“Deep in the Hollers”: LGBTQ+ Narratives of Addiction and Recovery in Appalachia

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The Professional Counselor™
Volume 15, Issue 4, Pages 312–330
http://tpcjournal.nbcc.org

doi: 10.15241/jp.15.4.312

This study employs narrative inquiry to explore the experiences of LGBTQ+ individuals in Appalachia as they navigate addiction and recovery. From in-depth, semi-structured interviews, five central themes emerged: becoming in Appalachia, seeking refuge, reaching a breaking point, recovery in the margins, and visions of wellness. These themes illuminate the complex interplay between LGBTQ+ identity development, structural marginalization, and lack of access to affirming recovery supports in the Appalachian region. Participants’ stories reveal how isolation, stigma, and cultural expectations shape both substance use and recovery trajectories. Themes also highlight resilience, chosen family, and the reimagining of wellness beyond dominant treatment models. This work contributes to the limited scholarship on LGBTQ+ recovery in rural regions and underscores the importance of culturally responsive, community-rooted approaches to care in Appalachia.

Keywords: **LGBTQ+, Appalachia, addiction, recovery, narrative inquiry**

LGBTQ+ individuals stand a significant chance of experiencing social stressors due to their sexual, affectional, and gender-expansive identities (Fernandez et al., 2021; Frey et al., 2021; Krasnova et al., 2021; Lee et al., 2016; Meyer, 2003; Moon et al., 2024; Nieder et al., 2025; Shelton, 2021). The Substance Abuse and Mental Health Services Administration reports that repeated exposure to societal stigma, discrimination, and harassment can cause LGBTQ+ people to face an increased risk of mental health conditions including major depressive episodes, suicidal ideation, and substance use disorders (SUDs; HC DrugFree, 2023). If LGBTQ+ individuals do not receive emotional support from caregivers or mental health providers during moments of distress, maladaptive coping strategies including SUDs can develop as a result (Allan & Johnson, 2017; Paschen-Wolff et al., 2024; Shelton, 2021; Zuccarini & Karos, 2011). Therefore, when working with LGBTQ+ clients navigating recovery from SUDs, counseling practitioners must conceptualize the individual’s symptomatology within the larger sociocultural factors that contribute to each person’s sense of relational disconnection (Allan & Johnson, 2017; Zuccarini & Karos, 2011).

Although the correlation between environmental stressors and substance use within LGBTQ+ communities has been extensively documented (Chaney & Mason, 2024; Fernandez et al., 2021; Lee et al., 2016; Meyer, 2003; Moon et al., 2024; Nieder et al., 2025; Shelton, 2021), there remains a critical need for qualitative inquiry that centers the voices of LGBTQ+ individuals pursuing recovery from SUDs (Chaney, 2019; Paschen-Wolff et al., 2024). Furthermore, most of the existing research on substance use treatment tailored to LGBTQ+ individuals consists of data sourced from highly populated urban areas where LGBTQ+–affirming resources are more readily available (Frey et al, 2021; Lavender-Stott et al., 2018; Nieder et al., 2025; Pachankis et al., 2020; Paschen-Wolff et al., 2024; Senreich, 2010; Ware et al., 2023), highlighting the need for firsthand accounts of recovering LGBTQ+ individuals residing in rural locations. Although the American South contains the highest concentration of substance use

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disorder treatment facilities nationwide (Ware et al., 2023), programs tailored to LGBTQ+ populations are disproportionately located in the Northeast and West (Qeadan et al., 2022). Given this gap, the present study utilized qualitative interviews and Meyer's (2003) minority stress theory to explore the following research question: What are the lived experiences of Appalachian LGBTQ+ individuals pursuing recovery from substance use disorders? Our primary aims were to examine the complex issues contributing to SUDs in Appalachian LGBTQ+ communities, identify factors that sustain recovery for these individuals, and inform culturally responsive treatment interventions for mental health providers working with this population.

Literature Review

Minority Stress and Substance Use Disorders

Meyer (2003) created the minority stress theory to illustrate the link between LGBTQ+ individuals' experiences of their social context and their sense of well-being in the world. Meyer (2003) views the "social environment as providing people with meaning to their world and organization to their experiences . . . interactions with others are therefore crucial for the development of a sense of self" (p. 675). LGBTQ+ people often encounter adversity ranging from microaggressions to acts of violence, interactions with the dominant heterosexual/cisgender culture that can negatively shape their self-perception. Meyer (2003) defines two types of minority stressors: distal (e.g., discrimination, sexual and physical victimization) and proximal (e.g., internalized homophobia/transphobia). Within the LGBTQ+ population, social stigma has historically led to isolation, lack of integration with one's community, and subsequent issues with identity development (Allan & Johnson, 2017; Meyer, 2003). Additionally, Meyer (2003) reports that "internalized homophobia, or the gay person's direction of negative social attitudes toward the self, can further lead to a devaluation of the self and resultant internal conflicts and poor self-regard" (p. 682). Meyer (2003) takes care to note that it is the process of marginalization that contributes to poorer mental health outcomes, not the holding of an LGBTQ+ identity itself.

One of the ways LGBTQ+ individuals cope with minority stress and negative self-image is through substance use (Chaney & Mason, 2024; HC DrugFree, 2023; Meyer, 2003; Moon et al., 2024; Nieder et al., 2025; Paschen-Wolff et al., 2024; Shelton, 2021). Shelton (2021) notes that LGBTQ+ individuals who report at least one SUD were significantly more likely to have experienced internalized homophobia than those who did not report an SUD. LGBTQ+ individuals may also use substances to soothe anxiety that comes from having to disclose one's sexual, affectional, or gender-expansive identity (Frey et al., 2021; Shelton, 2021); to lessen the burden of concealing one's identity to avoid potential discrimination (Allan & Johnson, 2017; Frey et al., 2021); or to alleviate the deleterious symptoms of post-traumatic stress disorder (Johnson, 2019; Meyer, 2003). In each of these examples, social isolation from the dominant heterosexual/cisgender culture underpins the LGBTQ+ person's need for substances to mitigate the mental health symptoms stemming from minority stress.

