LESBIANS' EXPERIENCES OF DEPRESSION:

LINKING EXPERIENCE TO SOCIAL DISCOURSE

by

Amy Grace Barnard

A Dissertation Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

2 0 0 4

APPROVAL FORM HERE

STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowable without special permission, provided that accurate acknowledgment of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the copyright holder.

SIGNED: _____

ACKNOWLEDGEMENTS

The completion of this project required the support and assistance of many individuals. I would like to thank some of those whose efforts allowed me to move forward with this work. I am very grateful to the 12 women who volunteered their time to speak with me. I am humbled by the trust they placed in me as they so willingly shared very personal details of their lives.

There are no words to describe my appreciation for the support and guidance I have received from my dissertation chair, Dr. Terry Badger. Thank you for your unwavering belief in my abilities and the importance of this work. Your expertise as a depression researcher along with your finely tuned skills as an academic advisor, and your keen intuitive abilities, always recognizing what I needed at every turn, has been invaluable to me.

To Miranda Joseph, Ph.D, my minor committee chair, I am very grateful for your patience and encouragement over the past four years. Your willingness to always find the time to meet and help me sort through my confusion while always challenging me to see through a different lens is wholeheartedly appreciated.

To Dr. Mary Koithan, your amazing creativity and indomitable spirit are always an inspiration. To Dr. Joyceen Boyle, your thoughtful insights and suggestions kept my project focused. I am grateful to Drs. Sandra Cromwell, Cathy Michaels, and Marylyn McEwen whose open office doors offered an invitation for respite and good conversation.

Finally, I must thank my children, Aaron, Naomi, and Dov for being such wonderful human beings. Your vitality and senses of humor help me maintain perspective on what is really important in my life.

TABLE OF CONTENTS

TABLE OF CONTENTS – *Continued*

TABLE OF CONTENTS – *Continued*

TABLE OF CONTENTS – *Continued*

LIST OF ILLUSTRATIONS

LIST OF TABLES

ABSTRACT

Depression is being diagnosed worldwide at rapidly increasing rates. The World

Health Organization has identified depression as the second leading cause of disability

worldwide. Women are diagnosed with depression at twice the rate of men. Although

much research has been conducted on depression in women, there is very little research

on depression in lesbians. The impact of living within a heteronormative society upon

lesbians' experiences of depression is unknown. The purpose of this study was to explore

lesbians' subjective experiences of depression.

Critical ethnographic methods were used to study the ways that lesbians construct

their experiences of depression. Twelve self-identified lesbians participated in up to three

in-depth interviews conducted over an eight month period. Social constructionism and

critical theories underpinned the study's methodology. Thematic analysis led to a schema

of themes, domains, and categories that described the participants' experiences.

The analysis found no commonalities across the narratives linking being a lesbian

with experiences of depression. However, many patterns did emerge describing the ways

that the participants construct their experiences of depression. Four themes were

identified: *Being depressed: Describing the experience*, *The roots of depression:

Emotional dissonance*, *Managing depression: Desire for relief*, and *Explaining

depression: Needing to know why*. The dominant discourses of depression forwarded by

psychiatry and psychology have penetrated the popular culture and shaped the

participants' understandings of their feelings of depression. These discourses assist in the

maintenance of social hegemonies. Further analysis of the study themes led to the discovery that experiences of depression are class-mediated, with study outliers offering glimpses into alternative class-based constructions of depression.

The participants shared a number of constructs in formulations of their sexuality. Lesbian identity and radical-cultural feminist discourses underpinned the participants' narratives of identity. Class privilege was identified as significant in these women's abilities to comfortably negotiate their marginalized sexuality within a heteronormative society.

Implications of the study for nursing practice, education and research include the formulation of new understandings of lesbianism and sexuality. Findings indicate future depression research must explore of the ways social class influences experiences and perceptions of depression.

CHAPTER I

INTRODUCTION

Background

Depression is identified as a mental health disorder that is reaching pandemic proportions. The World Health Organization (WHO) reports 213 million people worldwide are affected by the disorder (WHO, 2000). Depression is now the second leading cause of disability worldwide and by the year 2020 it is predicted to be the leading cause of disability worldwide. Currently in the United States, 15% of the population reports suffering from symptoms of major depression at some point in their lives (Davidson & Meltzer-Brody, 1999).

Depression is potentially lethal with 10% of depressed individuals attempting suicide at sometime in their lives (WHO, 2000). Yearly 800,000 deaths by suicide occur worldwide, most attributed to depression (WHO, 2000). Depression is predicted to follow a long-term trajectory and is classified as a chronic state causing increased mortality and morbidity (Davidson & Meltzer-Brody, 1999; Panzarino, 1998). Individuals suffering from depression have increased susceptibility to the development of concurrent medical illnesses as well as increased participation in self destructive behaviors such as smoking, overeating, and substance abuse (Szewczyk & Chennault, 1997).

Despite the recognition of the enormity of the problem of depression and the immensity of the body of work written on depression in our contemporary society, there

exist few studies documenting lesbians' experiences of depression. Lesbians'

experiences of depression are of interest, as these women live with a set of circumstances

unique amongst women in our society. Social scientists and medical researchers have

made assumptions that living as a sexual minority increases their risks for depression.

The existing studies of lesbians and depression are quantitative and fail to capture

lesbians' subjective experiences and personal perceptions. This qualitative inquiry was

conducted to begin to address the dearth of information on depression in adult lesbians.

Statement of the Problem

Depression is a serious health problem affecting large numbers of the population

globally. Women are diagnosed with depression at twice the rate of men (Badger, 1993;

Falco, 1995; Heifner, 1996; Kaplan & Sadock, 1998). A large body of research has been

conducted on depression in women (Bebbington, 1998; Bebbington, Dunn, Jenkins,

Lewis, Brugha, Farrell & Meltzer, 1998; Gershon, 1983; Kessler, McGonagle, Swartz,

Blazer & Nelson, 1993; Klerman & Weissman, 1977, 1985; McGrath, Keita, Strickland,

& Russo, 1990; Newmann, 1984; Nolen-Hoeksema, 1990; Strickland, 1988). However,

despite this large body of literature on women and depression, little research has been

conducted on lesbians and depression. Lesbians' lives parallel those of heterosexual

women in many ways; however lesbians live in a heteronormative society that

marginalizes their sexuality. The ways lesbians are both vulnerable and resistant to

feelings of depression is unknown. It should not be assumed that understandings about

depression in heterosexual women are appropriate for lesbians for the normative

institutions of marriage, nuclear family, and motherhood may or may not have the same significance to lesbians as heterosexual women (Renaud, 2000; Weston, 1991).

