way that a therapist or support group chooses to talk about a subject give unique meaning to those interactions, as supported by symbolic interactionism.

Despite men still having a higher prevalence of substance use disorders, rates among women are steadily increasing (McCrady, Epstein, and Fokas 2020). Women also face higher risks of trauma and sexual violence, leading to unique mental health concerns (McCrady et al. 2020). Prior research on women who entered SUD treatment has shown them to have similar or even higher rates of comorbid mental health concerns, as well as an up to 80.0% chance of lifetime abuse and trauma (McCrady et al. 2020). Transgender women are particularly likely to experience trauma or violence during their lifetimes (SAMHSA 2021). In addition to facing different challenges than men, they are also perceived differently due to socialization and gender norms. Bryde Christensen et al. found that women in mixed gender peer-support groups were described as "nurturers" as opposed to the "self-reliant" and "emotionally restricted" men in the same group (2023).

In her book *Gender Trouble*, Judith Butler describes gender as an act and a performance, where "the various acts of gender create the idea of gender" (1990 p. 178). The gendered expectations that affect one's behavior is "often assumed rather than reflexive," can heavily influence how an individual shows up within a support group (Newton 2021). Gender operates as an enforced binary, which relies on 'male' and 'female' being perceived differently and adhering to hegemonic norms (Budgeon 2014). Femininity and female identity are based on expectations of passivity, emotionality, and oftentimes motherhood. Gendered and heteronormative expectations impact individual choices and group interaction, as well as how one perpetuates the current structure (Budgeon 2014). Therefore, women's socialization impacts not only how they act within support groups, but how they perceive their own conditions. Women are more likely than men to attribute SUD to a moral failure, rather than a genetic predisposition (McCrady et al. 2020). This feeling of shame doesn't only apply to SUD, but any stigmatized condition.

Furthermore, it could impact how one presents themselves in a group, their level of participation, and how they act in their daily lives.

Culture can have major impacts on one's perceptions of mental health and recovery support programs. Culture affects what is considered normative behavior, including what is considered deviant, how mental illness presents in an individual, and what help-seeking behaviors are accepted (Gureje et al. 2020). Current understandings of mental illness are rapidly developing, particularly in the past few decades, and it is still seen as incurable or stigmatized in some cultures (Alegria et al. 2010). Instead of seeking treatment, individuals may be guided to ignore any discomfort or "tough it out" instead of burdening others with their emotions (Alegria et al. 2010). Additionally, when one does seek out treatment, many of the diagnostic tools used to identify mental illness may fail to diagnose or misdiagnose someone not from the region's dominant culture (Alegria et al. 2010). This is because diagnostic tools like the Diagnostic and Statistical Manual of Mental Disorders and other patient health questionnaires are often written by therapeutic experts within a Western medicine framework and don't always reflect the unique ways in which certain conditions present in different populations (Alegria et al. 2010).

One's racial identity also impacts the barriers that one faces both regarding their mental health and in their daily life. People of color are more likely to be exposed to violence, live in underfunded neighborhoods, and interact with the justice system, all of which can exacerbate and create a high-risk environment (Alegria et al. 2010). It's essential that peer-led groups are equipped to support people of all backgrounds, not just those who can access the programs. Additionally, when peer-led groups are more diverse, they are more likely to appear welcoming to others and acknowledge different cultural attitudes regarding mental health.

When culturally conscious programming is unavailable, there are numerous barriers individuals can face when accessing treatment, including language. A shared, or "common language," is necessary to facilitate communication between care providers and their patients (Gureje et al. 2020). It is also necessary within peer-led groups, as without a common understanding of language and experiences, connections are harder to form. Knowledge of multiple languages and training of how to support diverse communities have been shown to be two major barriers to effective peer-led support groups (Jonikas et al. 2010). When an individual may be uncomfortable with the idea of peer support groups to begin with, the lack of inclusion and connection they are confronted with negates much of the benefit of a support group (Jonikas et al. 2010). Oftentimes, a paradigm shift is needed because concepts introduced in these groups are unfamiliar (Hayes 2001). When one feels welcomed and supported in the group, the narrative shift can be easier to navigate.

University students, especially those living outside the scope of their families for the first time in their lives, can experience both mental health challenges and an overwhelming number of available resources. The World Health Organization found that 35% of full-time first-year university students screened positive for at least one of the six major disorders being assessed (Auerbach et al. 2018). This prevalence of mental health concerns creates a major challenge for universities to create cost-effective and accessible programs for students. Peer-led support groups can offer an alternative in the form of community, relieving the burden from university health centers, and putting power back in the hands of the students. However, at this point it's unclear whether peer-led support groups have a significant effect on students' levels of depression, stress, or anxiety (Pointon-Haas et al. 2024).

Group Narratives

A primary way in which peer-led support groups operate is through a construction and discussion of personal narratives. These narratives offer diverse interpretations of shared experiences and create a cohesive group identity and worldview, further connecting the group members through two main functions: communalizing individual experiences and recontextualizing one's one experience (Hitzler 2024). When one tells a story about their situation, it can be an attempt to seek out others to determine how their experiences should be interpreted (Hitzler 2024). Deviation from "normal" experiences, such as mental health disorders or addiction, can create feelings of alienation. Peers within a support group can provide a frame of reference for what is considered "ordinary" within a certain community (Hitzler 2024).

In some groups, like Alcoholics Anonymous (AA), a dominant narrative can come to be seen as the typical or normal experience. Bill W., one of the founders of AA, was responsible for writing the Big Book – the "sacred text" of the AA program (Jensen 2000). In the book, Bill shares his experience with alcoholism, and his story has come to be seen as *the* experience of addiction and recovery (Jensen 2000). From trying alcohol in a celebratory context, to drinking so much one damaged relationships and financial opportunities, to finding faith in a power above oneself, Bill's story is the basis for the 12 Steps. Through telling their own stories in meetings, members can assert how their stories are different and create a more nuanced and relatable shared experience. Group members can discuss the reading and agree upon a group "truth," or what Veen et al. (2010) would consider a "proper context" (Hitzler 2024). Likewise, some groups can integrate outside literature sources into their meetings, which can serve to expose the group to others' experiences or undermine the group's current understanding of an issue (Hayes 2001). Either way, everyone's narrative draws from a broader social context, which allows

groups to examine how their experiences adhere and differ from established norms. In addition to the stories themselves, the way that these narratives are spun can add to how groups connect with peers through storytelling. When members are sharing during AA meetings, they begin by saying "Hi, my name is [name], and I'm an alcoholic," to which the group responds "Hi, [name]" (Jensen 2000). This dialogue between the speaker and the audience allows each group member to acknowledge the experience of the peer and open the conversation to their own interpretations. This exchange also serves to create labels for members of the group.

As all group members are identified by the same label, it becomes a symbol of shared experiences and identity. However, there is mixed research on whether these labels alleviate feelings of shame and deviance, or whether they promote a negative self-conception (Hayes 2001). Similarly, the balance between intragroup differences and similarities affect one's embeddedness in the group and their perception of shared narratives as a communal "we" or an individual "I" (Hayes 2001). Additionally, by sharing narratives in a support group setting, members are able to recognize familiar behavioral patterns in others (Jensen 2000). By providing feedback, they insert themselves into others' narratives and create opportunities for reflection on harmful practices.

Conflict and Mediation

As support groups are inherently composed of multiple people, it's necessary to have a method of dealing with conflict and clarifying group norms. The term 'anti-group' describes "destructive processes that threaten the functioning of the group," like anxiety, fear, and hostility, that stand in opposition to Foulkes' ideas focused on group harmony and the constructive power of groups (Nitsun 2014). The anti-group is not a permanent aspect of a group, but a process, and can ultimately lead to a stronger, more communicative whole. In fact,

interpersonal conflict within a group can allow for more cohesion over time (Viverito et al. 2013). Conflicting personalities can lead to a group separation that allows members to feel more comfortable voicing their concerns and grievances with the larger group (Viverito et al. 2013). When peer facilitators model how to provide and receive constructive feedback, they allow for discontent to fuel group discussions, while also maintaining a separation between group members.

Additionally, regardless of the many positive social exchanges that happen in peer-led support groups, there can also be unwanted social exchanges. These exchanges can be both given and received and include dominating the group conversation or talking over others (Brown et al. 2014). Group members may not be aware of when they participate in unwanted social exchanges, perhaps because other members choose not to explicitly address these issues and instead model the desired behavior (Brown et al. 2014).

Theory

The concept of the 'looking glass self', developed by sociologist Charles Cooley in 1902, posits that one formulates their identity based upon the perceptions and opinions of others around them. Oftentimes, people in recovery are told they are wrong or deviant and therefore perceive themselves and act in ways congruent with that identity. 'Dramaturgy,' or dramaturgical analysis, developed by Erving Goffman in *The Presentation of Self in Everyday Life* (1959), uses the metaphor of theater to describe how individuals and groups interact. The front stage area is the play, or performance of daily life. This setting is where actors are cognizant of their behaviors, expressions, and how others are perceiving them. This mirroring is discarded back stage, where actors are freer to be more authentic with their actions, and often contradict their front stage role.

The way that an individual portrays themself varies depending on the context. In professional-led support groups and treatment centers, there is a more delineated separation between the front and back stage interactions that take place in recovery as opposed to peer-led support groups. The professional field may desire to view clients as their own "agents of change," but professionals often end up being the ones with authority over plans and treatment (Andersen 2014). Props and setting in the back stage meetings are not arranged for the client, as opposed to support groups, and these back stage interactions may sometimes seem more authentic to clients than their front stage interactions (Andersen 2014). This background lends the question: how do peer-led support groups balance the front stage environment set up for participant interactions, while still remaining authentic to participants? Furthermore, the back stage area of peer-led support groups is not as obvious. Is there a back stage area to support groups and how would it impact group interactions? Group members may be able to drop their roles before or after the group, where the environment is more relaxed. However, it's also possible that the entire group operates back stage, where individuals are more explicit about their struggles and internal experiences. By involving individuals in back stage activities, group facilitators can reach recovery communities despite their potential identification with a deviant identity (Skatvedt 2017).