LGBTQ+–Affirming Substance Use Treatment

Although LGBTQ+–affirming treatment for SUDs has shown to be effective in reduced reliance on or sustained abstinence from substances (Krasnova et al., 2021; Nieder et al., 2025; Paschen-Wolff et al., 2024), scholars have noted a lack of research, treatment protocols, and facilities catering to the specific needs of this population (Chaney, 2019; Chaney & Mason, 2024; Guy et al., 2023; Ware et al., 2023). When pursuing recovery in residential or outpatient health care facilities, many LGBTQ+ patients have noted stigma, harassment, and alienation from providers or fellow patients that mirrored their experiences of minority stress in the outside world (Gorritz FitzSimons & Byrd, 2025;

Micale et al., 2025; Paschen-Wolff et al., 2024; Senreich, 2010). These unfavorable conditions have been associated with elevated rates of relapse, leaving treatment prematurely, and dismissal of treatment as a viable option altogether (Chaney & Mason, 2024; Paschen-Wolff et al., 2024).

Conversely, when LGBTQ+ individuals have engaged in treatment tailored to their population, patients reported higher rates of sustained abstinence and satisfaction with recovery (Chaney & Mason, 2024; Guy et al., 2023; Nieder et al., 2025; Paschen-Wolff et al., 2024; Senreich, 2010). Paschen-Wolff et al. (2024) emphasize that in settings often marked by stigma, the presence of even one staff member advocating for LGBTQ+ inclusion offered participants a sense of safety and belonging, helping to ease experiences of fear and isolation. In addition to LGBTQ+–affirming staff members, building community with other LGBTQ+ people while pursuing recovery can mitigate the ramifications of minority stress that may contribute to substance use relapse (Kidd et al., 2018; Nieder et al., 2025; Paschen-Wolff et al., 2024). As Gorritz FitzSimons and Byrd (2025) state, companionship, opportunities to discuss trauma related to LGBTQ+ identity, and diversity within substance use counseling are three considerable benefits that arise from LGBTQ+–affirming treatment programs, especially if the program welcomes discussion of intersecting sexual and racial/ethnic identities (e.g., LGBTQ+ Black, Indigenous, or people of color).

LGBTQ+ Recovery in Appalachia

If empirical and qualitative data supports that LGBTQ+–affirming treatment increases the likelihood of LGBTQ+ individuals achieving and sustaining recovery, what are the experiences of this population in rural areas with less access to culturally responsive substance use treatment? Although the American South has the greatest number of substance use disorder treatment facilities when compared to the West, Northeast, and Midwest regions (Ware et al., 2023), LGBTQ+–tailored programs were more likely to be found in the Northeast and West (Qeadan et al., 2022). These findings suggest geographic sociocultural views may contribute to the availability of culturally responsive interventions for this population (Frey et al., 2021; Ware et al., 2023). Frey et al. (2021) found that 100% of their North Carolina–based study participants had experienced stigma because of their sexual identity; many of them inferred that politically conservative and faith-based views contributed to the discrimination they had faced. For example, the implementation of legislation such as House Bill 574 and Senate Bill 49 in North Carolina supports these participants' concerns about their sociopolitical climate impacting their ability to safely express their LGBTQ+ identities (McClellan, 2023). These pieces of legislation force transgender athletes to play on teams associated with their "reproductive biology and genetics at birth" and limit discussions of gender identity in K–4 classrooms, respectively (McClellan, 2023). Additionally, the lack of LGBTQ+–specific treatment in the Southern region has been attributed to fewer LGBTQ+ individuals living in sparsely populated areas (Ware et al., 2023). For these rural LGBTQ+ individuals pursuing affirming recovery options, the closest option may be many hours or states away (Nieder et al., 2025; Senreich, 2010).

When considering Meyer's (2003) minority stress theory, negative societal views toward LGBTQ+ people can produce distal and proximal stressors, which, as stated previously, have been shown to increase the likelihood of SUDs. If geographic barriers further limit access to LGBTQ+–affirming treatment, these SUDs are more likely to remain untreated (Senreich, 2010). To that end, scholars have called for further qualitative research to ascertain LGBTQ+ experiences of stigma and mental health treatment in rural regions (Frey et al., 2021; Nieder et al., 2025; Senreich, 2010; Ware et al., 2023).

Method

Narrative Inquiry

Narrative inquiry, rooted in interpretivist and constructivist paradigms, is centered on the belief that humans make meaning of their lives through stories (Clandinin, 2022). It is particularly well-suited for research involving marginalized populations, as it prioritizes their lived experiences and resists reducing individuals to overly simplified categories or variables (Bruner, 1991; Hendry, 2007). Within this methodology, the researcher's positionality is acknowledged as integral to both the co-construction and interpretation of participants' stories, as meaning emerges relationally between storyteller and listener (Clandinin, 2022). We chose to utilize this particular methodology because it allowed for the centering of the voices contributing their stories (Clandinin, 2022).

This study aimed to explore the recovery stories of LGBTQ+ individuals living in the Appalachian United States. Our inquiry was driven by the following research question: What are the experiences of LGBTQ+ Appalachians who have been able to sustain recovery? This approach focusing on personal narratives allowed for the exploration of how LGBTQ+ participants construct and make sense of their identities in traditionally conservative rural contexts and how those identities intersect with substance use, recovery, and access to care. Stories offered nuanced insight into not only individual recovery trajectories but also the broader sociocultural and geographic landscapes that shape them.