Nursing researchers have thus far approached lesbians from the perspective of marginality and vulnerability. Marginalized groups such as lesbians are "othered" by mainstream society based upon their difference from mainstream norms (Hall, 1999). Studies based upon marginality lead to findings perpetuating the differences between the mainstream groups and the "othered" groups (Gergen, 1994). Lesbian research based upon the concept of marginality, recognizes the role of lesbian as a vulnerable outsider and the effects of this social position are examined with suggestions forwarded in ways to treat the individual. This study was based upon social constructionism and critical social theories, perspectives that vary from studies based upon marginality in that the responsibility for the problem is identified as existing within the greater society not within the individual. Findings focus upon the need for transformative changes within the social order rather than assisting the marginalized outsider in accepting their situation. Gathering stories of depression from lesbians was the first step in understanding the effects of marginality upon the experiences of depression in lesbians. The analysis examined the participants' vulnerabilities as well as the resistances to the role of outsider and its influences upon feelings of depression. Discourses within the participants' narratives were identified to learn how it is that this group of lesbians comes to construct their feelings of depression and their sense of sexual identity within a socio-political context.

Statement of Purpose

The purpose of this study was two-fold; (1) to explore and explicate lesbians'

experiences and perceptions of depression; and (2) to critically examine these

experiences identifying and critiquing the discourses that serve to frame their life

experiences as lesbians and their experiences of depression.

Research Questions

Two questions guided this study. The study asked the following questions:

(1) What are lesbians' experiences and perceptions about feelings of depression?

(2) What are the conditions of lesbians' lives contributing to feelings of depression?

Significance of the Study to Nursing

Our current nursing paradigms are focused upon individualism with the goals of

nursing interventions being the realignment of the individual patient within their existing

context (Cowling, 1999; Holmes, 1991; Lather, 1993; McEwen, 2003; White, 1995).

Currently in nursing, context is the backdrop for the individual experience but not a

dynamic interactive component of the change process. This study's use of the theoretical

frameworks of social constructionism and critical social theories will situate individuals

within the contexts of their lives. Socio-political influences upon the participants'

constructions of reality are germane to understanding lesbians' experiences and beliefs

about depression.

The call for increased social responsibility in nursing practice and research resounds throughout the nursing literature (Drevdahl, Kneipp, Canales, & Dorey, 2001; Hagedorn, 1995; Holmes, 1991; Stevens & Hall, 1992; 1994; White, 1995). White (1995) argues for socio-political knowing to be a fifth epistemological perspective of nursing. The integration of social activisms and critical theories into nursing research is necessary as the future of the profession depends on the ability to recognize the influences of social, economic, and political events upon health and health care systems (Hagedorn, 1995; Moccia,1988; Stevens, 1996).

This study's significance to nursing is that it shifts the focus of responsibility for feelings of depression from the individual to the interplay occurring between the individual and the larger society. As nursing mounts a response to the problem of depression, this study's findings will begin to develop a foundation of understanding of depression in lesbians moving beyond the maintenance and reproduction of the status quo to the formulation of meaningful and socially transformative actions.

Theoretical Perspectives

This study will be informed by the perspectives of social constructionism, and critical theory. Social constructionism is an antifoundationist perspective challenging the dominance of the empirical way of making meaning and developing knowledge (Schwandt, 2000). Social constructionist perspectives serve to expose the agendas of dominant discourses that underlie empirical scientific research that marginalizes and oppresses groups within our society (Gergen, 2001; Harding, 1986; Schwandt, 2000).

Social Constructionism

Social constructionism is a perspective asserting the idea that all meaning is constructed through social processes and rejecting essentialism and the belief in intrinsic realities (Schwandt, 2000). Gergen (1985) identified four assumptions of social constructionism; (1) We must be critical of conventional knowledge. Personal observations of the world are actually only our perceptions of reality not reality itself. (2) Our understandings are historically and culturally derived. Reality is situated in a time and place and created within that context. Authority does not extend beyond that context. (3) Knowledge is a social production. Knowledge is sustained through the daily interactions of people who share common language, activities and understandings. (4) Knowledge and social action are dialogical processes. Constructions are negotiated and evolve through ongoing interactions. Negotiations require language and it is language that shapes our ability to describe experiences as language predates experience (Burr, 1995). Language is a site of contestation as it both shapes our meanings as well as being shaped by our meanings. This unstable entity of language is formulated into socially mediated discourse.

Burr (1995) defines a discourse as "referring to a set of meanings, metaphors, representations, images, stories, statements, and so on that in some way work together to produce a particular version of events" (p.49). Discourses are socio-politically and historically constructed and become available within contemporary cultures to be drawn upon as frameworks to explain our experiences. Each aspect of personal identity is shaped by a social discourse and, for example, there are discourses of race, age, gender,

class, and sexuality. Dominant discourses serve the purposes of sustaining social control. Cultural norms are maintained by the perpetuation of these discourses. The maintenance of society requires that all aspects of our lives be controlled through dominant discourses including discourses related to family life, sexuality, race, gender, class as well as education, the judicial system, and the medical system, amongst others. In response to dominant or hegemonic discourses are counter hegemonic discourses offering frameworks for experiences and behaviors challenging the dominant discourses. The lesbian and gay identity discourses are counter hegemonic discourses that have garnered power over the past thirty years and contest the dominant heteronormative discourse (Kitzinger, 1987).

In this study, I elicited lesbians' narratives of their embodied experiences of depression as well as their perceptions and beliefs about the phenomenon. From these narratives, I identified some of the discourses these women utilized to create their identities as lesbians as well as to frame their experiences of depression. The discussion of these discourses occurs in Chapter VI. Social constructionism underpins critical social theories (CST), another theoretical perspective contributing to this study. In critical social theories issues of power amongst available discourses are exposed and critiqued.