Symbolic interactionism is a sociological framework that examines how individuals create unique meaning from their environments and interactions and how socialization allows them to identify these symbolic meanings (Vejar 2024). What many think of as ordinary gestures, can be "sacred and profound" to someone who feels othered by themselves and those around them (Skatvedt 2017). The ways in which we converse hold additional meanings. Hollander and Gordon (2006) defined nine ways in which individuals verbally create meaning in

their conversations such as the words and connotations that one chooses, as well as the tone and framing of one's experience. Goffman (1959) uses the terms 'given' and 'given off' to describe the actions or words that individuals use to both present themselves in a certain way, as well as their unintended expressions. All of these signals create meanings within support groups, and through interviews it's possible to identify commonly used language, behaviors, and possibly expressions that are given off, as opposed to given.

Best et al. identifies "identity change processes," where a new identity as someone in recovery replaces the identity of being someone in addiction (addict identity), as a key step in navigating recovery (2016). Therefore, in many social spheres, person-first language that acknowledges a neutral, individual identity first has increased in prevalence to highlight the other facts of identity someone may assume. However, self-stigmatizing labels are still used in recovery groups, specifically 12-Step groups and may signify to others their shared membership in the group (Brown et al. 2020). Howard Becker uses labeling theory to describe how social elites choose what is deviant and how social identity plays into who is labeled as deviant. When looking at recovery through this lens, it's possible to consider how language is used to influence one's self-conception, as well as how they're perceived both inside and out of recovery spaces.

Similarly, Robert Merton (1948) coined the phrase 'self-fulfilling prophecy' to examine how stigmatized labels can change one's self-perception and lead to future deviant actions – in this case relapse or not starting recovery. The language that a group and its members use are important in determining the group cohesion, as well as establishing norms around what language and labels are acceptable to use. Bruce Link's research in 1989 modified labeling theory to include five stages for how labeling and stigmatized identities play out for individuals with mental illness. This research acknowledges how seeking treatment can be stigmatized and

leave lasting impacts on an individual's future opportunities, despite the long-term benefits of being in recovery/recovered.

Gaps in Existing Literature

Although qualitative methods have been used frequently in research surrounding recovery resources, there is little information on how peer-led support groups specifically create meaning and establish relationships within the group. Tracy and Wallace (2016) conducted a study on various peer support groups, including residential or sober living and 12-step recovery programs, to determine the benefits of participation in those groups. Although technically a "peer support group" in the way that peers are together in a recovery environment, my research will focus exclusively on on-campus time-limited support groups.

Additionally, there is myriad research on the mental health struggles of university students, as well as the various support services available to them (Pedrelli et al. 2015). Students are still usually dependent on their parents, learning how to balance work and school, and at an age where several substances become legal to use. However, the intersection between how support groups work specifically for students in this transition stage is lacking comprehensive research.

Methods

This research used both a digital survey and follow-up interviews for data collection, wherein I received thirteen survey responses and completed three interviews. The survey was distributed via Qualtrics and was expected to take approximately 15 minutes to complete. The survey was emailed to 183 members of the Association of Recovery in Higher Education, including universities, community colleges, and nonprofit organizations. I then followed up via phone and email directly with CRP directors for over 80 universities. Survey questions asked participants to rank how accepted they felt by the support group they are involved with, identify how long they have been a part of the group, and how they found out about the group. Complete questions are included in the appendix. Interviews lasted between 45 and 90 minutes and took place virtually over Microsoft Teams. The interviews were open ended, and specific questions differed depending on the individual's experience and the group(s) they participated in. Interview audio was recorded and supplemented by handwritten notes. By incorporating interviews in this study, I was able to clarify data collected from the survey as well as understand more of the underlying motivations to initially participate and continue participating in a support group. Survey and interview collection lasted for approximately two months.

To analyze data, I used a coding framework described by Johnny Saldana in the *Coding Manual for Qualitative Researchers* to identify themes in survey results and interviews. During first round coding, I read through interview transcripts and wrote brief descriptions of each separate event or talking point. During the second round, I started to group data under more unified codes, which I further refined during the third round of coding. The complete codebook is included in the appendix. Major themes emerged surrounding how relationships are formed, norms and norm violations, and how one's identity impacts their group involvement.

Qualitative methods, such as surveys and interviews, which I used in my research, are frequently used to analyze support groups and participants' perceptions of their experience. Sharma & Khadka (2019) used a survey to identify why individuals choose to remain part of a support group for chronic illness. Using a 5-point Likert scale, they asked members of multiple Facebook support groups how much they agreed with statements about the group's beneficence and aspects like patient empowerment and types of support. Because my research investigated similar phenomena, incorporating comparable questions such as those used by Sharma & Khadka (2019) was useful. Brown et al. (2014) used a two-part methodology for their study on social exchanges in support groups, similar to how my research used a survey and follow-up interviews. Participants responded to their survey questions using a scale ranging from 'Never' to 'Always,' as well as asking how often specific events had occurred within the last 3 months with responses from '0 times' to '10 or more times.' By using ranked responses in my survey, I matched standard field practices, while also gathering clear and concise information about the relationships within the group, that I expanded on during the interview stage.

Interviews and ethnographies are two other methods that allow researchers to acquire more nuanced information about participants' experiences within treatment environments, such as peer-led support groups. Andersen (2014) conducted interviews with treatment providers and clients within two treatment centers. While loosely using an interview guide, Andersen's questions centered around how participants perceived and interpreted their experiences and relationships with others during their treatment. While Andersen (2014) didn't include their research guide, they asked participants questions such as "How do you feel about [meetings]? and "How do you think [they] experience it?" Open-ended questions center around personal feelings and motivations and were an excellent model for my study.

Discussion

Recovery is both an individual and communal process as group work to form a common idea of what recovery looks like within their group. Through finding one's own path through recovery, discussion norms and violations, navigating different identities, and creating relationships with peers and staff, peer-led support groups develop a shared understanding of what recovery means to them.

What is Recovery

Although the participants of this study are primarily in recovery from an alcohol use disorder or an eating disorder, recovery has expanded to include a range of conditions, including self-harm, gambling, and substance use disorder. Recovery groups have also broadened their ideas of recovery and are more inclusive, with several universities in this study featuring "all-recovery" groups that serve anyone in recovery.

Relapse is often a part of recovery and can impact group participation. A participant described how while she relapsed, "it felt inappropriate to have the group when I was using." Although peer-led support groups are places to work through recovery, those who are relapsing may feel like they aren't meeting the group expectations and, instead of bringing it up to others, may opt to leave the group entirely. However, remaining in a group can help break down stigma, as there is a common understanding of the loss of control that those in recovery may feel. Participants described the "mental prison," "inability to stop ruminating," and feeling of being "completely out of control" as common themes in recovery. However, an interviewee mentioned that "there's solidarity on it because other people will be like, 'oh, I'm going through that too.'" Numerous groups emphasize that members only have control over their own thoughts and actions to handle the feeling of losing control that may be present in recovery. A participant

described her group's ethos of "unconditional self-acceptance, unconditional others acceptance, unconditional life acceptance" and how it's helped her gain a sense of agency in her recovery.

While individuals may join a peer-led support group for a variety of reasons, the most prominent reasons are to socialize with others in recovery and for distraction. Recovery is a topic that most participants don't feel comfortable talking about outside of the CRP space, so being allowed to connect with others who have similar experiences and feelings about addiction can be freeing. Even if an individual is having a difficult time, peers can validate those experiences. As for distraction, one participant stated that "the more time [others] spend in the space, I feel like the more time they spend feeling like things are okay." Not only does recovery normalize one's experiences, but it can ease the strain of playing a role outside of the group, on what Goffman would call the front stage. An interviewee stated that the CRP "makes me feel happy. It makes me feel thankful." CRPs can be a strong, positive space for identity formation and community building.

Finding One's Own Path

Recovery is unique to each individual, and it's important that group members identify what works best for them. One interviewee explained how although some peers in her CRP aren't fully sober, "it would consume [her] life" if she tried to drink at all. Therefore, although it can be helpful, she described the CRP as "a gamble, because sometimes it's not as helpful to me personally because it's… not always people with the same goals as me, which I think I need for my recovery." Despite the shared ideas of what recovery looks like, participants must identify their own goals and how to maintain their own recovery. Participants also detailed the different ways in which individuals get sober–including 12-step programs, spiritual healing, or independently without meetings. One interviewee commented how recovery is "kind of fluid.

There's no black and white, and we can find healing and acceptance of ourselves in many different forms." As long as group members are rebuilding their life in a way that is authentic and balanced, peer-led support groups can support them in that journey.

Group members may also have differing motivations to recover. When describing the balance between recovering for herself, as opposed to recovering for others, she said:

> "It might not be 50/50 all the time. It might be more of one thing or the other. Sometimes when I want to drink really bad, it's just for other people. I'm like 'OK, if I drink I won't be able to do my service position for my AA meeting outside of campus. I have to tell people that I relapsed. I have to tell my best friend I relapsed'… and then sometimes I'm like, 'hell yeah, I'm awesome. I'm sober. I'm so strong.'"

Recovery is not linear. While some participants in long-term recovery were adamant about their recovery being for them only, sometimes external factors are large drivers of early recovery. Until one is comfortable enough in their recovery to maintain it for themselves, the perception of others that they're in recovery can hold them accountable and help facilitate the identity shift.

Structure

The physical space and leadership structure of CRPs can both connect and separate participants in peer-led support groups. One component of the CRP space is comfortable seating, often arranged in a circle. Whether that includes beanbags, couches, or a large table in the center, the ability to see all other group members is important to creating an atmosphere where vulnerability and connection are possible. All participants mentioned that groups take place in a space where doors can be closed to separate the group from the outside space. This physical separation creates privacy, as well as a mental separation between the masks that participants wear in front stage environments from the transparent masks they wear in peer-led support groups–still a front stage, just to a lesser extent. Additionally, all groups have food available during meetings. A participant from the University of Oregon mentioned how there is a white

board with peers' names and sobriety dates that they can elect to present. This board is a visual symbol of students' goals and the community that they are surrounding themselves with.