Participants

Participants in this study were individuals who identified as LGBTQ+, had lived experiences with addiction, had been in an active state of recovery for at least 90 days, were currently residing in the Appalachian United States, were 18 years of age or older, and had access to Zoom. We engaged in purposive and snowball sampling strategies, which were particularly appropriate given the close-knit, often private nature of the LGBTQ+ Appalachian community. These methods facilitated access to participants who might otherwise be difficult to reach due to concerns about stigma and confidentiality. A digital research flyer containing an invitation and link to our informed consent document and eligibility screening demographic survey was distributed through LGBTQ+ social media groups and professional networks within the Appalachian addiction recovery community.

Six individuals responded and were admitted to the study. Their demographic information is presented in Table 1. Although our sample was diverse in terms of sexual, affectional, and gender identity, all participants identified racially as White. Additionally, the age distribution of participants ranged from 30–45, not representative of younger and older adults.

Data Collection

Participants who responded to the research call completed a demographic questionnaire via QuestionPro as a prescreening mechanism. Here, they also denoted their preferred pseudonyms, which were used to protect their privacy and confidentiality. For respondents who met the inclusion criteria, we scheduled 60–90-minute interviews that were conducted via Zoom and transcribed verbatim using Otter.ai. We developed a semi-structured interview protocol informed by minority stress theory (Meyer, 2003) and existing literature centered at the intersection of LGBTQ+ identity and substance use (Chaney & Mason, 2024; HC DrugFree, 2023; Meyer, 2003; Moon et al., 2024; Nieder et al., 2025; Paschen-Wolff et al., 2024; Shelton, 2021; see Appendix). Interview questions sought to capture the narratives of our participants, placing emphasis on storytelling. We debriefed after

each interview to discuss emerging themes and to engage in reflexive dialogue about how our own experiences impacted our perception of the participant interviews. Both researchers kept a reflexivity journal for trustworthiness and bias-checking purposes.

Table 1

Participant Demographics

Pseudonym	Gender Identity	Sexual/Affectional Identity	Pronouns	Racial Identity	Age
AvP	Cisgender Female	Lesbian	she/her	White	42
Michael	Nonbinary	Trixic	they/them	White	45
Alan	Cisgender Male	Gay	he/him	White	30
Avery	Cisgender Male	Gay	he/him	White	31
Em	Nonbinary	Queer	they/them	White	32
Beans	Genderqueer	Pansexual	he/they	White	44

Data Analysis

Upon completion of data collection, we reviewed all transcripts for accuracy and to familiarize ourselves with the data, noting points of convergence and divergence across participants' accounts. Transcripts were then uploaded into Atlas.ti, a qualitative coding software, for the purpose of facilitating data analysis. In alignment with paradigmatic narrative analysis (Polkinghorne, 1995), we sought to identify themes across participant stories that revealed shared meaning, recurring challenges, and sites of hope. We began with a round of open and in-vivo coding, allowing the participants' language to inform initial codes. Although we did not use a code book, we did engage in consensus coding to ensure that both researchers were in alignment with primary codes. We met after coding each transcript to discuss divergences in our codes and to provide transcript-based rationale to come to consensus and to minimize researcher bias. In the second round, we generated axial codes to begin organizing patterns across the data. These coding strategies primarily served to group participants' stories for narrative analysis, with particular attention paid to how meaning was constructed within each narrative and how that meaning varied or aligned across participants. Through this iterative process, we identified five overarching themes that illustrate the participants' experiences.

Trustworthiness

To ensure ethical rigor and transparency, several strategies were employed to enhance the study's credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Institutional

Review Board approval was obtained prior to recruitment and data collection. Credibility was strengthened through meaningful engagement with participants, iterative data analysis, and participant member checking. Regarding member checking specifically, participants were provided copies of their transcripts and associated codes and were offered the opportunity to provide feedback, make edits, or provide additional context to their interviews. Transferability was addressed by providing thick, contextualized descriptions of participants' experiences, settings, and sociocultural climate within Appalachia.

To promote dependability, the research team maintained a detailed audit trail that documented methodological decisions and changes made throughout the research process. Research reflexivity was supported through individual and team reflexivity journaling, memoranda, and positionality discussions conducted before, during, and after data collection. This was essential considering the positionality of the researchers to the research topic. Regular research meetings were used to bracket assumptions and collaboratively interrogate emerging interpretations. During the data analysis process, we considered the participant transcripts, research memos, and research positionality statements provided below to engage in triangulation. This enhanced confirmability and ensured that findings were grounded in participants' narratives rather than researcher preconceptions. Finally, participant voices were centered in the findings through rich description and extensive use of direct quotations.

Research Positionality Statements

Jacob Perkins

As a gay cisgender White male in recovery from chemical addiction and a current graduate student in clinical mental health counseling, my personal and professional identities inform this research. I got sober in New York City, where LGBTQ+–centered recovery spaces were more accessible. Since relocating to Appalachia, I've experienced firsthand the scarcity of culturally affirming support systems for LGBTQ+ individuals in recovery, particularly within Appalachian contexts. This gap has influenced my decision to explore LGBTQ+ Appalachian recovery narratives.

My recovery journey has been shaped by the intersection of my sexual identity and substance use, and this lens influences how I approach both the topic and the participants. I occupy a dual position as both insider and outsider: I share lived experience with many of the individuals whose stories I seek to understand, yet I also recognize the diversity within LGBTQ+ communities and the unique cultural dynamics of Appalachia. My aim is to amplify voices that are often marginalized in recovery discourse and to contribute to the development of services that are both culturally competent and personally resonant—services I would have benefited from in my own early recovery.