Critical Theories

Critical social theories (CST) are a cluster of theories striving to oppose positivism (Agger, 1998). The origins of CST are the writings of the scholars of the Frankfurt School in Germany between 1919 and 1939. Horkheimer, Adorno, and

Marcuse, influenced by Marx' critique of ideology, explicated ways dominating and oppressive structures operate within societies. Contemporary schools of thought including postmodernism (i.e. Foucault), deconstruction (i.e. Derrida), and French feminisms (i.e. Kristeva and Irigaray) are rooted in the works of the early critical theorists (Kuiken, 2001). Agger (1998) has delineated seven features of critical social theories. Though none of the critical social theories contain all of the seven themes, the commonalities amongst the theories help explain the goals of CST. The seven themes are (1) CST opposes positivism. Knowledge is an active construction with theory development never being value free; (2) CST links past, present, and future. Its role is to raise consciousness about present oppressions by offering insight into past events that have led to potential political and social activisms; (3) CST argues that oppression is structurally rooted in national and global institutions. People's lives are affected by the social institutions of politics, economics, culture, discourse, gender, and race; (4) Domination is reproduced through false consciousness that is fostered by positivist social sciences. Society appears to be governed by fixed patterns of behavior. CST opposed false consciousness by forwarding collective and personal agency and collective activisms leading to social transformation; (5) CST begins in the everyday lives of people; (6) Knowledge of the structures maintaining society's norms can lead to social activisms. CST builds a dialectical bridge between structure and agency; (7) Freedom is a dialectical process occurring between structure and everyday life. In this way CST rejects the possibility of oppressed people gaining power only to repeat the patterns of domination.

This study acknowledges the influences of the perspectives of social constructionism and CST upon its development and findings. Critical social theories offer a critique of the influences of hegemonies upon the making of meaning.

This study was guided by social constructionism and critical social theories in order to develop nursing knowledge that moves our understandings of depression in lesbians away from the placement of responsibility upon the individual and toward the responsibilities of the larger social order. Understanding that all meaning is socially constructed and that our dominant discourses exist to benefit those with power allows us formulate transformative ideas. The findings of this study directly confront the motivations of the current underpinnings of the development of nursing knowledge about lesbians as a category of women and about lesbians' experiences of depression.

Locating Myself Within the Study

In this work, I identified constructs that are integral to the participants' formulations of their identities and those that frame their experiences. Like those of the participants, my own identity and beliefs are socially produced and have influenced this work. I am currently practicing as a psychiatric/mental health nurse practitioner. As a clinician, I am critical of the dominant discourses of psychiatry and psychology. My training was based upon these discourses, and I must engage with them every day in my professional practice. I am knowledgeable in them and practice within safe and reasonable parameters; however, I philosophically do not support their foundations and struggle with this conflict on an on-going basis.

I call myself a lesbian though I do not like my sexuality being categorized. I was heterosexually married for many years. It was interesting to be identified as a privileged heterosexual one day and then be identified as a marginalized lesbian the next day. I found that confusing as I have always felt like the same person. I have never perceived myself as marginalized by my lesbianism, and I become angry and defiant when I detect a heteronormative bias. These types of experiences underpin my choice of research topics and my beliefs about heteronormativity. As a nurse researcher and soon to be nurse educator, I feel I am well positioned to make important and needed changes in the nursing profession's conceptualizations of sexuality.

I am a secular Jewish, middle class, baby boomer, liberal. I grew up on a precipice between being hated for my ethnicity and having all the privilege of my class. I was raised in a small Catholic working class town 15 miles from Boston, MA. As Jewish and middle class, I was hated and taunted by many of my peers. Once escaping that small town, being Jewish and middle class has brought me great opportunities. As a post-WWII child of educated Jewish parents, I was indoctrinated in liberal political ideology and the all too familiar images of the Nazi Holocaust. These life events greatly impact the importance I place upon exposing hegemonic processes and my willingness to speak out against social injustice.

Chapter Summary

Depression is recognized as a very serious problem in our contemporary world. Feelings of depression are often thought of as separate from the social and political order

of life. However, stories of depression are social constructions. This study explored

lesbians' constructions of their experiences and perceptions of depression bringing new

nursing knowledge to light to assist nursing educators and researchers in the

demythologizing of our current beliefs about depression in lesbians. This chapter

reviewed the statement of the problem, purpose of the study, the research questions, and

the significance of the study to nursing. The theoretical perspectives of social

constructionism and critical social theories that guided this study were discussed.

Chapter II discusses some of the contemporary discourses of depression and identity that

construct the category of lesbian and the phenomenon of depression.

CHAPTER II

REVIEW OF LITERATURE

This chapter will review current literature on depression, lesbians and depression, and theories of sexuality. Review of the current literature presents the discourses pertinent to a study on depression in lesbians describing a myriad of ways that depression is constructed within contemporary society. The chapter ends with a review of a few of the many books available within the popular culture about depression.

Depression

Depression is thought to negatively impact the quality of life for large numbers of people throughout the world. Due to the enormous significance of depression in contemporary society it is studied across many disciplines, each adding a unique dimension to possibilities of etiologies and treatments of the phenomenon. This chapter will review theoretical writings and research findings on depression in the areas of nursing, medicine, psychology, sociology, cultural studies, and women's studies. As depression is significant to so many people in our society, a growing body of work within popular culture has also arisen pertaining to the phenomenon. Thus, a sampling of lay writings on depression circulating within popular culture will be reviewed. The body of contemporary literature on depression is immense and this review of depression literature is organized around current theories of depression.

Theories of Depression

Theories of depression abound and circulate within a number of disciplines. The fields of medicine, psychology, sociology, and recently cultural and feminist studies offer an array of etiologies and treatments for depression. This chapter will present many of the theories of depression that have developed over the past decades.

Neurobiological Theories of Depression

The medical model locates the cause of depression within the individual body and studies the biomedical processes and alterations that lead to feelings of depression. Treatments are based upon the identification of problematic occurrences within the physical body and the successful manipulation of human biochemistry, leading to the modification of negative affective feelings. Nemeroff (1998) acknowledges depression to be a result of the interactions between environmental factors such as trauma and stress and the physical body. Psychiatric research on depression is based exclusively upon understanding the neurobiological changes occurring within humans as they interface with varied environments.

Biomedical theories purport that alterations in neurochemical, neuroendocrine, neuroanatomical structuring and genetic vulnerabilities underpin depressive symptomology (Kaplan & Sadock, 1998). Epidemiological studies show that 40-50% of the risk of developing depression is genetic (Sadock & Nemeroff, 2000). An individual's genetic vulnerability interacts with physiological alterations secondary to life stressors, innumerable medical conditions, and anatomical and endocrine brain alterations to

manifest in depressive symptomology *(*Nestler et al, 2002). Serotonin and

norepinephrine enhancing agents are found to offer partial response in 80% of patients

taking these medications with 50% of patients achieving complete remission (Nestler, et

al., 2002). It has been thought for many years that low levels of serotonin and

norepinephrine result in depressive symptoms but this idea is losing favor in the medical

establishment. The focus of research is now on the understanding of how the serotonin

and norepinephrine enhancing agents alter brain plasticity leading to the abatement of

symptoms (Nestler, et al., 2002).