Although the physical space of CRPs is consistent, there is variation between the types of groups offered and who leads them. Research participants attended University of Texas at Austin, Brown University, University of Oregon, West Texas A&M University, and University of Alabama, and shared a variety of experiences. At the University of Oregon, there are different meetings, including all-recovery, AA, cannabis support, and eating disorder support. One participant described how all of these groups have open sharing time, but they may also read literature as a group, have reflective writing time, and usually start with one person reading aloud the group's format. One activity that stood out to a participant was practicing gratitudes which helped them feel "happy" and "thankful" to be in group. All of those groups are also led by peers, but there are student workers and a director who hold office hours and provide general support to students. Similarly, at UT Austin, there are multiple groups including open recovery, SMART, cannabis recovery, yoga, and a social group on Fridays. Groups typically start with going over guidelines, a check-in, and talking about recent successes and challenges. At AA meetings, a group member may read out the 12 steps or a specific passage from the Big Book that is relevant to that week's theme. Their CRP is part of their university health center and is run by three full-time staff: a director, a communications and event coordinator, and a program coordinator, in addition to student interns who "provide peer support." Not all the groups are peer-led, but those that are, are run by student workers who have lived experience. The University of Alabama CRP offers AA groups, an eating disorder anonymous group, a Tuscaloosa Young People's meeting, and social events, like a sober tailgate. Full-time staff members include a director, assistant director, and community coordinator. To be a member at

the UA CRP, one must demonstrate "active participation in community activities such as seminars, recovery nights, service opportunities, and academic advising," otherwise they are considered a provisional member (University of Alabama 2026).

Groups at Brown University are slightly different, as the groups offered explicitly through their CRP are all led by licensed staff members. However, there are peer-led groups that are led by community members that take place on the campus and are sponsored by the CRP. These include NA, AA, and Al Anon. These groups include a CRP proctor, currently a Brown PhD student, who "staffs" the group while a peer leads them. Most recovery-oriented social events are facilitated by a student organization, SoBear, that are open to all students who "choose to not use substances that day." The CRP at West Texas A&M also differs from other universities. As a relatively new program currently having been active for three terms, the CRP is still navigating how to function. The program has board members who are "outside community members that have been invited in as representatives of the community," and the peer-led support group voted for a student liaison to meet with board members as a "representation of [the] student body." Above the board and student liaison and listed in increasing power are the program coordinator, then CRP director, then the Dean of the College of Nursing. Although a participant expressed respect for the program coordinator and director, they felt "resentment" towards the dean, as they felt unsupported and that "our politics are factoring how we're able to run our program." An unclear chain of command led to issues that were brought up with leadership being "swept under the rug." In addition to the hierarchical challenges, students in this program must maintain a certain GPA and although many students were "recruited with big promises of scholarships and financial help" they are struggling to find community amidst the growing pains.

Differing Identities

As described earlier, demographic factors can influence one's health through their willingness to both seek treatment and change behavioral patterns (Alegria et al. 2010). This research has found that the participation of individuals in peer-led support groups is heavily impacted by one's gender identity, age, spiritual identity, and existing stereotypes of who belongs in peer-led support groups, yet when initially asked in the survey, the majority of participants did not state that their identity affected their experiences. Although race, ethnicity, and sexual orientation are likely to also be prominent factors, they fall outside the scope of this research.

Participants were interviewed on how recovery shapes which identities they connect with. One interviewee stated, "when it comes to my sense of identity, I don't cling to my age group or race. I think it's things like being a sex worker, being a person in recovery." Being in recovery supersedes other identities that might be seen as more important outside recovery spaces. Another interviewee commented how she felt she "lost [her] identity" before recovery, and peer-led support groups are a key space to reclaim her sense of self. When being perceived as a person in recovery by others in groups or the CRP, the idea of the 'looking glass self' contributes to the idea that that perception helps form the new identity.

Gender

Of the 13 survey respondents who responded with their gender, ten respondents identified as women. Additionally, of the three interviewees, all of them identify as women. Two intertwining themes emerged: topics surrounding sex/sex work and an idea of safety in groups.

One interviewee mentioned that her involvement in sex work had a large impact on her addiction and recovery, as substance use was encouraged in the spaces that she frequented.

However, she viewed talking about sex work in the on-campus support group as too explicit or as endangering to the sobriety of others in the group but viewed discussions of drug and alcohol use as acceptable. She was concerned for individuals who had dealt with "pornography or sex addiction" and didn't want to trigger them, despite the inherent nature of the group being to talk about personal experiences. Sex workers are predominantly young women, specifically women of color, and the field is highly gendered and stigmatized. Even in spaces that are dedicated to talking about recovery and the associated experiences, this participant didn't feel comfortable sharing–perhaps due to the overall stigma felt by those in the sex work industry and the gendered divide between what is seen as acceptable to share. Her disinclination to share may have unintentionally reinforced in others that sex work and sex in general is not to be discussed in the group. She also said that she was afraid of "people automatically thinking [...] I should talk to her because she will have sex with me." She didn't want to be taken advantage of in an environment that was supposed to be safe for her.

Another interviewee shared that she "[feels] like there may be a responsibility to warn the young girls that are coming in [to support groups] like, hey, take caution." She mentioned "predatory" behavior in her previous off-campus groups yet noted that this had not continued in her on-campus groups. This could be in part due to three major reasons: the smaller number of participants and the age range of the group members or the presence of the group within a CRP. Another participant mentioned that in AA "[women] can talk to the men, but it's more encouraged to talk to the women and get help from the same sex. I don't know why. It's like a safety thing." Although AA promotes itself as inclusive to all genders and promotes a safe environment, wider concerns of sexual harassment still exist within the smaller environment of the group. Additionally, another interviewee mentioned that talking about sexuality in group

"probably was not unsafe, but it felt that way." The perception of safety to vulnerability is just as important as the actual level of safety when it impacts what topics members feel comfortable talking about.

Although female participants said they still have friendships with the men in their groups, there are differences in how they interact and what they share. For example, several participants shared that they were more comfortable sharing in a group where there's a facilitator or peer with the same gender identity. A male participant said he is in "a predominantly female group so sometimes [he feels] less represented." However, having a peer-leader who also identifies as a man "helps." Although other participants viewed their gender identity as secondary to their identity as someone in recovery, gender still impacts one's experience in a peer-led support group. Furthermore, an interviewee mentioned a close bond with a male staff member, but instead of mentioning how she "used sex in a really negative way" when she was drinking, she would instead say she "put [herself] in unsafe places." This minimization and vagueness of experience is a way to navigate issues that she wants to discuss but still maintain a level of separation from a man, despite his position as a trusted adult.

Age

College is a major time of transition for students, but even more so for those in recovery. College drinking culture is a cultural phenomenon in which binge-drinking, drug use, and increased risky behavior are not only more accepted, but even encouraged. Out of three interviewees, two are non-traditional students in their mid-30s, while the third is a traditional college student in her early 20s. The younger interviewee mentioned that in her classes, classmates will bring up drinking in small group conversations. She says that she "[doesn't] want to be seen as some kind of 'pick-me'" because she previously would have thought "oh, that's

weird, they don't drink, they're missing out" if someone had told her they didn't drink. For context, a "pick-me" is someone who looks for validation and approval from others for acting in ways that are different from others of their same group, and is often a gendered term, shortened from "pick-me girl." There are societal expectations that college students participate in drinking culture in order to fit in, otherwise they can be perceived as dramatic. Instead of sobriety indicating simply a choice not to drink, it has instead grown to symbolize a conscious choice to be different from others, even if unintended. Additionally, another interviewee mentioned how her university campus used to be a "dry" campus but is now a "wet" campus and sells alcohol at closer locations than previously. She expressed concerns about how these "young, impressionable college kids" will navigate a new environment and increased access to alcohol. Easier access to substances like alcohol can contribute to the college drinking culture.

Despite the presence of alcohol on college campuses, college students may not fit one's idea of someone disposed to a SUD. One interviewee said that she herself did not fit her previous conception of someone struggling with alcohol use:

> "I don't have any people in my family with substance use disorders or anything like that. And my perception of an alcoholic specifically was an older man that I didn't think I was. I thought I was too young. I thought a lot of people binge drink and do stupid stuff. I thought it was more of a mental health problem and more of a self-control problem."

Although the increasing consideration of mental health is an overwhelming positive addition to college life, substance use and recovery are secondary in comparison. Because traditional college students are not included in the stereotype of someone with a SUD, they may struggle to identify when they need outside help. However, not being labeled with stigmatized labels like 'addict' or 'alcoholic' may potentially ease the shift to a 'recovered' identity.

Participants also raised the idea of 'normal' and 'normal drinking.' One interviewee stated that "it would take a lot of effort and energy for me to just drink like a normal person," in

which “normal” is taken to mean in moderation. They expressed envy that others can drink and participate in ‘typical’ college activities, while she can’t. Being in recovery deviates from behavior that is often expected from college students and can lead to a negative perception. peer-led support groups on university campuses offer a community that shares a single identity–‘in recovery’–that can lessen this deviant identity.

The younger interviewee also described how her on-campus peer-led support group consists of students who are mostly her age. She attends off-campus AA young people meetings as well, but even there, the age demographic leans older. She described how one positive factor of her CRP is “seeing people who are sober at [her] age” and that she’s not “a weirdo.” On the other hand, another interviewee mentioned how her age can make it harder to connect with others in her group. She said:

> “They’re on a traditional path that even though substance use has gotten involved, they’ve managed to keep their grades up and they have been in college since they were 18 and now they’re seniors and they’re 23… It’s hard to relate. You know, I’ve lost so many years to addiction.”

Being a non-traditional student on a university campus can be difficult, even more so in CRP programs when one’s life path may be different from others in the community. It brings up feelings like those shared by one participant when she expressed feeling like “I should be further in life.” However, the CRP can also be a space to find a community with a shared understanding of a life event regardless of age. Instead of being the “geriatric student” in each class, students in recovery have the opportunity to bond over their shared identity and understanding of university life.