Harley Locklear

As an Indigiqueer person and counselor educator who has been impacted by the prevalence of substance misuse in my communities—rural, LGBTQ+, and Indigenous—I approach this research with both lived experience and a deep professional and communal commitment to improving substance use treatment and recovery outcomes. My positionality informs how I understand healing, resilience, and systemic inequity, as well as how I interpret participants' narratives of recovery. I recognize that my insider perspectives afford unique insight into the cultural and relational dynamics shaping addiction and recovery in these contexts yet also require continuous reflexivity to ensure that my interpretations do not overshadow participants' distinct experiences.

Findings

Five overarching narrative themes emerged that encapsulate the reconstructed stories of our participants. These themes are presented both chronologically and thematically, tracing a journey from growing up LGBTQ+ in Appalachia, through experiences of addiction and recovery, and culminating in a reimagined vision of LGBTQ+ sober joy in the region.

Becoming in Appalachia: Formative Experiences of LGBTQ+ Identity Development

Each participant detailed experiences of nonaffirming messaging regarding their LGBTQ+ identity during childhood and adolescence. In Appalachia—where each person in our study came of age—religious, familial, and sociocultural ideologies about sexual/gender minorities contributed to a sense of alienation, shame, and identity confusion. Michael (45, nonbinary, they/them, trixic) recalled a sentiment expressed by many of the participants: "I was told by my church when I was 12 that I was going to hell." Beans (44, genderqueer, he/they, pansexual) echoed this statement when they said: "[The church] always told me that I was going to die if I left . . . and that I was going to go to hell."

Alongside these faith-based doctrines, participants' families of origin often impacted identity development. Alan (30, cis male, he/him, gay) stated:

> I come from a very conservative background . . . I didn't really receive a lot of education on acceptance of different people or differences within myself, so I didn't really understand . . . the feelings that I was experiencing, or attractions that I tended towards.

Regarding culture, AvP (42, cis female, she/her, lesbian) expressed that Appalachian norms informed her reservations about disclosing her sexual identity: "Growing up here . . . [an LGBTQ+ identity] just wasn't acknowledged. It was sort of like pushed down. . . . I was afraid to discuss my same-sex attraction."

As a result of these early encounters with discrimination and stigma, all participants noted that identity concealment became a crucial way to lessen the possibility of social rejection and/or violence. Avery (31, cis male, he/him, gay) described masking as a learned ability:

> I'd mastered this skill of duality. I was able to present one image to the public . . . while withholding what was really going on, or how I really felt . . . and that was a skill that I had really honed during my adolescence, when I was hiding who I was as a homosexual.

Others sought to hide their LGBTQ+ identity by entering and sustaining heterosexual partnerships. Michael explained an early "lavender relationship" as an attempt to "make my parents happy by marrying," which turned out to be "a very miserable experience for me and unfortunately for my husband. I had to almost put on a mask and become somebody else."

Although all participants encountered forms of marginalization related to their minoritized sexual/gender identities in Appalachia, many of them also detailed moments of acceptance and affirmation in their communities. AvP discussed coming out to her godmother:

> I was like, "I just kind of have to tell you something. . . . Maybe I'm not going to have a boyfriend." And she was like, "Are you trying to tell me that you're gay?" And I was like, "Probably." And she was like, "You think I didn't already know that?" So, she was much more accepting than I imagined.

Similarly, Avery "never really struggled . . . with [his] parents when it came to coming out as homosexual."

While some participants received support for their LGBTQ+ identities from their families of origin, others found it through chosen family. Em (32, nonbinary, they/them, queer) said, "I was engaged in a lot of environmental justice work in the area. . . . What community I did have, queer community, were generally people from other areas who had come to Appalachia to fight the pipeline." This support from participants' immediate environments—familial or peer-to-peer—proved even more important amidst the anti-LGBTQ+ rhetoric many of them witnessed in the larger cultural atmosphere. Michael said:

> I would go to school auditorium functions, and they would have not necessarily blatantly anti-LGBTQ stuff, but it would be kind of obvious that they were hinting at the fact that good people don't do these things, and that was just the way proper society was. So that's the kind of shorthand that I grew up with. I grew up with the knowledge that certain people were not safe, like Jerry Falwell or Jim Bakker. And [the queer community], we would tell each other who was safe and who was not.

These formative experiences of identity suppression, religious trauma, and social marginalization shaped the conditions under which substance use became a meaningful, if often dangerous, response. For each participant, the initiation into drugs or alcohol was not merely recreational; it reflected a deeper negotiation with an LGBTQ+ identity in environments that denied its legitimacy. Substance use functioned as self-medication, camouflage, relational currency, or even rebellion against the roles they were forced to inhabit.

Seeking Refuge: Precipitating Factors With Substance Use

As identity concealment pervaded participants' formative social interactions, substances provided many of them with momentary bouts of courage to explore salient parts of self that they hid out of necessity. Michael stated, "I was more queer when I was drinking than I was when I was sober. It freed me up to express who I really was, and it was like taking the mask off. It was liberation." Michael also conveyed that substances provided a safeguard if others questioned their sexual identity: "[Substances] gave me an excuse. Because if something were to have happened and my parents caught me, 'Oh no . . . I'm not gay. I was just drunk.'" Alternatively, Avery stated that substances "helped [him] combat some of the feelings and emotions that [he] was having . . . that [he] didn't know how to express" or wasn't comfortable feeling. Drugs and alcohol could either inhibit or inspire a participant's identity expression, depending on their circumstantial need.

Because social alienation often dominated participants' daily lives, substances sometimes offered the comfort of connection. Alan explained: "The group that I started to get to know while using drugs, there was much more acceptance. . . . [There was] no judgment in those circles." Similarly, AvP discussed how her early drug use was entangled with romantic validation in her first same-sex partnership:

> I met this girl. . . . She's the one who introduced me to drugs. . . . I really was in love with this chick, and I was, like, willing to do whatever to do that relationship. I would have done anything to have [my LGBTQ+ identity] be normalized . . . the substances were like an afterthought. I don't know that I would have actually participated in [drug use] if it wasn't for, like, the desire to feel normal and to feel validated in those feelings.