The focus of biomedical depression research is the investigation of hypotheses of

three unique subsets of depression. The first hypothesis proposes there is a direct

relationship between perceived stress and feelings of depression. This theory focuses

upon an abnormally excessive activation of the HPA axis secondarily to perceptions of

stress within an individual. A positive feedback loop process occurs beginning with the

increase in CRF (corticotropin releasing factor →release of ACTH →release of cortisol)

leading to hippocampal damage. Approximately half of individuals with depression

show increased cortisol levels and respond to anti-depressant medications that apparently

work upon healing the hippocampus.

A second hypothesis posits that acute and chronic stress decreases BDNF (brain-

derived neurotrophic factor) that in turn contributes to hippocampal pathology. The slow

response time of anti-depressants may occur as the process of upregulating BDNF levels

is gradual. Anti-depressants may actually be repairing stress induced damage and

providing protection from further decreases in BDNF (Pezet, Malcangi, & McMahon, 2002).

The third hypothesis locates sites within the brain other than the hippocampus that may be significant in the development of depressive symptoms. These areas are the nucleus accumbens, hypothalamus, and the amygdala and are the areas regulating the reward centers in the brain. Drugs of abuse alter dopamine levels in these areas that may be significant in mood variability. This hypothesis is significant for the subset of depressed individuals with comorbid substance abuse disorders. Little research has been conducted investigating this hypothesis.

The neurobiological basis for the higher rates of depression in women is unknown but may be related to hormonal differences, stress response differences, or to sexual dimorphism in any of the above mentioned areas of the brain. A review of current biomedical research studies conducted on women about depression determined that current research is focused on issues of menopause, the menstrual cycle, pregnancy and motherhood (Medscape, 2004).

Early life trauma is recognized as a potent precursor to the development of adult onset depression and anxiety disorders (Heim, Newport, Heit, Graham, Wilcox, Bonsall, Miller, & Nemeroff, 2000; Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000). Women with a history of early trauma particularly physical and sexual abuse or the loss of a parent have a four fold increased risk for the development of major depression in adulthood compared to women with no trauma histories (Sadek & Nemeroff, 2000). Preclinical studies suggest that early life stress induces long term hyper reactivity of CRF

systems that ultimately lead to increased stress responsiveness. The mechanisms of the neurobiological responses have been discussed in the previous section.

Adult-onset depression secondary to early life trauma is being considered as a subtype of depression often occurring comorbidly with anxiety. There is evidence that a similar neural response occurs in maltreated children. Preclinical studies indicate that these neurobiological responses are not present in depressed nonabused children. Further research is needed to determine the role of environmental trauma to neurobiological effects (Heim & Nemeroff, 2001). Though epidemiological studies indicate a similar incidence of abuse in both boys and girls, adult women develop depression at twice the rate as men (Kendler, et al., 2000). This fact needs further investigation as it may indicate that there exist vulnerability differences between the sexes. It is suggested that adaptations to stress including HPA reactivity vary between males and females.

Psychological Theories of Depression

Psychodynamic approaches. Psychodynamic theories of depression are based upon Freud's psychoanalytic principles (Karasu, 1990a). Freud's (1915) seminal work on depression, "Mourning and Melancholia," discusses pathological depression as an experience similar in presentation to normal grief but with its own unique etiology. Grief is the reaction to the actual loss of an external loved object as occurs with a death of a loved one. Melancholia is the "loss of the object, ambivalence and regression of libido into the ego." Anger and disappointment over the loss of love is turned inward upon oneself instead of outward toward the lost object. Freud states repressed rage is what

underlies depressive symptomology. Abraham (1924), a classical psychoanalyst, further refined the pathogenesis of depression. He identified the following five factors to be instrumental in the development of melancholia: (1) overemphasis on oral eroticism, (2) fixation of psychosexual development at the oral stage, (3) early and repeated childhood disappointment in love, (4) a first major developmental disappointment before oedipal wishes are resolved, and (5) repetition of primary disappointment (Abraham, 1924; Karusu, 1990a). Other psychoanalysts, including Lindemann (1944) and Clayton, Herjanic and Murphy (1970), recognized functional impairment, suicidal ideation and overwhelming feelings of worthlessness as being specific to pathological depression, further delineating depression from grief.

With the progression of psychological theory from classical psychoanalysis to psychodynamic approaches, a shift occurred emphasizing the importance of object relations and the development of self including issues of self-esteem (Karusu, 1990a). The crux of psychodynamic approaches to depression is the belief it is the erosion of one's sense of well-being rather than the response to a loss that leads to feelings of depression.

Jacobsen (1971) identified depressed patients as possessing harsh superegos, unrealistic idealizations of love objects, distorted body images and self critical egos. Treatments within the psychodynamic realm are based upon closed dyadic systems consisting of the patient and the therapist in which a transferential relationship is developed in order to explore "unconscious repetition of defensive and adaptive coping patterns formed in the past" (Karusu, 1990a). Psychodynamic treatments for depression

involve the development of insight into and a catharsis of unresolved, repressed feelings

of loss or failure that originally injured the ego. The therapist attempts to resolve

intrapsychic conflicts in an attempt to restructure the ego and superego as well as provide

symptom relief (Jacobson, 1971).

Cognitive Behavioral Theory. Cognitive behavioral theory is a school of

psychology synthesizing phenomenology and behaviorism. Adler's school of individual

psychology shifted the origins of psychopathology from the Freudian emphasis upon

repressed experience to the individual's conscious perceptions of those same experiences

(Karusu, 1990a). Adler (1958) described the individual's perception as the "phenomenal

field." In the next decade Albert Ellis (1962) applied behaviorist techniques to Adler's

concept of the phenomenal field, developing rational-emotive therapy as a treatment for

affective disorders. Over the next 15 years cognitive-behavioral techniques were further

developed, gaining respectability within the fields of psychology and psychiatry as an

effective treatment for depression amongst other affective disorders (Karusu, 1990a).

Cognitive behavioral therapies (CBT) explore the relationships amongst thoughts,

feelings and actions. CBT challenges an individual's assumptions about themselves and

the world in which they live (Corey, 2000; Kaplan & Saddock, 1998). The inner

emotional worlds of the client are explored while simultaneously identifying embedded

cognitive patterns. Beck's cognitive behavioral theory of depression posits that:

(1) depressive symptoms are a result of negative views shaping how one feels about

oneself, the world, and the future; (2) irrational ideas are based upon perceptions of past

experiences; and (3) logical errors are imposed upon current assessments of one's self and life (Beck, 1995). CBT offers a focused, active and structured way to address subjective reality, offering effective and fast treatments for clinicians in the contemporary economically based mental health industry (Corey, 2000).