Spirituality

Especially in AA or Narcotics Anonymous (NA) groups, where the concept of a ‘higher power’ is referenced explicitly in the Big Book, spirituality is often intertwined with recovery-

oriented support groups and can affect individuals' experiences in these groups. One interviewee explained how being involved in peer-led recovery groups has changed her faith, stating:

> "It was not something I truly believed in, but now it is… because it just makes sense in the way that my life has turned out… I have a few things in my life right now that I just have no control over and I'm like, OK, well I can't do anything. I'm just gonna release this to my higher power cause I can't do anything about it, and it sort of gives me a sense of peace because there's a lot of things I'm not in control of. I only have control of how I react to things and how I put myself out in the world, and other people and the way that they react is not my problem."

Religion can provide a sense of control that is often lost during active addiction. Spirituality may also provide a shared identity to group members in addition to their recovery identity. One interviewee mentioned a presenter at her group meeting who said, "the day I accepted Christ, all my sins were forgiven and I'm not the same. So, I have recovered." The idea of total recovery is often contested, but this individual tied their full recovery to their faith. Identifying as someone who is spiritual or religious can aid group members in shifting away from an "addict identity." Also, while not explicitly Christian, much of the AA and broader recovery literature features a God consistent with Christian teachings.

However, a higher power doesn't have to be religious. Another participant said that she understood a higher power as "kind of fluid–there's no black and white and we can find healing and acceptance of ourselves in many different forms." Despite this more free-form understanding of faith and recovery, the university is in the Bible Belt and numerous people in that peer-led group "have been freed of their addiction through their faith." However, "[they] don't push against each other…It's mutual respect." Diverse perspectives of faith can work together in a group with a common understanding of differences, but faith can also separate participants. An interviewee commented on a peer who is "incredibly faith-based and I think I just disgust him because I'm loud and a female and white… and at times I've kind of showed more of my ass just because I don't. I don't care." This reaction could suggest how different values within a peer-led

support group could contribute to future conflict. These different beliefs encouraged her to not dampen how she acts in the group space–indicating the group space may function more in line with how Goffman describes back stage spaces.

Similarly, a group or program's stance on religion and spirituality can affect an individual's choice to participate. One interviewee said that "the 12 steps were really off-putting for me because of the higher power concept, and I had some religious trauma." Their previous experience in groups with a "higher power" impacted their involvement and contributed to them no longer attending the meetings. However, meeting people at their CRP has "helped [them] let go of some of [their] own resentment towards the 12 steps" and increased their openness despite still not agreeing with the overarching sentiment. This participant prioritizes the relationships and closeness that they've developed over the initial discomfort that they felt. Additionally, a participant stated that SMART groups have a "very scientific approach" that they resonate with more than the 12 step groups. Finding the group that most closely matches one's values can be difficult, yet a strong factor in continued group involvement.

Norms and Norm Violations

Groups establish norms and the consequences for their violations in different ways. Although not always described as norms or rules, these guidelines are often expectations to keep everyone safe. This section will describe what is acceptable to share in a group, how norm violations are handled, and what is expected of group leaders when norms are violated.

Some norms are common across different groups and universities. One example of a common norm is not talking while others are talking, also known as no crosstalk. An interviewee described other norms in her group as "regulations on how we talk." Some norms she mentioned are to "use I statements, don't give unsolicited advice, don't criticize people." Additionally, what

is said in the group is expected to stay in the group. To learn these norms, some groups' opening statements "kind of go over the norms a little bit," but norms may also include what one interviewee described as "social norms." Social norms can also be described as cultural scripts, which are expectations for how individuals should act in daily scenarios. By this phrase, she meant common behaviors that people are expected to abide by in their daily interactions. In general, norms encompass the idea that one must "be mindful of how what you're saying might affect other people."

Language

Language, including the specific terms that are used in peer-led support groups, is important in creating and maintaining an identity. Some key terms in SMART groups are the "cost-benefit analysis" and a "balanced life." One interviewee mentioned how "a lot of the tools go into figuring out am I living a balanced life or am I putting all of my energy into one thing and neglecting everything else? So now the word balance comes up all the time." Frequently used terms can originate from designated recovery literature or through the language a group adopts together to describe their experiences. An individual in a 12-step group who is not actively working the steps said, "If I don't know something, if I ask, they'll explain it, but I don't think they ever expect me to learn it." Although a unique situation, academic terms or terms aligned with group literature are not expected to be integrated into everyone's recovery. Even the previously mentioned phrase "working the steps" is a saying common in recovery and AA groups. Language is used to describe the experiences of individuals and their process of recovery in group-specific terminology. By using unified language, group members construct a shared understanding of recovery.

A group's language can also be formed through norms about what is considered acceptable language. For example, a participant said, "we don't just call [group members] addicts." Another participant expanded by stating, "we try to stay away from stigmatizing labels… If you use that label for yourself, then you're free to keep doing that, but don't assign it to other people." While each group member is allowed to choose how they would like to identify, it's considered correct to use other labels like 'person in recovery.' By moving away from labels like "addict," groups simultaneously shift away from that identity to someone in active addiction. The language that the group uses creates a self-fulfilling prophecy, where members start to identify with and embody traits consistent with a recovery identity.

In some cases, if a group member uses a stigmatizing term, the group will likely consider it a minor norm violation. An interviewee describes how:

> "Maybe somebody would say something about, 'oh, I have this friend, he's an alcoholic too.' Technically that's a violation of the assigning labels to other people, but it's minor enough… but if someone starts trauma dumping and it's triggering to all the other members, that would be more of a major violation because that puts a whole group at risk."

There are different tiers of severity for norm violations, and they are handled according to their classification. While it's not encouraged to use labels for other people, in this case it's considered harmless enough, partly because the person being labeled was not present and because "addict" is still a label that some individuals in recovery use. However, when one's comments cause emotional reactions from present group members and bring up painful memories or thoughts, the violation is considered more major. Both scale and intent of norm violations contribute to how they're handled and perceived.

What is Shared

Sharing others' stories or experiences is also a practice that group members refrain from. One interviewee's recovery journey was complicated by having a previous spouse in active addiction. Despite the intense "shame and embarrassment" she felt, she ultimately didn't go back to her peer-led support group because she "would be sharing something of his story." Even though his story was deeply entrenched in hers, the norms around sharing others' stories held her back from attending the group. She ultimately joined a peer-led support group because it was not a community that she had been a part of before with her ex-husband. Furthermore, one interviewee mentioned how "if you go to a meeting, you can share what you want to share with your peers, but… if you see them at the grocery store, you're not going to be like, hey, how are you doing today?" There's a separation between how individuals present when they are in the group, as opposed to how they interact outside of that space. In group, they can drop their masks and behave in more authentic ways, but outside the group they are expected to maintain composure as if the level of vulnerability they have shared with this peer has not taken place.

Another topic that group participants are hesitant to share about is their negative emotions and thoughts. Although all survey participants stated they either "somewhat agree" or "strongly agree" that they feel comfortable sharing both positive and negative experiences in their group, interview respondents held slightly different views. One interviewee mentioned that she didn't have anything negative to talk about at that point in her recovery. Another interviewee described the discrepancy between how she feels and how she expresses those feelings. For example, when sharing thoughts via a worksheet for the group, which asks questions like "How are you feeling? How are your cravings this week? How do you feel about your recovery?" she said she might respond with "My cravings were a 10. I really wanted to drink." However, when

asked to share verbally in group, she might respond with "my cravings are bad… I'm not feeling well… I don't feel good." This generalization or vagueness may indicate that she's censoring her language. She may not be truly comfortable sharing her negative experiences, or she may be avoiding these topics to protect her peers. Although the peer-led support group often functions as a place where individuals can be more vulnerable and honest than they can be in other spaces, the peer-led support group does not function as true back stage. Another interview commented how "we can't just say what's on our mind without somebody getting their feelings hurt, and so a lot of us have really tamed our conversation." While still concerned with how peers interpret what is said, she expressed frustration with how group members regulate their language. Group members regulate their behaviors to present a more polished and acceptable version of themselves.

Trauma Dumping and Triggers

One interview mentioned that their group expects no "trauma dumping," which they described as "[saying] something really crazy," often including one's personal history. Trauma dumping can also include stories of difficult experiences that contain emotions or behaviors typically associated with addiction or mental struggle and may be mentally harmful for others to hear. Trauma dumping may also seek reactions from peers, either positive or negative. However, during a structured time, even trauma dumping has its place:

> "I was talking about something like really fucked up I did. And then my friend was saying something fucked up they did. And then nobody was really like, 'oh, I feel like mine is worse.' I feel like there's a time and place for everything. I guess social norms are just the rules, like don't be rude."

This interaction took place during a 12-step meeting focused on sharing a self-assessment of relationships and emotions with a peer. Although time and place don't necessarily define what is "fucked up," they do contribute to whether those experiences are deemed acceptable to share

with the group. In this instance, what could be considered ‘trauma dumping’ is instead in compliance with the designated 12-step curriculum. Similarly, one interviewee mentioned how group members “may need to do a little bit of a dump because they’re trying to process.” However, when the intention is to “prove themselves to be the one that’s had it the hardest” the sharing becomes more inflammatory and harmful towards others in the group. Although the intention of trauma dumping may be to process recovery challenges, it can be interpreted as creating an unsafe space for peers. Therefore, it’s essential that expectations are communicated and violations are addressed to create a group where all members are supported in their recovery.

Handling Violations

The manner that norm violations are dealt with depends on their severity and the context in which they occur. Although norm violations have not been an issue for one interviewee, she commented that if one occurred during a group she “would be like, ‘hold on, let me stop you. I have a question,’ and then try to distract without making them feel like they’ve been interrupted.” A simple diffusion would be enough to redirect the conversation. Location also matters for how norm violations are handled. Another interviewee suggested that if a group member violated a norm she “would definitely say something in the [CRP], probably not like out in a meeting like off campus. [She] probably would avoid that person because it's not really someone [she needs] to have a relationship with.” The positioning of the CRP on a university campus has made the space inextricable from her recovery–to the point where confrontation would be desired.