When this connection was not achieved, however, some participants used substances as a coping strategy. Em discussed the escalation of substance use that came with being the only LGBTQ+ person in most spaces: "Whenever I came back [to Appalachia] . . . there was never a place I could go where . . . I wasn't one of the only queer folks, if I wasn't the only one. . . . The environment that I [used substances] in was very lonely."

Lastly, some participants felt empowered by their substance use as a form of rebellion. As a response to the anti-LGBTQ+ messaging they received through their church, Beans said:

> I figured that if I was going to sin and I was going to die, I was going to do it in a fun way. So my ass took off to New Orleans, and I didn't sober up for the month that I was in New Orleans, and then I hitchhiked across the U.S. and spent 18 months on the road. . . . And there was always weed. And then there were people with [cocaine]. And [cocaine] was amazing. . . . It slowed my brain down. Because I went from like all of this confusion and everything in the church and always being told that if I just prayed hard enough, all of the shit in my head would go away, and then suddenly I'm like, "Oh my god. . . . Maybe this is what normal people sort of feel like."

Together, these narratives illustrate how substance use served as a complex mechanism for survival and self-exploration. For many participants, substances were not merely a form of escape—they were a means of negotiating visibility, accessing belonging, and reclaiming autonomy. While this experimentation with drugs and alcohol introduced varying degrees of risk and harm, it also provided an entryway into LGBTQ+ identity exploration.

Reaching a Breaking Point: Pivotal Moments in the Recovery Journey

For all participants, the initiation of substance use arose not only from impulsivity or peer influence, but as a response to chronic marginalization. After developing a reliance on substances, each of the participants described distinct turning points when their relationships with drugs or alcohol shifted from coping mechanisms to sources of harm. These revelations regarding physical dependence, interpersonal strain, and emotional rupture led to participants' initial attempts at recovery.

Physical dependence and withdrawal symptoms were many participants' first hints at their problematic relationship with substances. Michael recalled, "I started shaking really bad in the morning, and I didn't ever know if it was nerves or the alcohol or what, but I did know that if I drank, it would stop." Avery detailed the reckoning with his dependence:

> When you're in jail, you have all these thoughts, "I'm going to change. My life is going to be different." I said everything I needed to say to get out of jail. My boyfriend picked me up . . . and within 30 minutes, I was high . . . using drugs again.

> It took about 2 weeks for me to get re-arrested on felony possession charges. . . . I had come to a realization . . . the second time I was in jail, that, like, I'm not cut out for this. . . . I'm not going to do well in jail, and I had to take . . . some responsibility.

Secondly, each participant remembered how substances impacted their close relationships. Michael stated, "When I was 21, I got drunk and slept with my husband's roommate. . . . I said, 'No, I can't do this anymore, I'm hurting way too many people.'" Em said, "I was living with two friends. My substance use was getting to the point where it was impacting our relationship, and they finally decided that they needed to move out and . . . de-escalate our friendship."

In addition to physiological ramifications and interpersonal strain, all participants noted moments of emotional rupture and clarity related to their substance use. AvP stated:

> I had burnt all my bridges at this point. When I got out of jail . . . I was sitting outside, and I remember looking up at the sky, and I was like, "Wow. The sky is so pretty." That sounds, like, so wild, but I never looked up. And I was sitting there, and I was like, "Okay, maybe you should really . . . do what these people want you to do, and that way, if you try it for a year, when you do go back on the street, you'll know you did everything you could."

Beans recognized that their substance use was impeding their treatment for nonsuicidal self-injury:

> My cutting became really extreme. . . . I ended up contacting a friend of mine when I was kind of in the depths of despair, and I disassociated so much that I woke up, and it was a horrific scene of self-injury, and I was like, I just can't do this anymore. And he picked me up and took me home. . . . And I realized that I had to stop . . . because I knew that I needed to take meds to help with my self-injury and my depression. And if I drank with that, then it could really fuck with the rest of my world.

Em detailed their critical breaking point:

> I had a night where I drove, I think, very much intending to end my life, and at one point something changed. Instead, I drove to my mom's house . . . where she basically said, "I buried my younger brother when I was 12 years old. I had to become . . . the person holding my family together and . . . that's made it hard for me to always hear you and see you. I don't know how to fix [your reliance on substances] . . . but I don't want to bury my child the way I buried my brother." And I think that full vulnerability . . . from my mom . . . that was maybe the biggest moment where I was like, "I've got to make a change."

Each participant's journey toward recovery began not with a singular decision but through cumulative contemplation. These moments catalyzed a recognition that substance use was no longer a refuge but a source of harm. What followed was a complex process of seeking support—not simply entering treatment but infusing their recovery with personal meaning.

Recovery in the Margins: Turning to Chosen Supports

Although many of our participants pursued traditional recovery routes, it was consistently emphasized that there was a devastating lack of LGBTQ+–affirming recovery services within

Appalachian communities. These barriers to care resulted in experiences where participants felt alienated, unsafe, or discontent, forcing them to turn inward and focus on the strength of their personal networks.

Participants' experiences with 12-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were mixed. Some found resonance and stability through structure and sponsor relationships. For example, AvP described a turning point:

> I rode my bike to an AA meeting, and I got a sponsor, and I began the process, and I just dove in. . . . They really reached a nerve in me. . . . I went through the 12 steps, and I really never looked back.

Michael similarly recalled feeling immediate rapport: "Something about the way they talked about drinking clicked with me, and I knew I fit with these people."