Interpersonal approaches. Interpersonal theories of psychotherapy emphasize the role of familial and social interactions upon an individual's emotional state. Depression is a response to disappointing interpersonal relationships and a disruption in social roles (Karusu, 1990a). Harry Stack Sullivan, trained in psychoanalysis, is considered the founder of interpersonal psychotherapy. Sullivan did not reject the ideas of Freud but reframed the understanding of psychopathology from being strictly of internal origins to being a response to social interactions. A number of psychologists base their theory development upon this interpersonal approach, including Perls' gestalt therapy, Yolam's group therapy, Berne's transactional therapy, and Roger's client-focused therapy. The works of Horney, Fromm, and Klerman are also based upon these principles (Stuart, 2001).

Within this theoretical framework it is believed depression occurs when (1) strong nurturing maternal bonds are not established early in life, (2) negative experiences related to loss occur in childhood, (3) intimacy cannot be achieved in adulthood resulting in chronic marital discord and divorce, and (4) poor communication and other factors disturb supportive social relationships.

Therapy for depression is a three phased process. First, the therapist assesses current interpersonal relationships, identifying a specific relationship or patterns in multiple relationships to target for therapeutic intervention. The second phase engages the client in the therapeutic process. The identified issues are addressed with the therapist using themselves for advocacy, guidance, teaching and a support system. The goal is to examine maladaptive perceptions, faulty communications, and non reciprocal expectations underlying the feelings of depression. The therapist clarifies the problem and offers new ways to formulate the difficult interpersonal relationship. The third phase is one of "closure" signifying the therapeutic relationship is ending. At this time the client and therapist reinforce what has been learned and the ways the client will incorporate changes within their personal interactions (Karusu, 1990a).

The interpersonal approaches to depression have dominated the psychotherapeutic milieu over the past two decades (Karasu, 1990b; Klerman & Weissman, 1986; Singer, 1998; Teichman, 1986). Research findings have supported its efficacy for treatment of depression. Geets, Bouhuys and Bloem (1997) conducted a study of eleven depressed patients who met individually with a therapist. All showed a decrease in depressive symptomology from the nonverbal support of the therapist. Spanier and Frank (1998) found interpersonal therapy to be superior in the treatment of depression over no treatment, use of medications only and placebo. Schwartzberg and Schwartzberg (1990) found the use of Yolam's interpersonal techniques in a short term psychotherapy group composed of 14 female adult children of alcoholics resulted in a significant decrease in the subjects' depression and anxiety with a concurrent increase in self esteem and insight.

Integrative Approach. With the increasing popularity of cognitive behavioral approaches, brief psychotherapy and neurobiological understandings of mood disorders, contemporary therapists are practicing an integrative approach to psychotherapy. The integrative approach allows the therapist to shift from one theoretical framework to another dependent upon the situation arising within a single therapy session. It is now thought that therapists versed in a number of different therapeutic modalities are able to offer effective treatment tailored to each individual (Corey, 2001).

Critical Theories of Depression

Critical theories attempt to understand how power and oppression operate within a society, and in doing so provide people with knowledge necessary to promote social change (Agger, 1998). When applied to understandings of mental illness and particularly theories of affective disorders such as depression, critical theories trouble the continuity of the dominant theories of psychopathology by exposing the underlying social and cultural constructions inherent within these theories (Drier, 2000; Gaines 1992). Basic assumptions that underlie understandings of what constitutes mental health are questioned and those benefiting from such assumptions are identified.

Within a critical framework the subjective experience is understood as a response to social and cultural imperatives. Transformative approaches to the understanding of depression occur through exposing the assumptions embedded in personal narratives. Research conducted from this theoretical perspective is necessarily qualitative, allowing the individual story or narrative to dominate the project (Weiss & Fine, 2000).

Subjective experience is understood to be situated within a socio-political and historical context. The focuses of these theories of depression shift the responsibility of the mood disorder from the individual to the social system creating the circumstances surrounding individuals' lives (Denzin, 2003). A small but robust body of work has been developed reflective of a critical perspective of affective disorders (Drier, 2000; Hennessy, 2000; Hochschild, 1983; Jack, 2000; Massumi, 1995; Mullen, 2000; Stoppard, 2000). Other critical works problematize the practice of psychiatry (Castillo, 1998; Gaines, 1992; Kleinman, 1988; Shweder, 1990; Waxler, 1974). Three critical theories of depression will be reviewed, those of critical psychology, feminist social constructionism, and relational theory. These are relevant to this study as they contribute to understandings of how the concepts of depression and women are constructed within our contemporary society.

     <u>Critical psychology perspective.</u> Critical psychology, based upon Marxist traditions, originated in Europe during the early 1970s in protest to mainstream psychology. Critical psychologists believe that human needs and psychic processes are "governed by the society we are born into" (Hennessy, 2000, p. 218).   Human needs, including emotional needs, are regulated by one's capacity to participate in societal arrangements. Capacity to participate is related to current modes of production underlying issues of class (Massumi, 1995). Action potence refers to the ability of an individual to accomplish what is necessary to fulfill their expectations of an acceptable quality of life. Action potence is either restricted or generalized dependent upon one's

ability to meet needs (Dreier, 2000; Hennessy, 2000; Massumi, 1995). Restricted action

potence leads to feelings of inadequacy. Individuals blame their low mood upon

themselves, their families, or other local factors rather than upon the larger social systems

that are creating their inability to realize a greater action potence (Hennessy, 2000).

Transformation occurs through community based interventions, consciousness raising

groups and social activisms rather than individual pharmacological or therapeutic

treatments (Stevens, 1994).

Hochschild (1983) conducted an ethnographic study on female airline attendants

in the 1980s. Airline attendants are required by their employers to prioritize customers'

demands over their own emotional needs, demands that often included tolerating sexual

advances and the verbal and even physical abuse of rude and angry passengers. The

effects of subjugating one's own feelings for those of the company were examined in this

study. Hochschild (1983) found that the need to always appear happy and congenial

interfered with the women's abilities to be emotionally present within their private lives.

Difficulties in intimate relationships were common in this group, as well as behaviors of

isolation and feelings of resentment. The airline attendants perceived themselves as

depressed, and felt their emotional lives were owned by the company.