Interviewees described three different norm violations and how they were handled. In one case, a peer who was watching inappropriate videos was asked by a student staff member to turn the show off. This same peer made triggering comments to the interviewee outside of the CRP

space. Later, a professional CRP employee spoke with the peer about his actions where "he was also talking about inappropriate things, making people uncomfortable." The student said that "I think that he handled it well. I think it just had to do with me [projecting]." She brushed it off as the peer not having "social awareness" and offered more leniency because the peer only had a few months of sobriety under their belt. After processing the experience with staff and friends at the CRP, she said "I don't want to create a space where I'm talking badly about someone else to another student… It just puts people in an uncomfortable spot." She viewed discussing the uncomfortable actions of a peer in the CRP as talking negatively about them–thereby creating an environment where others might not feel able to be authentic or vulnerable later. The inability to speak honestly mirrors the performances that individuals often put on in frontstage areas.

Another interviewee described how peers in her group were not meeting expectations concerning group attendance and she "spoke up very loudly about it." She said that she's "not favored because of it" by her peers who view her actions as excessive. These individuals had been told the expectations in writing, one-on-one conversations, and through discussions with higher ups, but she stated how "there's no resolution or solution or addressing it." However, her disapproval has "kind of caused a ripple effect to where our leaders are supposed to meet with them and then maybe the group is going to get together and take a vote outside without the leaders." The group is starting to take these issues into their own hands in an attempt to hold boundaries.

Group Leader Initiative

Group members may be expected to take the initiative to inform peer leaders of any concerns or norm violations, and group leaders are expected to take charge from there. Therefore, it's only seen as a failing of the group leaders when the issue is brought to their

attention, and they fail to address it. It may not be expected that they proactively handle these violations, and one participant even mentioned they were “very surprised” that other leaders handled the situation when it arose. Another said, “I would try not to reach,” and instead leave it up to the peer leaders to address. Additionally, an interviewee mentioned how their group is “self-monitoring.” They have been disappointed by the group leaders’ lack of initiative in the past and mentioned that “even if we bring it to their attention, doesn't mean that it's going to be addressed.” Aside from whether group leaders are expected to identify norm and rule violations, they seem to be expected to mitigate these violations–something that when it doesn’t happen can be “very activating and at times triggering.”

One interviewee defined a strong leader as someone who believes in forgiveness, transparency, second chances, and growth. Additionally, they expressed a desire for a peer-leader who understands the complex connections between one’s life circumstances, like socioeconomic status and relationships, and the struggles that come with the recovery process.

Relationships

Relationships within a group, as well as the community in which a CRP is located affect how group members interact with each other. The length of time one has been in recovery, as well as the multiple roles that one may be balancing complicate the relationships that peers form. Ultimately though, similar experiences, humor, and interacting outside of a group with peers aids in strengthening both interpersonal relationships and one’s recovery.

Making Connections with Peers

Peer-led support groups are a place for people in recovery to find community and connection, but individuals’ experiences vary. One interviewee has a close connection at their university’s CRP, whom they knew before joining and now consider their best friend and

roommate; they're a student worker and spend a large amount of time together in the CRP. This friend is "the reason [she is] sober. She stated that "if it wasn't for my best friend, I wouldn't know where to go or that it is possible to get sober at this age." Although she initially started interacting with the CRP and recovery in general because of her friend, the relationships that she has since made have been important factors in her continued involvement. She mentioned how a student worker would greet her warmly when she was in the CRP, even though she hadn't met him before. She says that "It's just easier to talk to people [there]." This language and understanding link participants together in ways that aren't as attainable outside of that environment.

Social relationships are another key part of peer-led support groups, and there are many ways to form these connections. One way is to consistently attend meetings and stay to talk with peers afterwards. An interviewee stated, "There are some people that I've never seen outside of certain groups, and they're not people I would want to talk to about [sensitive topics]."Another interviewee described how the individuals who consistently attend groups were the same ones who would spend time in the CRP space for office hours. Relationships in peer-led support groups are strengthened by spending more time in the space with peers. The entire CRP center operates as a back stage space, where individuals are able to be their authentic selves without playing the role of a college student not in recovery.

Additionally, the way that information and experiences are shared can contribute to building new relationships with peers. A participant described how she "would slip small things into conversations and kind of gauge their reaction" when first attending her group. She would then assess whether she could trust them and share comfortably. Likewise, she mentioned how she didn't form strong connections within her previous online groups, but at the CRP she has

found a recovery community. By finding a group and peers who are also "education focused," she feels connected to the program as a whole. When peers hold the shared identity of being in recovery and also that of being students, they are able to form a common understanding of recovery.

Time in Recovery

Participants mentioned observing differences between those who are newer to recovery and those who are in long-term recovery. One interviewee described long-term recovery as a phrase to use when "you don't want to say that you have 3 years or 15 or 30, you just say long-term recovery and it's left open-ended… If we're gonna say long-term, I'm gonna assume you have more than 30 days. But I've seen it not be the case." Long-term recovery is a phrase open to interpretation, but it delineates a separation between those with more recovery experience from those who are just beginning their recovery journey. By leaving the decision of what constitutes long-term recovery up to those who are actually in recovery, those individuals are able to use language to facilitate their shift away from the identity of someone who may not maintain their recovery to someone who will continue to stay sober.

The length of time an individual has been in recovery can also affect with whom they form relationships. For those new to a CRP, including those new to recovery entirely, an interviewee mentioned, "it's probably easier to talk to the student workers and then when you feel comfortable, it's easier to talk to your other peers." For clarity, student workers at this CRP do not lead groups. This observation supports the notion of a gradual process where group participants new to recovery and CRPs learn to trust those around them, beginning with staff. One interviewee commented, "It's just kind of weird when you first go in and people care and you're like, 'why do you care so much? What's your ulterior motive?' But there is none."

Individuals new to recovery may question the intentions of others when entering a recovery community for the first time. While members of the community often have good intentions, to those new in recovery, they may give off the impression that they are trying to take advantage of them. However, with time, these meanings shift.

Research participants who consider themselves to be in long-term recovery have concerns for the continued recovery of their peers that are new to recovery. One interviewee expressed concern about newcomers in AA-style groups:

> "I'm strong enough in my recovery that nothing shakes it. But it does make me worry about other people a little bit. Like, where is the positivity? Where is the joy in recovery? Right now, it just feels like everyone's seeing how hard it is to be doing this and we're never really looking forward. Like how it's not always gonna be that way. So yeah, I don't worry about me. I worry about everybody else."

During early recovery, challenges and hardships may seem more prominent, but "old-timers" are more likely to see the positive future outcomes of continuing in recovery. Their experience can contribute to them being taken more seriously by their peers. There's a sense that individuals further along in their recovery have "earned their time" and are in a position to give guidance to newcomers. One interviewee mentioned she has been told that she is a "beacon of hope" for these newcomers, and can tell them "yes, I felt that way, but I don't feel that way anymore. And you can trust that you're not gonna feel that way forever." Although not designated peer-led group facilitators, her identity as a peer leader creates a community where she can provide hope and comfort to others.

However, those in long-term recovery are still in recovery and have unique challenges that they face. One interviewee described how leaders may sometimes overlook her and other long-timers' struggles by saying, "We look OK. We don't complain the same as a newcomer, but we're still dealing with real life problems that we don't have guidance to know how to handle." Some participants discussed not necessarily needing peer-led support groups to stay sober, but

the consequences of struggling with addiction may still create challenges in their lives –such as one participant's legal battles for child custody. The advice that newcomers receive is not the same advice that those in long-term recovery need. Therefore, it's crucial that long-timers' needs are met by peers or others who understand recovery and addiction outside of these group spaces.

Responsibility to Others

Participants, especially those in long-term recovery, noted how they felt a responsibility to take care of and support others in recovery. One way to support peers is to include them in social opportunities. One participant explained how "It's a big thing in AA–you help other people. So, a lot of it is like, 'what's your number? Let's grab coffee.'" A core component of peer-led support groups is the creation of community, which is a priority for many members. Additionally, having more peers can be a motivator to stay in a group. One participant stated:

> "I questioned whether I would rejoin the group and, in the end, decided that I care. I value my peers enough to try to do this with them. Because if I'm uncomfortable [with] the time that I've built up, the years that I've built up, I can't imagine how that newcomer feels."

Despite her concerns about her own involvement, this individual felt a sense of responsibility to be there for her peers, and acts as a barrier between them and the organizational difficulties that their CRP is navigating. Furthermore, an interviewee mentioned how "even if you don't like someone… you still want them to be in this space and to be sober." Outside and personal factors are lesser compared to an individual's right to recovery and a safe environment. The community that peer-led support groups create are paramount and contribute to individuals' feelings of safety on campus.

Peers also feel a responsibility to provide guidance to other participants in their group. One interviewee with a "pretty decent amount of sober time" said she "[knows] that [she has] wisdom that people entering recovery are often looking for." However, she emphasized that she

tries “not to take people under [her] wing because a lot of people try to externalize their recovery, like seek it in others.” She acknowledges that group members can’t be the reason for others’ recovery but can alternatively offer perspective and motivation. The identity shift that recovery requires relies on being perceived as capable of maintaining that recovery, but also on having self-perception.

An obligation to support others in recovery is present outside of CRPs as well. Two interviewees expanded their consideration to those outside of their organization through their professional work. One recently obtained her drug counseling license and the other works at a nonprofit focused on youth prevention. One participant mentioned she wants to help youth because “I have a personal track record, and if somebody would have stepped in early on, maybe I wouldn’t have [used].” The responsibility to the greater community that peer-led support group members feel is consistent in their work outside of the CRP and can often stem from personal challenges or desires earlier in their recovery process.

Humor

Humor can be another method used to form relationships within support group settings. One participant mentioned how at AA meetings, there’s a behavior known as “heckling” wherein “you shout jokes while the people are reading the intro stuff.” She also explained how one peer in the group read the word “Guadalupe” in an unusual way and “we were just all laughing and then we would keep reading and then we would all just start laughing again.” This levity demonstrates that relationships within peer-led support groups are built on both the serious understanding of life-altering conditions, but also the small moments of joy and connection. Humor brings light to the group and allows participants to bond over shared moments. Another example of humor that an interviewee mentioned was their peers saying, “but for the grace of

God" which she changed to "but for my pocketbook." Her statement brings humor to the different views on spirituality that group members may hold, in a way that still expresses her own opinions. Joking about potentially divisive themes may only be appropriate in some situations, as it could push away other peers with differing opinions, but it clearly holds the power to bring group members together.