However, for others, the culture and rigidity of these programs was discomfiting, particularly when compounded by heteronormative or religious undertones. Alan recounted the judgment he experienced: "I've been told, while clean and sober from somebody who just relapsed, that my recovery is bullshit because I didn't work 12 steps. I got a really bad taste of NA in my mouth." Michael also noted that although they found affirmation in certain spaces, the lack of turnout for LGBTQ+–specific meetings reflected ongoing stigma: "There used to be an LGBTQ AA meeting, and it folded because nobody showed up. . . . People are willing to go to AA meetings and admit they're alcoholics but not show up to an AA meeting specifically for queer people." These accounts were consistent among participants, denoting a lack of LGBTQ+–centric addiction and recovery programs and interventions.

Participants also spoke to the emotional toll of navigating recovery in the absence of visible LGBTQ+ exemplars. Avery said, "I didn't have any role models within my community to look up to that had gotten sober and maintained that sobriety." Alan confirmed that "all [he] saw were the gay drug addicts . . . that were described to [him] by family and friends."

Even after achieving a state of recovery, LGBTQ+–specific resources remained scarce. Avery reflected that since he's "gotten sober and really started the journey of recovery, [he's] not really found anything super productive or helpful locally for the gay recovery community." Michael expressed the need for sober LGBTQ+ spaces: "We've had several discussions where we've talked about starting a coffee club for the gay community . . . because there aren't enough places, queer or not, where you can hang out that aren't bars."

In place of formal support systems, many participants sought emotional safety and trust through chosen family and peer-based strategies. Beans described how their friends intuitively practiced harm reduction:

> I was like, "I haven't had a drink in months, but I'm gonna go out and lose myself in it." And they're like, "Hey, why don't we get a tattoo or a piercing?" And that moved into, oh, that's the same feeling I get when I self-harm or drink. So why don't I body mod [instead]?

Beans emphasized "that mutuality and community support 100% keeps [them] sober and level." Similarly, Alan credited his recovery to interpersonal accountability: "The expectations of somebody else . . . is what keeps me sober." Michael summed it up simply: "To be able to laugh . . . and to have a safe space where everyone can talk freely . . . that's what I would like to find."

These narratives point to the resilience fostered by LGBTQ+ communities without formal supports. When culturally responsive infrastructures were limited, participants carved out recovery on their own terms, often in the margins of systems not built for them. These chapters in the participants' lives were pivotal in their recovery journey and ultimately shaped their present and future perceptions of wellness.

Visions of Wellness: LGBTQ+ Recovery and Reimagined Support in Appalachia

Participants described a present marked by hard-won wholeness: stable recovery; authentic LGBTQ+ visibility; and a sense of belonging woven through family, partners, and chosen community. Yet their narratives did not stop at personal wellness. Each speaker pivoted toward an expansive future vision, imagining recovery supports that are culturally rooted in Appalachia. Their recommendations included staff trained in LGBTQ+ competencies, meeting spaces free from religious persecution, and peer-led groups that feel like home. In their eyes, true recovery captures a movement from personal success to collective advocacy for the next generation of LGBTQ+ Appalachians seeking recovery.

Several participants framed their recovery as an intentional disruption of intergenerational trauma and addiction. For Avery, recovery meant building a new kind of family legacy:

> [My husband and I] want to establish a family unit which breaks the cycle of addiction. We want to have children. We want to be an outlet for those children to feel safe, included, and part of a bigger community, regardless of how they choose to identify.

For some, sobriety created space not only for personal healing but also for service to others. Participants described their recovery as a catalyst for becoming counselors, facilitators, or peer mentors. Beans shared:

> I'm out of that . . . Maslow's hierarchy of needs . . . and I'm now at the place where I want to help bring people to that level. . . . Keeping folks alive if they're not ready to stop—being able to provide harm reduction resources for them to stay alive long enough to get that help. I want to keep them alive long enough that they can hopefully inspire and help other people.

Em described how one trauma recovery center became a turning point—not just for healing, but for becoming a leader within recovery communities:

> [X] Trauma Recovery Center was the space that I came into in recovery. . . . I joined as a participant seeking care, and then a year later was empowered to start facilitating my own groups. They supported me in getting certified as a peer recovery specialist. . . . So absolutely, that was a space that . . . my story could be a force of positivity for other people.

Both Alan and Avery turned lived experience into professional work in peer support and housing services, embodying recovery structures they wished had existed for them.

Across interviews, participants emphasized the importance of meaningful relationships in sustaining wellness. For many, especially those estranged from biological kin, these connections were formed within chosen LGBTQ+ families. Em reflected on the power of intimate, affirming community:

> Now I feel a lot more grounded in my few core relationships. . . . All of them are [with] trans people. That's not necessarily the qualifier in my mind, but it works out that way. They're the ones I can feel present with . . . who are doing the same kind of work.

Others spoke to the power of finding LGBTQ+ recovery networks online, particularly in rural or isolated communities. Beans noted, "Being able to find the Appalachian queer groups . . . queer folks on Facebook . . . having that kind of community and support in staying sober, and in connecting with people, is huge."

Participants called for reimagined recovery spaces that honor both LGBTQ+ identity and Appalachian culture. Avery envisioned "some kind of community center. . . . A place people in recovery can go to and identify as safe." Em suggested programming grounded in local traditions: "Recovery folks going on hikes together, sitting around the fire, playing music, doing art . . . being in our bodies in a way that helps us feel present." Additionally, visibility and early intervention were central to participants' recovery visions. Avery shared:

> I think it would have definitely decreased the negative impacts . . . if you had some kind of programming in schools that was affirming—that included, "It's okay to be gay. . . . It's okay to have these feelings." . . . It just wasn't talked about when I was young.

Digital platforms, social media, and informal events like cookouts were seen as powerful, culturally congruent ways to nurture LGBTQ+ recovery communities. As Alan expressed, "I think if we really want that community, it needs to be in people's homes. Events like cookouts or birthday parties. . . . It's not as loud, which is important to me, but it's effective, creating a family, essentially."