Feminist social constructionist perspective. The feminist social constructionist

perspective is a critical response to the hegemonic interpretations of the innate nature of

the feminine as well as the development of psychiatric criteria for the diagnosis of

depression. Feminist writers critique the legitimacy of biologically rooted theories of

depression, declaring that within these theories women's embodied experiences are either ignored or pathologized (Harding, 1993; Stoppard, 2000). Our Western contemporary society has predetermined roles and traits of a *real* woman. These expectations are based upon a binary gender system with a clear distinction made between femininity and masculinity (Jack, 2000; Mullen, 2000; Stoppard, 2000). Within essentialist models of depression, gender is conceptualized as a phenomenon existing within the individual rather than perceived as being culturally and socially derived. Female traits are believed innate and women whose lives do not reflect those traits are viewed as faulty. Negative consequences such as mood disorders may arise from these faults. Women's embodied experiences are reconceptualized as sets of symptoms signifying an underlying disorder either biomedical or characterlogical in nature. Their embodied experiences are decontextualized and ahistoricized with no consideration for the political and economic conditions shaping experience.

Feminist standpoint theory affords the opportunity to deconstruct the underpinnings of contemporary science leading to the development of the dominant understandings of women and their feelings of depression as a disease state (Stoppard, 2000). Feminist social constructionists believe the deconstruction of gender roles opens the possibilities for women's voices to be heard and their feelings to be reframed within the context of the political/social world in which they live. Qualitative research studies capturing women's perceptions of feelings and life experiences will offer insights for the development of transformational interventions (Harding, 1995; Stoppard, 2000).

Relational theory. Relational theory is a feminist based theory developed by feminist scholars at the Stone Canter in Wellesley, MA. The theory is an outgrowth of radical-cultural feminism of the 1970s (Jordan, 1997; Jordan, Walker, & Hartling, 2004). Relational theory developed out of the writings of Chodorow (1978) and Gilligan (1982) that reformulates dominant thinking underpinning traditional psychology. The foundational belief of relational theory is that women's "deepest sense of being is continuously formed in connection with others and is inextricably tied to relational movement" (Jordan, 1997. p. 15). In this theoretical framework, women are identified as inherently relational beings. It is a transformational approach that de-pathologizes the natural state of womanhood.

Chodorow (1978) explains that young girls develop deeper abilities to bond and interact with other humans because of their ability to maintain an uninterrupted relationship and identity with their mothers. This continuity of interpersonal connection allows girls to develop permeable boundaries increasing a lifelong potential for interactions and connection with others. When young boys realize that their mothers are "penis-less" they must shift bonds to their fathers and go on to experience a sense of otherness from the mother. This disruption in connections leads males to value separation and develop protective boundaries ultimately leading to decreased emphasis on interpersonal connections.

The relational theorists fault other theories of psychology for embracing the basic premise dating back to Aristotle that women are defective as a result of not having a penis (Jordan, 1997). Relational theory shifts the basis of women's understandings of

"self" from a deficit model to a "contextual, relational paradigm for the study of all self experience" (Jordan, 1997, p. 14). Our contemporary male-dominated society utilizes the strategy of isolation by devaluing relatedness and instead placing a high value on individualism. It is in the best interest of the male dominated society to pathologize the essential relational nature of women.

This theory identifies a chronic sense of disconnection from others as a primary source of suffering (Jordan, 1997). Relational theorists believe that mainstream psychological theories serve to perpetuate a sense of despair as the desire for connection is perceived as a weakness. Women are encouraged by their traditionally trained therapists to think of themselves in a more independent role. Traditional therapies assist in the process of teaching women to make decisions that are in their own best interests and minimize the importance of connection with others. (Finfgeld, 2001; Jordan, Walker, & Hartling, 2004).

This review of the literature of the contemporary theories of depression lays a foundation for this study on depression. A proliferation of the combination of the biomedical model and the interpersonal approaches to depression has occurred in contemporary psychology and psychiatry.

Depression and Lesbians

It has been well documented in the professional literature that women experience depression at twice the rate of men with large amounts of data amassed investigating experiences of depression in women (Bebbington, 1998; Bebbington, Dunn, Jenkins,

Lewis, Brugha, Farrell & Meltzer, 1998; Gershon, 1983; Kessler, McGonagle, Swartz,

Blazer & Nelson, 1993; Klerman & Weissman, 1977, 1985; McGrath, Keita, Strickland,

& Russo, 1990; Newmann, 1984; Nolen-Hoeksema, 1990; Strickland, 1988). There is a

dearth of research about lesbians and depression, and it is unclear if findings related to

women and depression is relevant to the population of lesbians.

     The historical omission of research conducted on mental health issues within the

LGBT populations and particularly lesbians (Rothblum, 1990) has been recognized by

researchers. There now exists a number of studies investigating psychological distress in

LGBT populations (Cochran, Sullivan & Mays, 2002; Gilman, Cochran, Mays, Hughes,

Ostrow, & Kessler, 2001; Mays & Cochran, 2001; Remafedi, French, Story, Resnick, &

Blum, 1998), alcohol abuse in lesbians (Cochran, Keenan, Schober, & Mays, 2000;

Hughes, 1990), domestic violence in lesbian relationships (Dowd, 2001; Kaschak, 2001;

Miller,Greene, Causby, & Lockhart, 2001), and depression in lesbians (Ayala &

Coleman, 2000; Mathews, Hughes, Johnson, Razzano, & Cassidy, 2002; Oetjen &

Rothblum, 2000).

    The existing studies of depression in lesbians are exclusively prediction studies

utilizing quantitative methodologies. Based upon the larger body of work compiled on

women and depression, Oetjen and Rothblum (2000) and Ayala and Coleman (2000)

investigated the influence of the predictor variables of family social support, social

support of friends, relationship status, and relationship satisfaction upon feelings of

depression. These factors were then considered in relationship to lesbians' sexual

orientation disclosure or "outness." The findings varied, with Oetjin and Rothblum

(2000) identifying a lack of social support from friends as the only significant predictor

of depression. Ayala and Coleman (2000) studied the same variables and concluded that

within their sample each of the measured variables had a significant effect upon levels of

depression in lesbians.

Mathews, et al. (2002) compared factors known or hypothesized to influence

depressive symptomology between a community sample of lesbians and a well matched

sample of heterosexual women. The studied variables included the influences of physical

violence, childhood sexual abuse, perceived levels of stress, coping strategies, lack of

social support from family, and lack of social support from friends upon levels of

perceived depression. Also measured were suicidal ideation either present or past, the

number of actual suicide attempts, histories of therapy or counseling and the reasons for

seeking mental health services. Two findings were statistically significant, indicating

differences between the lesbians and the heterosexual groups. Lesbians in this study

reported greater rates of sexual abuse as children, with rates of 30% in lesbians and 16%

in heterosexual women. The explanation of this statistic is unknown and may involve

different levels of comfort in disclosure.