Balancing Roles

Individuals, who are both members of a group and peer leaders, must learn how to navigate their dual roles. An interviewee commented how "I don't think the roles ever fully separate." Group members offer guidance and support to others in the group, but peer leaders may draw more from recovery literature, such as SMART tools or the Big Book. However, even as a peer leader, individuals can offer a "sober friendship." The same interviewee as above stated that:

> "I feel like when they met me in that facilitator role I had everything together, and it took a while to kind of break that down, to be like, no, I've been trained to do this thing and I'm very confident at doing this thing, but I'm still a human being. I'm still in recovery. I still have my own stuff going on, but I'm not showing you that in SMART because I'm in this facilitator role."

While some group members may perceive the group leader as separate from the rest of the group, seven of the nine survey participants that answered the question said they strongly disagree that they "feel intimidated by the peer leaders." This response indicates how peer leaders integrate themselves with the rest of the group. Additionally, a participant mentioned how "girl talk" and "building stronger friendships" humanizes the peer leaders and brings them into the fray.

Even if a peer is not a designated group leader, they may still hold sway in the group– especially if they have more sober time or have been in the group longer. One interviewee stated

how she's not a peer leader, but she does have a "leadership voice." Her group was relatively new and was having some difficulties, so another group member asked her to remain in the group for another term. Peers who are seen in a leadership role can guide the group in similar ways to peer leaders, including establishing norms and safe environments.

Relationships with Staff

Staff and their relationships with group members play a role in creating a welcoming recovery space. An interviewee described how in her experience, people not in recovery "didn't have the training or skill set or vocabulary to say something to me and say, hey, do you need some help or are you OK?" Professional staff members at CRPs often have training or lived experience that helps them connect with others in recovery. Group members can share sensitive information with them and still maintain the promise of privacy that they would have if talking with other group members. Additionally, staff can provide another avenue for group members to talk to others their age. For non-traditional students, staff members may be older, in their late 20s or early 30s, while student workers tend to be closer to traditional students' ages. One interviewee stated, "One of [the staff members] is my boss, but she still feels like more of a friend." CRP staff are in a position to create relationships with group members, while not listening to them in group every week. Individuals are able to share with staff in a more controlled way; staff can meet them where they are in recovery individually, without concern for how others in the group will respond.

Staff and CRPs are also able to provide more support outside of recovery, like campus and professional resources. During office hours at certain universities, staff members help group members with job applications, class work, and various administrative forms for academic life. Students are not only prepared for recovery, but life in the general university and outside

community. By treating group members as people in recovery first, they are in a prime position to rebuild their identities around those two themes.

Outside Community

The broader community outside of a CRP can impact the internal affairs of a group. An interviewee mentioned the idea of "outgrowing" a group and stated how she feels "like I've outgrown some of the understanding within our community." Her group is in a small, rural town, and she didn't think some individuals "were really growing with their time. They just kind of kept regurgitating." One expectation that this member had for their group was continued effort and growth within their recovery. She had participated in recovery environments in a different, more urban state, and felt that she had gained insights in her recovery and life that others had not. After moving back, she no longer connected with the group in her "very conservative, religious, Bible Belt of a community."

The community where a CRP is located affects the leadership and logistics of a group. One group member said to the new director of her CRP, "you're going to need to practice pulling [your boots] up and getting shit done cause Texas runs a little bit different than Oregon." Referring to the differing political and social atmospheres, what works best for each group depends on the outside culture and norms of the wider community. Similarly, an interviewee at West Texas A&M University commented how the university's proximity to Texas Tech –which has a long-standing CRP program– affects funding and group participation. She commented that "we just can't compare to them," which limits the community support that her own CRP receives, especially as a new program. Additionally, meetings outside of a designated recovery space may be "kind of hush hush" as one interviewee described it. Instead of being an explicit meeting, one participant mentioned how they attended a group called "Friends of Bill," in

reference to the founder of AA. This subtle way of participating in recovery is reminiscent of the mid-1900s phrase "friend of Dorothy" that queer men would use to identify others in the LGBTQ+ community without explicitly stating their sexual orientation (Deutsch 2016). This language cues others in the community of a shared identity. Although the norms within CRPs and peer-led support groups differ from non-recovery communities, they are still influenced by the expectations of the broader community.

Socializing Outside of Group Spaces

Group members connect both during group and in outside spaces. One interviewee mentioned how her group "only [gathers] for like 45 minutes on one day a week as a group" and how that can be "kind of superficial." All interviewees described how their groups meet outside of designated meeting times, both in-person and through virtual chats via GroupMe or text for "support and encouragement." Some CRPs also have social opportunities, such as one university's "celebrate recovery meeting" once a month or another's Friday Recovery Circle consisting of a craft, movie, or other relaxing activity. Moreover, West Texas A&M highly encourages its group participants to participate in a community outreach project and volunteer project each term with others in the CRP. All these events take group members out of their back stage location in the CRP into more front-facing spaces. This change allows group members to see their peers in new environments and observe how their roles may shift with new activities. Peers are able to strengthen their relationships with others through this extended time and altered interaction.

These social opportunities often move into socializing outside of the group space. One participant mentioned how social meetings led to "just hanging out with each other, like all the time." Whether an impulsive suggestion to hang out after a meeting ends, meeting at a peer's

apartment, or “[sitting] over mocktails and [talking] about some really, really heavy stuff,” socializing outside of meetings can create strong bonds between group members. Peers are able to strengthen their relationships with others through this extended time and altered interaction.

Impact of Personal Relationships

Personal relationships with others, both in and out of the recovery community, often influence individuals’ recovery experiences. One interviewee commented how her motivation for first getting sober was her long-term boyfriend breaking up with her, and she thought “this isn’t good. I’m doing bad things.” Similarly, another interviewee’s husband was part of her same recovery groups and she “[didn’t] feel comfortable going to our local meetings because there’s… still a lot of the same people” who know her and her ex-husband. She moved away to find a community where she wasn’t considered a “delinquent.” Because these women believed they were being seen as deviant, they began to see themselves in that way as well. In order to create new identities, they both joined their respective recovery groups and moved away, which allowed the new people they met to form different opinions of them and rebuild their identities outside of being "delinquent" or deviant.

Another reason that the previously mentioned interviewee moved was the death of her late husband and the court’s decision to give custody of her children to their father who was in active addiction. She was “so disappointed not only in how the county courts handled the murder.” Her community left her with a sense of betrayal and, after she moved, she no longer participated in groups despite still being a member of the wider recovery community.

Limitations and Future Research

A major limitation of this research was the time and resources available. The methods for data collection underwent numerous changes, and time for data collection, as well as interviews, was limited. An ideal sample would include a larger number of participants from varying universities, as well as more interviews and survey responses.

Additionally, I examined interpersonal interactions without witnessing the interactions themselves. By relying solely on what participants described in the survey and interviews, it's possible this research doesn't present a full picture of the support groups. To combat this limitation, I included interview and survey questions that asked participants to imagine themselves in specific situations, for example if someone doesn't follow the group norms, so they could more accurately relay how they may act in a certain scenario.

Future research may examine peer-led support groups centering on specific conditions and how they differ from other groups, for example AA as opposed to all-recovery groups. Research may also focus on different aspects of identity, like sexual orientation or race and how those identities impact one's experience in a peer-led support group. By integrating other universities as well, geographical location and political ideology may have effects on a group's understanding of recovery as well.

Conclusion

Ultimately, members of peer-led support groups, specifically those on university campuses, utilize their relationships, language, and norms to navigate diverse identities and communities to construct a shared understanding of what recovery encompasses.

This research found that while university CRPs may be structured similarly, the leadership hierarchy of the space can heavily impact group member's feelings about the program. Also, although a group member's identity may impact how they choose to interact with their peers, group members don't initially feel that it affects how they are treated in the group. Age, while often providing more time to develop recovery skills, can make nontraditional students in recovery feel isolated from the group. However, support from staff and other peers can still integrate them into the recovery community. Overall, group members shift their identity and behavior to one that is recovery-centered based on how they think other group members perceive them. The looking glass self describes this process in which one's self-conception is strengthened by their perception of support and connection from peers.

Norms are learned both implicitly, through observing group members, and explicitly, through introductions made at the beginning of the group. Norms typically include not sharing others' experiences, not sharing excessively about one's own experiences, and not labeling others. These norms facilitate an identity shift towards considering oneself primarily as someone in recovery. Additionally, group members expect their peer leaders to identify norm violations and handle them accordingly, and when this is not the case, peers lose trust in their leaders. Trust is important in group relationships, and they are strengthened through humor and socializing outside of the group space. Group members, especially those in long-term, feel a responsibility to care for and advise their peers who are newer to recovery and help them to create stronger

connections in the group. Although peer-led support groups operate with more honesty and vulnerability than other spaces, group members are still cognizant of how they and others present themselves through their language, behaviors, and values.

Some merits of my proposed study include a better comprehension of how complex conditions like mental health conditions and addiction can be treated in an accessible environment. These conditions are becoming increasingly prevalent (NIDA 2023), and it's imperative that knowledge about how an individual's identity and lived experience impact the efficacy and overall experience of their recovery community. Furthermore, peers are an important point of connection and there's little research on the differing experiences in professional-led versus peer-led support groups. My research adds to the current body of knowledge surrounding support groups, human interactions, and socialization processes. By understanding how an individual learns to interact in a nuanced environment like a support group, future research can explore how to make these groups more effective. Through qualitative methods, this research provides a broad overview of group dynamics, while also using participants' direct interpretations of their experiences to understand norms and hierarchies within the group.

In a larger context, university students are facing increasing rates of poor mental health and it's imperative to understand how background and identity affect one's support systems and the ways they respond to recovery and peers. By looking at the factors that create healthy, equitable, and empowering recovery spaces, it's possible to replicate these circumstances elsewhere. Also, by learning more about social interaction within spaces where vulnerability is not only expected, but required, there may be cues and patterns that differ from more public, front stage interactions.