Collectively, these visions point to a future in which recovery is community-led, culturally grounded, and unapologetically LGBTQ+. For participants, recovery was not the end of their stories; it was a springboard for advocacy, care, and collective joy in the face of systemic erasure.

Discussion

The lived experiences of Appalachian LGBTQ+ individuals in this study offer vivid accounts of Meyer's (2003) minority stress theory. Participants' early exposure to religious condemnation, familial rejection, and cultural dismissal created conditions of chronic ostracism. For many, these distal stressors became compounded with proximal stressors like shame and internalized homophobia/transphobia. Avery's "mastery of duality" and Michael's "lavender relationship" reflect how participants developed survival strategies to navigate hostile environments, often at the cost of authenticity and mental health.

Substance use emerged as a complex response to these stressors. Participants described using drugs and alcohol as tools for LGBTQ+ identity exploration and emotional regulation. Michael's assertion that alcohol "freed [them] up to express who [they] really [were]" exemplifies Shelton's (2021) findings that LGBTQ+ individuals often use substances to manage the anxiety of choosing identity disclosure or concealment.

The Appalachian context intensified the effects of minority stress through geographic and cultural isolation. Participants like Em described being "the only queer person in most spaces," underscoring the lack of LGBTQ+–affirming community. As previously noted, LGBTQ+–specific treatment programs are disproportionately located in urban centers, leaving rural individuals with limited access to culturally responsive care (Qeadan et al., 2022; Ware et al., 2023). This geographic barrier heightened the effects of minority stress for many participants, making recovery more difficult and substance use more likely to persist.

Even when participants sought formal recovery services, they encountered heteronormative and religious undertones that mirrored the very stigma they were trying to escape. Alan's experience of having his recovery dismissed for not following the 12-step model and Michael's account of the dissolution of an LGBTQ+ AA meeting due to low turnout suggest ongoing stigma within recovery spaces. These findings echo Gorritz FitzSimons and Byrd (2025), who emphasize the need for LGBTQ+–affirming treatment environments that welcome intersectional identities and trauma narratives.

In the absence of affirming clinical care, participants turned to chosen family and peer-based strategies to sustain recovery. Beans's friends practicing harm reduction by suggesting body modification instead of drinking illustrates the healing power of relational safety. Our participants' narratives align with Paschen-Wolff et al. (2024), who found that even one affirming provider or peer can mitigate feelings of isolation and foster recovery.

Participants also described joy, humor, and emotional openness as key aspects of LGBTQ+ recovery culture. Michael's desire for "a safe space where everyone can talk freely" and not be afraid of judgment reflects a longing for community-based recovery models rooted in mutual aid and authenticity. Em's grounding in trans friendships and Beans's connection to Appalachian LGBTQ+ groups online demonstrate how peer networks can bridge geographic isolation and nurture belonging.

Our findings call for a reimagining of recovery supports in rural Appalachia—ones that are culturally rooted yet explicitly LGBTQ+–affirming. Participants envisioned meeting spaces free from religious judgment, staff trained in LGBTQ+ competencies, telehealth to bridge rural distance, and peer-led recovery groups. Em's vision of recovery through land-based practices—hiking, music, and storytelling—suggests that Appalachian cultural traditions can be powerful tools for healing when integrated with LGBTQ+-affirming care.

Visibility and early intervention were also central to participants' recovery visions. Avery's call for affirming school programming and Alan's emphasis on informal events like cookouts reflect a desire for culturally congruent, grassroots approaches to wellness. These aspirations align with the literature's call for inclusive treatment models that honor regional specificity while addressing the structural conditions that make substance use a survival strategy (Frey et al., 2021; Senreich, 2010).

Importantly, participants did not merely survive their substance use; they used recovery as a pathway to reclaim autonomy and serve others. Em's facilitation of peer recovery groups and Beans's commitment to harm reduction reflect a shift from personal healing to community leadership. Avery's goal of building a family that "breaks the cycle of addiction" exemplifies how recovery can turn individual liberation into greater communal gain.

These narratives of Appalachian LGBTQ+ individuals pursuing recovery from SUDs reflect a journey from survival to flourishing. Their stories underscore the urgent need for culturally

responsive care (Paschen-Wolff et al., 2024), the transformative power of chosen community (Gorritz FitzSimons & Byrd, 2025), and the potential for recovery to become a site of LGBTQ+ possibility, resilience, and advocacy.

Implications

The findings from this study have important implications for both clinical practice and community interventions in Appalachia. Foremost, the noted lack of LGBTQ+–affirming recovery services within the region illuminates the need for more programs that support these individuals in active addiction and recovery. It is imperative that practitioners take necessary steps to improve their capacity for care while also increasing the volume of LGBTQ+ services. Given the reverence shown to chosen family and peer support by the participants, it is essential that practitioners are intentional about integrating these networks into their clients' treatment plans. Additionally, practitioners should place emphasis on ensuring that peer-led models are accessible to community members within formal treatment. We encourage practitioners to familiarize themselves with and have an expansive referral list of peer support specialists within their communities. Many of the participants noted that these models proved paramount to their recovery journey, establishing strong evidence of efficacy.

Beyond clinical settings, we noted that Appalachian community hubs (e.g., schools, faith communities, etc.) can serve as access points for early intervention. Counselors should cultivate relationships with stakeholders within these spaces to promote LGBTQ+ visibility, foster a culture of acceptance, and raise mental health awareness for both youth and adults. These advocacy initiatives are imperative for Appalachian counselors considering the close, tight-knit nature of these communities. Lastly, incorporating Appalachian cultural values and traditions into recovery interventions should be prioritized, as they can serve as powerful tools for healing. Em noted that "Appalachian culture involves getting your hands into things," so "connecting folks to art, or woodworking, or maker spaces" along with music and hiking is culturally responsive.