The other notable finding was the difference in rates of suicidal ideation and

actual suicide attempts between the two groups. Lesbians reported having seriously

considered committing suicide at some point in their lifetime at a rate of 51%, compared

to 38% of the heterosexual sample. Lesbians between the ages of fifteen years and

twenty-nine years were twice as likely as heterosexual women to have attempted suicide.

A final finding of interest is the possibility that younger lesbians may be at greater risk

than any other group of women studied for use of alcohol and other drugs to combat anxiety and depression associated with a stigmatized identity. These findings offer guidance for further research studies with the reasons for the identified disparities between the groups remaining unclear.

Studies investigating psychological distress amongst members of sexual minorities have focused upon the measurement of the effects of perceived discrimination. Mays and Cochran (2001) found that lesbian, gay and bisexual individual's psychiatric morbidity is negatively impacted by perceived discrimination. The authors suggest that discrimination within society may be the basis for higher rates of psychological distress in lesbian, gay and bisexual individuals. Further study on this issue is suggested.

Though none of these studies offer definitive findings on depression and lesbians, a number of topics relevant to the phenomenon have been proposed. This study began to address the paucity of research on depression in lesbians.

Sexuality

Theories of Sexual Identity

In studying lesbians it is important to consider the contemporary theories of sexual identity that have informed the participants' personal identities and beliefs about their sexuality. Reviewing the literature on these theories assists the readers of the study in understanding the data collection and analysis processes employed in this study and the interpretation of results.

Sexual identity formation occurs within an individual in conjunction with current circulating theories of sexuality. Jagose (1996) documents the progression of sexual identity formation from the 1860s to the present. German sexologists in the mid 1800s introduced and popularized the essentializing categories of heterosexuality and homosexuality (Jagose, 1996; Katz & Joiner, 1990). Same-sex sexual relationships have always existed (Foucault, 1978) but it was not until this time in history that the dichotomous relationship of mainstream/other or heterosexual/homosexual dominated discussions on sexuality. Various explanations have been forwarded concerning the underpinnings of this binary. The responsibility of explanation is placed upon homosexuality to determine its etiology of deviation from the norm of heterosexuality. Biological determinants such as genetic variability and alterations in neuroendocrine systems are thought by some to be the determinant of an individual's sexuality (Stein, 1993). Scientists have thus far been unsuccessful in attempts to discover a "gay gene."

Psychiatrists and psychologists attribute homosexuality to arrested emotional development in childhood (Renaud, 2000). They purport that the inability to separate from the father or mother at critical points in childhood leads to abnormal sexual development and confused sexual identifications and desires. The American Psychiatric and American Psychological Associations classified homosexuality as a mental illness, carrying a DSM diagnosis, until the mid 1970s. Even upon removal of homosexuality as a mental illness, mainstream psychiatrists and psychologists believe in a singular lifelong sexuality supporting a binary system of sexuality. A number of theories of lesbianism are forwarded, including the idea that women become lesbians as a result of a maladaptive

love for their mother, or that sexual abuse by men in childhood disrupts their normal

sexual development. Therapies exist offering hope for the healing of the deviant

homosexual and restoring an individual to a "normative" sexuality.

A third theory of sexual identity formation is social constructionism. Social

constructionism considers the socio-political and historical events that shape and

maintain sexual identity (Kitzenger, 1987). The social construction of lesbianism is well

documented by a number of feminist lesbian writers (Faderman, 1991; Kitzenger, 1987;

Miller, 1995). Feminist social constructionists argue that lesbianism is understood and

defined within the context of a male-dominated, heterosexual society. Lesbianism as a

category of identity exists because a normatively heterosexual society has created this

grouping. Relationships between women have always occurred but it is through the

mechanisms of social construction that these relationships have come to exist as a unique

identity and given particular significances.

The commonality amongst these theories is the recognition and acceptance of the

homosexual/heterosexual dichotomy. In the 1970s and 1980s, Foucault (1978, 1984,

1986) published three books reformulating the history of sexuality based upon

poststructuralist and postmodern thinking. His writings deconstruct the binary system of

sexuality creating breaks in the linkages of normative understandings of sexuality. In

Butler's (1990) Gender Trouble, the idea of queer identity was first introduced. Butler

blurred the boundaries between sexual identity groupings. During the decade of the

1990s queer theories flourished and now present a formulation of identity describing a

synergistic relationship amongst all aspects of one's being. Queerness offers resistance

to hegemony. There are many socio-political implications of these two divergent formulations of sexual identity that will be discussed in the next sections. The following review of the literature will trace the historical progression of identity formulation from theories of difference to queer theories. The evolution of the sexual identity of lesbians is not a cohesive or linear story.

Lesbian Theories

The *lesbian* category is used in contemporary society to depict women who are sexually attracted to other women and may engage in primary intimate relationships with women. This understanding is a simplified interpretation of a very complex aspect of identity. The category of lesbian has historically been interwoven with social conditions and political movements such as the feminist movement and equal rights movements also referred to as identity political movements.

Identity political movements are based upon theories of difference (Agger, 1998; Howarth, 2002). Race, gender, sex, nationality, and religion, amongst other singular characteristics, are perceived as unique aspects of the whole being. Each is available for discussion as if separate and independent from the influences of other aspects of identity. Identity political movements isolate one aspect of identity and seek to expose and eradicate oppressive conditions that exist for membership of that group within society (Sandoval, 2001). The Civil Rights movement, La Raza, The National Organization of Women (NOW) and gay liberation are examples of identity political movements. Inequities between dominant groups exemplifying hegemonic characteristics and the

oppressed group are exposed. The goal of identity political movements is equal rights, an

avenue pursued through battles for change within legal, educational, and political

institutions (Seafstreom, 1999).

Identity political movements also seek to improve the self worth of members of

marginalized groups. Unique characteristics of a group such as language, appearance,

and rituals are reformulated from perceptions of weaknesses to proud affirmations of

being. Inherent in identity politics is membership, and with membership comes

belonging and exclusion. Identity politics creates solidarity of voice and has historically

been successful in realizing profound societal changes for the causes of social justice.

The Stonewall Rebellion of 1969 in New York City was a turning point for gays

and lesbians after which the gay liberation movement gained recognition as an equal

rights movement (Jagose, 1996; Parks, 1999). However, feminist lesbians in the 1970s

distanced themselves from the gay liberation movement believing that lesbians were

being subjugated by gay men. Power differentials between male and female reflected the

dominant culture's values and lesbian feminist began to pursue political activisms

particular to lesbians (Jagose, 1996).