This research can broaden sociological insights on the understanding of other confidential spaces, like interactions within medical, religious, and educational spheres, especially when considering peer-led interactions.

Appendix

Survey Measures

Q1 Consent form for participants 18 years old and older

Q2 Assent form for participants 17 years old

Age Req: By checking this box, you are confirming that you are 17 years old or older and consent to participate in this study.

Yes

Q3 At which university do you attend a peer-led support group?

Q4 Is this the same university you currently attend?

Yes (1)

No (please explain) (2)

Q5 How many years have you participated in an on-campus peer-led support group

Less than 1 (1)

1 (2)

2 (3)

3 (4)

4 (5)

5+ (6)

Q6 Have you ever participated in other support groups?

No (1)

Yes (please explain) (2)

Q7 Gender

Man (15)

Non-binary (16)

Transgender (17)

Woman (18)

Prefer not to say (19)

Other (please specify) (20)

Q8 Race/ethnicity

Asian (4)

Black or African American (5)

Hispanic/Latine (6)

Middle Eastern or North African (7)

Native American or Alaska Native (8)

Native Hawaiian or Other Pacific Islander (9)

White (10)

Prefer not to say (11)

Other (please specify) (12)

Q9-19 Measure on scale:

Strongly disagree – Somewhat disagree – Neither agree nor disagree – Somewhat agree – Strongly agree

In the group, I...

Q9 Feel accepted within the group

Q10 Feel comfortable sharing my experiences

Q11 Can talk about positive experiences and feelings

Q12 Can talk about negative experiences and feelings

Q13 Feel I can be my authentic self

Q14 Feel in control of my experience within the group

In the group...

Q15 I feel intimidated by the group leaders

Q16 I feel like an equal in the group

Q17 My voice is heard when I want it to be

Q18 I wish I had more power

Q19 I trust the group leaders to handle any conflict that arises

Q20 How would you react if another group member violated one of the group's norms?

Q21 How do you think your identity affects the ways you show up in the group?

Q22 Do you know how your university's collegiate recovery program (CRP) is structured?

Yes (1)

No (2)

Q23 Please describe the structure of the CRP. If possible, please include to what extent your support group is related to the university.

Q24 Are there any experiences, thoughts, or ideas you don't feel comfortable sharing in the group setting?

Yes (1)

No (2)

Q25 Please explain your answer to the previous question. Are there other settings or people you feel more comfortable sharing with?

Q26 Is food offered during the group?

Yes (1)

No (2)

Q27 Does your group meet in a space specifically dedicated to the group?

Yes (1)

No (2)

Sometimes (please explain) (3)

Q29 Please describe the physical arrangement/set-up of the group space.

Q30-32 Measure on scale:

Strongly disagree – Somewhat disagree – Neither agree nor disagree – Somewhat agree – Strongly agree

Q30 I consider myself to be friends with other group members

Q31 I trust the other members of the group

Q32 I feel trusted by other members of the group

Q33 What are some common narratives that are brought up in group?

Q34 Is there a common vocabulary used in the group?

Yes (1)

No (2)

Q35 Please provide examples.

Interview Questions

INTRODUCTION

- How did you get involved with this group?
- Have you ever been a participant in a group? A peer-led group?
- How would you define recovery? / What does recovery mean to you?

QUESTIONS

- What is the setting like for the group? Do you have a designated space/food?
- How does the group fit into the university's CRP?
- How do you run groups? How is the group structured?
- What rules or norms do you have?
- What do you do if things go 'off the rails' or someone doesn't follow the group norms?
- How do you think the group helps combat stigma?
- Are there common language or narratives you see used in the group? Could you describe a situation in which you would hear this?
- How does it feel to lead the group as a peer as opposed to a trained professional?
- What are some factors that have contributed to your continued group involvement?
- What is your comfort level sharing personal experiences with the group?
- How do you think your identity as _____ shapes your experiences within the group?
- What are some factors that affect your comfort when sharing personal experiences with the group?
- Are there any experiences/thoughts/ideas that you wouldn't feel comfortable sharing with the group? Why?
- What settings do you feel comfortable in?

- Would you trust others in the group outside of the group setting? Why or why not?
- In the survey, you said _____. Could you describe a situation where this happened?
- In the survey, you mentioned _____. Would you be able to elaborate on how/why you think that?

CONCLUSION

- What have you learned through your experience as a group facilitator/member?
- How do you see the importance of the group in connection with college students' struggles and values?

Codebook

Code	Definition	Example
Differing identities		
Age	Impact of age on group participation	
College dynamics	How college drinking culture impacts group participation and recovery	
What is "normal"	Expectations for college students or individuals not in recovery	
Stereotypes	Expectations for what someone in addiction or recovery looks like	
Gender	Impact of gender on group participation	
Safety	Causes and consequences of feeling "safe" in a group due to one's gender	
Sex	Comfortability talking about sex/sex work	
Spirituality	Belief in a higher power and how it impacts group participation	Christianity, AA's "higher power"
Structure		
Groups	How groups are organized	
Physical space	The physical (as opposed to virtual) layout of a group space	Chairs in a circle, white board with sober dates
Literature and materials	The readings and various materials that are incorporated into group	AA's Big Book, SMART literature
CRP	How CRPs are organized	Physical location, personnel hierarchy, staff
Learning process	The development process of a new CRP and group	

More than recovery	The resources that CRPs offer outside of recovery support groups	
Leadership	How does the group or CRP fit into the university and how is leadership perceived	Often distrust and breakdown of communication between university leadership and CRP
Relationships		
With group members	How relationships are formed between group members	
Balancing roles	How individuals handle being both a group member and a group facilitator	
Trust	Role of trust in relationships	
Honesty/transparency	Importance of honesty and transparency in relationships	
Humor	Role of humor in relationships	
Old vs new	The needs and behaviors of individuals new to recovery compared to those in long-term recovery	
Responsibility to others	What those in a group or recovery community owe to others in recovery	
Peer leaders	Forming relationships with peer leaders	
Previous relationships	Impact of previously interacting with others in peer-led recovery support group settings	Ex-husband, previous group members
"Outgrowing" a group	Feeling like a group is not providing the benefits it once did	
Outside community	Forming relationships and connections with those outside of the support group or CRP	Courts, other universities, wider population

Privacy in other settings	Comfortability and willingness to share about recovery outside of group	
Shame/judgement/stigma	Development/handling of judgement and negative feelings of self	
Socializing outside group	Social meetings and talking outside of a group meeting space	Group chats, hanging out at a group member's apartment
What is recovery	Defining recovery and specifically how groups contribute	
Finding own path	Finding the groups and recovery methods that work for a specific individual	
Preference on group	Factors that affect which group an individual chooses to participate in	Choosing AA vs. SMART
Acceptance	Accepting past and behavior of others	
Rebuilding a life	Finding a new normal in recovery	
Relapse	Fear and behaviors associated with relapse	
Loss of control	Internal feelings of being out of control in recovery	
Norm Violation	Going against a group's expected or stated behaviors	
How violations are handled	How individuals mitigate and manage behaviors that go against a group's norms	
Triggers	Behaviors that may negatively impact another individual's recovery/sobriety	
Safety	Associated with behaviors and attitudes that protect others' recovery	

Disappointment with group	Negative emotions associated with other group members	Group members often not adhering to norms
What is shared	What information or feelings are deemed acceptable to share in a group setting	
Sharing others' stories	Expectations surrounding talking about others' recovery/experiences	Interviewee did not want to talk about (ex-)husband's relapse in AA
Language	What language is used in groups	
Why join a group	Factors that contribute to group participation	
Social aspect	Participating for social interaction	
Common understanding	Shared experiences and beliefs	
Distraction	Participating to distract from potential discomfort of recovery	

Bibliography

Alegria, Margarita, Marc Atkins, Elizabeth Farmer, Elaine Slaton, and Wayne Stelk. 2010. "One Size Does Not Fit All: Taking Diversity, Culture and Context Seriously." *Administration and Policy in Mental Health* 37(1–2):48–60. doi: 10.1007/s10488-010-0283-2.

Andersen, Ditte. 2014. "Giving Clients a Backstage Experience: A Case of Dramaturgical Trouble in the Professional Performance of Drug Treatment." *Symbolic Interaction* 37(4):483–99. http://www.jstor.org/stable/symbinte.37.4.483.

ARHE. n.d. Retrieved April 24, 2026. https://collegiaterecovery.org/crps-crcs/.

Auerbach, Randy P., Philippe Mortier, Ronny Bruffaerts, Jordi Alonso, Corina Benjet, Pim Cuijpers, Koen Demyttenaere, David D. Ebert, Jennifer Greif Green, Penelope Hasking, Elaine Murray, Matthew K. Nock, Stephanie Pinder-Amaker, Nancy A. Sampson, Dan J. Stein, Gemma Vilagut, Alan M. Zaslavsky, Ronald C. Kessler, and WHO WMH-ICS Collaborators. 2018. "WHO World Mental Health Surveys International College Student Project: Prevalence and Distribution of Mental Disorders." *Journal of Abnormal Psychology* 127(7):623–38. doi: 10.1037/abn0000362.

Barta, Kristen, Katelyn Wolberg, and Nazanin Andalibi. 2023. "Similar Others, Social Comparison, and Social Support in Online Support Groups." *Proceedings of the ACM on Human-Computer Interaction* 7(CSCW2):1–35. doi: 10.1145/3610086.

Becker, H. S. (1963). Outsiders: *Studies in the sociology of deviance*. New York: Free Press.

Best, David, Melinda Beckwith, Catherine Haslam, S. Alexander Haslam, Jolanda Jetten, Emily Mawson, and Dan I. Lubman. 2016. "Overcoming Alcohol and Other Drug Addiction as a Process of Social Identity Transition: The Social Identity Model of Recovery (SIMOR)." *Addiction Research & Theory* 24(2):111–23. doi:10.3109/16066359.2015.1075980.

Brown University. 2026. "On-Campus Recovery Student Groups | The College | Brown University." Retrieved April 25, 2026. https://college.brown.edu/seek-advising-support/types-advising-support/recovery-substance-free-initiatives/campus-recovery.