Limitations

Although this study has yielded rich narratives detailing the nuances of addiction and recovery for Appalachian LGBTQ+ individuals, it must be noted that our participant pool was limited. Participants were primarily recruited through snowball sampling and community-based networks, which may have limited the diversity of narratives that we were able to collect. The sample was relatively homogeneous, consisting entirely of White participants between the ages of 30 and 45. As such, the findings may not fully capture the heterogeneity of racial, ethnic, or age-related experiences within the broader LGBTQ+ Appalachian community.

Additionally, all interviews were conducted via Zoom at a single point in time, which may have constrained the depth of relational engagement and limited our ability to observe changes in participants' perspectives or recovery processes over time. Given the sensitivity of the topic and the close-knit nature of many Appalachian communities, social desirability and recall bias may also have influenced participants' willingness to disclose certain experiences or to recall them in ways that aligned with community or researcher expectations.

Lastly, although our analysis attends to regional context, it is important to recognize that Appalachia itself is not a monolithic space. Cultural, economic, and social conditions vary widely across subregions, and these differences shape how individuals experience their LGBTQ+ identities, addiction, and recovery. Our sample was drawn primarily from Central and Southern Appalachian communities, and thus the findings should be interpreted with that regional specificity in mind.

Recommendations for Future Research

Considering the limited scope of the current literature base, future research should build on this study, with the imperative to investigate the experiences of community members who are in active addiction and early recovery. This would offer a more in-vivo assessment of how traditional and nontraditional treatment options are experienced by LGBTQ+ individuals in Appalachia. Focusing future research on community members with other marginalized identities (e.g. ethnicity, race, disability) could also offer a new richness in terms of understanding recovery in Appalachia. Moving forward, we hope that findings from this study will prove insightful in the development of LGBTQ+–affirming interventions for individuals who are both in active addiction and recovery. A multi-methodological approach to assess the efficacy of these interventions is warranted. Additionally, community-engaged and culturally responsive approaches such as community-based participatory research, participatory action research, and creative methods like photovoice and digital storytelling can meaningfully involve Appalachian LGBTQ+ people as partners in shaping the research process. Finally, future scholarship should further explore the role and utility of recovery supports referenced within the findings of this study: mutual aid, peer support, and Appalachian-based interventions.

Conclusion

This study explored the intersections of identity, geography, trauma, and resilience as they shape the recovery journeys of LGBTQ+ individuals in Appalachia, revealing that recovery is both a process of healing and an act of resistance. Participants' narratives illuminate how affirming relationships, community belonging, and self-determined resilience sustain recovery amid religious condemnation, sociopolitical isolation, and systemic neglect. For practitioners, these findings underscore the importance of peer-led and affirming care models, place-based and community-embedded supports, and accessible telehealth and hybrid services that honor the geographic realities of the region. Collectively, these approaches move toward care that is locally grounded, culturally responsive, and unapologetically affirming of LGBTQ+ Appalachian lives.

Conflict of Interest and Funding Disclosure
The authors reported no conflict of interest or funding contributions for the development of this manuscript.

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Appendix

Semi-Structured Zoom Interview Protocol

Participant's Pseudonym:
Researcher/Interviewer:
Date:
Scheduled Time:
Start Time: End Time:

Researcher: *Thank you for taking the time to talk with me today. As you know, the purpose of this study is to explore the experiences of LGBTQ+ Appalachian Individuals in recovery from substance use, and to uncover what factors have sustained their sobriety. The researchers' primary aim is that insights generated from the study will inform counselors who serve members of this population and aid in generating more positive outcomes for clients in treatment. It is also hoped that the findings will prove decisive in the curation of interventions/approaches to working with the population. This study will provide participants with the opportunity to share their individual narratives through the use of semi-structured interviews. These narratives will then be reconstructed in an authentic way to share the collective story of all participants involved.*

Throughout this interview, I will ask you questions about your experiences in recovery from substance use/addiction with centrality placed on your identity as an LGBTQ+ person living in Appalachia. Please refrain from sharing names or other identifying information about others. I may ask you to elaborate or clarify responses to questions. Please feel free to ask me for clarification at any point during the interview process if questions are unclear.

Do you have any questions regarding the informed consent form that you previously signed or in general?

Do you still consent to participating in the Zoom interview and having this interview recorded?

Semi-Structured Interview Questions

1. Can you tell me a little bit about your background? Where did you grow up, and what was it like for you being LGBTQ+ in your community?
2. Can you tell me about your first experience(s) with using substances?
    a. How did your identity as an LGBTQ+ individual shape or influence your experiences with substances?
    b. When did you first recognize that your relationship with substances was becoming problematic? What led to that realization?
3. Can you share with me the story of your journey toward sobriety? What were some of the key turning points for you?
4. On your path toward sobriety, what kind of support did you seek out and what did you find to be most helpful?
    a. Were there specific people, communities, or resources that you found particularly affirming of both your LGBTQ+ identity and your recovery journey?
5. Throughout your journey what has aided you in remaining sober?
6. Looking forward, what does a healthy, sober life look like for you?
    a. How does your LGBTQ+ identity influence your vision of recovery and your future?
7. If you could design a support system or intervention specifically for LGBTQ+ Appalachian individuals in recovery, what would it look like?
8. How would that support system or intervention have changed your experience in seeking recovery?
9. Is there anything else you'd like to share about your experiences in recovery that we haven't touched on yet?

Researcher: *Thank you again for taking the time to participate in this interview. During the data analysis process, you will be provided the opportunity to review your transcript and any codes generated from it to ensure accuracy. Please don't hesitate to contact me if you have any questions at any time.*