Brown, Austin M., J. M. McDaniel, V. H. Johnson, and R. D. Ashford. 2020. "Dynamic Labeling Discernment: Contextual Importance of Self-Identifiers for Individuals in Recovery." *Alcoholism Treatment Quarterly* 38(2):215–30. doi:10.1080/07347324.2019.1642170.

Brown, Louis D., Xiaohui Tang and Ruth L. Hollman. 2014. "The Structure of Social Exchange in Self-Help Support Groups: Development of a Measure." *American Journal of Community Psychology* 53(1-2):83-95

Bryde Christensen, Anne, Sofie Krohn, Michaela Høj, Stig Poulsen, Nina Reinholt, and Sidse Arnfred. 2023. "'Men Are Not Raised to Share Feelings' Exploring Male Patients' Discourses on Participating in Group Cognitive-Behavioral Therapy." *The Journal of Men's Studies* 31(1):3–24. doi: 10.1177/10608265221077298.

Budgeon, Shelley. 2014. "The Dynamics of Gender Hegemony: Femininities, Masculinities and Social Change." *Sociology* 48(2):317–34. doi: 10.1177/0038038513490358.

Butler, Judith. 2006. *Gender Trouble: Feminism and the Subversion of Identity*. New York; London: Routledge.

Chaudhary, Sarah, Mark Avis, and Carol Munn-Giddings. 2013. "Beyond the Therapeutic: A Habermasian View of Self-Help Groups' Place in the Public Sphere." *Social Theory & Health: STH* 11(1):59–80. doi: 10.1057/sth.2012.14.

Davison, Kathryn P., James W. Pennebaker, and Sally S. Dickerson. 2000. "Who Talks? The Social Psychology of Illness Support Groups." *American Psychologist* 55(2):205–17. doi: 10.1037/0003-066X.55.2.205.

Deutsch, James. 2016. "Are You a Friend of Dorothy? Folk Speech of the LGBT Community | Smithsonian Center for Folklife and Cultural Heritage." https://folklife.si.edu/talkstory/2016/are-you-a-friend-of-dorothy-folk-speech-of-the-lgbt-community.

Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday.

Gray, Ross, Margaret I. Fitch, Manon Labrecque, and Marlene Greenberg. 2005. "PERSPECTIVES OF PROSTATE CANCER SUPPORT GROUP MEMBERS ON MEN'S HEALTH ISSUES AND MASCULINITY." *International Journal of Self Help and Self Care* 2(3):255–68. doi: 10.2190/H9L9-14UU-2MQG-P4RH.

Gureje, Oye, Roberto Lewis-Fernandez, Brian J. Hall, and Geoffrey M. Reed. 2020. "Cultural Considerations in the Classification of Mental Disorders: Why and How in ICD-11." *BMC Medicine* 18(1):25. doi: 10.1186/s12916-020-1493-4.

Halasz, Judith, and Peter Kaufman. 2023. "Social Structure and the Individual." *A Sociology Experiment*. (https://sociologyexperiment.com/product/social-structure-and-the-individual-a-sociology-experiment/).

Hayes, Terrell A. 2001. "POTENTIAL OBSTACLES TO WORLDVIEW TRANSFORMATION: FINDINGS FROM DEBTORS ANONYMOUS." *International Journal of Self Help and Self Care* 1(4):353–68. doi: 10.2190/PLE7-543Q-7NTF-NQ2H.

Hitzler, Sarah. 2024. "Doing Being Ordinary Nonetheless: Navigating Social Expectations in a Peer Support Group." *Discourse Studies* 26(4):510–27. doi: 10.1177/14614456241229874.

Hollander, Jocelyn A., and Hava R. Gordon. “The Processes of Social Construction in Talk.” *Symbolic Interaction*, vol. 29, no. 2, 2006, pp. 183–212. *JSTOR*, https://doi.org/10.1525/si.2006.29.2.183. Accessed 25 Apr. 2026.

Jason, Leonard A., Mayra Guerrero, Gabrielle Lynch, Ed Stevens, Meghan Salomon-Amend, and John M. Light. 2020. “Recovery Home Networks as Social Capital.” *Journal of Community Psychology* 48(3):645–57. doi: 10.1002/jcop.22277.

Jensen, George H. 2000. *Storytelling in Alcoholics Anonymous : A Rhetorical Analysis.* Carbondale, IL: Southern Illinois University Press.

Jonikas, Jessica A., Stephen Kiosk, Dennis D. Grey, Marie M. Hamilton, James McNulty, and Judith A. Cook. 2010. “Cultural Competency in Peer-Run Programs: Results of a Web Survey and Implications for Future Practice.” *Psychiatric Rehabilitation Journal* 34(2):121–29. doi: 10.2975/34.2.2010.121.129.

Keohane, Aisling, and Noel Richardson. 2018. “Negotiating Gender Norms to Support Men in Psychological Distress.” *American Journal of Men’s Health* 12(1):160–71. doi: 10.1177/1557988317733093.

Link, B. G., Cullen, F. T., Struening, E. L., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, 54(3), 400–423.

Majer, John M., Carolina Plaza, and Leonard A. Jason. 2016. “Abstinence Social Support Among Ex-Prisoners With Substance Use Disorders.” *The Prison Journal* 96(6):814–27. doi: 10.1177/0032885516671890.

McCrady, Barbara S., Elizabeth E. Epstein, and Kathryn F. Fokas. 2020. “Treatment Interventions for Women With Alcohol Use Disorder.” *Alcohol Research : Current Reviews* 40(2):08. doi: 10.35946/arcr.v40.2.08.

Medvene, Louis J., Scott Wituk, and Douglas A. Luke. 1999. “Characteristics of Self-Help Group Leaders: The Significance of Professional and Founder Statuses.” *International Journal of Self Help and Self Care* 1(1):91–105. doi: 10.2190/2KTL-LVNW-VCH6-TBV8.

Merton, R. K. (1948). The Self-Fulfilling Prophecy. *The Antioch Review*, 8(2), 193–210.

Mowat, Joan. 2007. *Using Support Groups to Improve Behaviour*. London, UNITED KINGDOM: SAGE Publications, Limited.

National Institute on Drug Abuse. 2023. “NIDA IC Fact Sheet 2024 | National Institute on Drug Abuse (NIDA).” https://nida.nih.gov/about-nida/legislative-activities/budget-information/fiscal-year-2024-budget-information-congressional-justification-national-institute-drug-abuse/ic-fact-sheet-2024.

Newton, Heather. 2021. “Dramaturgical Analysis | Research Starters | EBSCO Research.” https://www.ebsco.com.

Nitsun, Morris. 2014. “Introduction.” Pp. 1-12 in *The Anti-Group: Destructive Forces in the Group and Their Creative Potential*. London: Routledge.

Pedrelli, Paola, Maren Nyer, Albert Yeung, Courtney Zulauf, and Timothy Wilens. 2015. “College Students: Mental Health Problems and Treatment Considerations.” *Academic Psychiatry : The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry* 39(5):503–11. doi:10.1007/s40596-014-0205-9.

Pistrang, Nancy, Chris Barker, and Keith Humphreys. 2008. “Mutual Help Groups for Mental Health Problems: A Review of Effectiveness Studies.” *American Journal of Community Psychology* 42(1):110–21. doi: 10.1007/s10464-008-9181-0.

Pointon-Haas, Julia, Luqmaan Waqar, Rebecca Upsher, Juliet Foster, Nicola Byrom, and Jennifer Oates. 2024. “A Systematic Review of Peer Support Interventions for Student Mental Health and Well-Being in Higher Education.” *BJPsych Open* 10(1):e12. doi: 10.1192/bjo.2023.603.

Saldana, Johnny. Coding Manual for Qualitative Researchers, SAGE Publications, 2009. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/uoregon/detail.action?docID=585421. Created from uoregon on 2024-10-10 15:56:28.

SAMHSA. 2021. “Addressing the Specific Needs of Women for Treatment of Substance Use Disorders.”

SAMHSA. 2026. “Peer Support.”

Shalaby, Reham A. Hameed, and Vincent I. O. Agyapong. 2020. “Peer Support in Mental Health: Literature Review.” *JMIR Mental Health* 7(6):e15572. doi: 10.2196/15572.

Sharma, Shwadhin, and Anita Khadka. 2019. "Role of Empowerment and Sense of Community on Online Social Health Support Group." *Information Technology & People* 32(6):1564-1590. doi: https://doi.org/10.1108/ITP-09-2018-0410.

Skatvedt, Astrid. 2017. “The Importance of ‘Empty Gestures’ in Recovery: Being Human Together.” *Symbolic Interaction* 40(3):396–413.

Tracy, Kathlene, and Samantha P. Wallace. 2016. “Benefits of Peer Support Groups in the Treatment of Addiction.” *Substance Abuse and Rehabilitation* 7:143–54. doi:10.2147/SAR.S81535.

University of Alabama. 2026. “Find a Meeting - Collegiate Recovery and Intervention Services | The University of Alabama.” Retrieved April 25, 2026. https://cris.sl.ua.edu/community/find-a-meeting/.

University of Oregon. 2026. “Recovery | Dean of Students.” Retrieved April 25, 2026. https://dos.uoregon.edu/recovery.

University of Texas at Austin. 2026. “Meetings | Center for Students in Recovery.” Retrieved April 25, 2026. https://recovery.utexas.edu/meetings.

Veen M, te Molder HFM, Gremmen B, et al. (2010) Quitting is not an option: An analysis of online diet talk between celiac disease patients. *Health* 14(1): 23–40.

Vejar, Cynthia. 2024. “Symbolic Interactionism | Research Starters | EBSCO Research.” https://www.ebsco.com.

Viverito, Kristen M., Scott A. Cardin, Leigh A. Johnson and Richard R. Owen. 2013. "Lessons Learned from Two Peer-Led Mutual Support Groups." *International Journal of Group Psychotherapy* 63(4):593-600.

West Texas A&M University. 2026. “Collegiate Addiction Recovery Education & Support (Buff CARES).” Retrieved April 25, 2026. https://www.wtamu.edu/academics/college-nursing-health-sciences/buffcares.html.