The parameters drawn around membership within the category of lesbian vary

from very rigid to fuzzy borders (Jagose, 1996; Parks, 1999). For some, lesbian identity

provides a specific formula for all aspects of being from understandings of "truth" to

appropriate dress, where and with whom to socialize, where to live, shop, etc., while for

others it is a personal knowing never articulated to the world (Cabrera, 2001; Krakauer &

Rose, 2002). The commonality of all *lesbian* identities is based upon their difference

from heterosexual women (Fuss, 1991; Phelan, 1993; Ponse, 1978).

In response to the rise in lesbian identity politics, the phenomenon of *lesbian*

community proliferated. Lesbian community has many variants, from small underground

networks to huge displays of lesbian solidarity such as exists in San Francisco and other

large cities. Lesbian community exists to provide a support system for lesbians (Cabrera,

2001; Henderson, 1999; Kennedy & Davis, 1993; Shugar, 1999). It is purported to be a

place where lesbians feel safe and accepted, a place to socialize and meet friends and

lovers. This expectation may be grandiose and unrealistic but the belief in lesbian

community has survived over the past 30 years (J. McDaniel, personal communication,

March 28, 2000). Lesbian communities engage only a small percentage of lesbians.

However, those who support and participate in lesbian community often describe it as if

it is representative of all lesbians.

Another concept that is particular to the identity category of lesbian is the

phenomenon of *coming out*. Coming out occurs when one acknowledges being lesbian

and differentiates oneself from heterosexual women. It is purported to first be a personal

and then to varied degrees a public statement about one's sexuality. A large body of

literature exists on the concept of lesbians' coming out processes (Carrion & Lock, 1997;

Cass, 1979, 1984; Floyd & Stein, 2002; Morris & Rothblum, 1999; Reynolds &

Hanjorgiris, 2000; Saphira & Glover, 2001; Szymanski, 2002). Cass (1979) proposed a

linearly-staged coming out process that gained much acceptance in the clinical and

research worlds. Others propose more fluid stages with movement in and out of stages as

one encounters varied life experiences (Levine, 1997; Reynolds & Hanjorgiris, 2000).

Despite the form this process takes, all authors attest to the fact that in claiming a lesbian

identity one must come out, at least to oneself.

Plural Identities

Post-Stonewall, it was white, feminist, lesbian political movements that offered

the most visible rendering of lesbian identity. It was in the early 1980s that lesbians of

color rose up and rejected this formulation of identity. Lesbians of color troubled the

dominant beliefs on lesbianism by opening them to the complexities of plural minority

identities. Black, Latina, Native American, and Asian women began speaking out on

how it was to be a female, a lesbian and often a poor, woman of color in America. Black

writer Audre Lorde (1982), in her automythology, *Zami*, articulates this situation in the

following passage.

> Being women together was not enough. We were different. Being gay-girls
>
> together was not enough. We were different. Being Black women together was
>
> not enough. We were different. Being Black dykes together was not enough. We
>
> were different. It was a while before we came to realize that our place was the
>
> very house of difference rather than the security of any particular difference (p.
>
> 226).

The publication of Moraga and Anzaldua's (1981), *A Bridge Called My Back:*

Writings of Radical Women of Color unleashed the rage these women felt toward white,

middle class, feminist lesbians as well as toward the hegemonic discourses of race, class,

gender and sexual dominance in our society. Moraga and Anzaldua (1981), along with

Lorde (1984), Parker (1985), and Smith (1983), resisted prioritizing sexual identity over

racial or class identities. These women described how their lives as lesbians of color are

even further complicated by cultural difference in approaches to sexuality (Carlston,

1993). The notions of lesbian community and coming out as had been previously

theorized are not valid descriptors of the life experience of these women.

From this coalition of women the concept of plurality of identity developed.

There cannot be a singular understanding of lesbian identity but understandings

integrating the complexities of the realities of women's lives. These women laid the

foundations for queer identities, a concept that developed in the 1990s.

Queer Theories

Queer theories are a compilation of counter hegemonic discourses identifying the

ways sexuality is regulated in our society. Queer theories are a "distinctly postmodern

rescripting of identity, politics, and cultural critique" (Hennessy, 2000, p. 113).

Foucault's postmodern writings on power relations underpin queer theories. Foucault

(1978) discussed the mechanisms employed by dominant and resistant sexualities in the

maintenance of heteronormative sexuality. Power is not possessed or exercised over

another but rather a fluid and unstable social relation (Halperin, 1995). Foucault (1978)

stated "power comes from below" indicating that domination of one group over another

indeed exists but this "does not tell the whole story." Resistance takes place from within

power, offering possibilities for both opening and foreclosing opportunities for change

(Halperin, 1995).

Queer theories focus upon the ways power is inscribed within sexuality,

concurrently recognizing that continuity of social norms is stabilized through the

interrelationships of all hegemonic systems. Marxist queer theorists argue that capitalism

creates, maintains and benefits from a society dominated by white, male, middle class

heterosexuals. Our American capitalistic system thrives in a society valuing the integrity

of an intact nuclear family composed of white, middle class, heterosexuals, honoring

monogamy, motherhood and patriotism (Berlant, 1997; Berlant & Warner, 1998; Kipnis,

1998; Zaretsky, 1986). The educational, judicial, medical, and political institutions

uphold these values and employ the media as a mechanism for circulation of these values

throughout our contemporary society (Berlant, 1997).

The early postmodern queer writings have been criticized for their inherent

reiteration of the dominance of white, middle class, patriarchal systems. Foucault was a

gay, middle class, white, French academician widely criticized for his omission in

addressing his own subjectivity within his works (Halperin, 1995). Marxist queer

theories are a response to the belief that queer writings of Foucauldian postmodernists

deemphasize the importance of class and capitalism (Hennessy, 2000). Stoler (1995)

repositions hegemonies by placing race at center stage and utilizes postcolonial

discourses to critique Foucault's writings on sexuality.

Political activists divorce themselves from academic debates of critical

discourses, instead working toward the building of a queer coalition. A meaning for the

term *queer* has evolved over the past decade and now is available for use by any person who does not consider themselves *straight* (Duggan, 1992; Stein, 1990). Queer refuses and deconstructs sexual and gender categories (Walters, 1996). Queer politics, like any political movement, is a fragmented affair with calls for radical "in your face" activisms as well as tamer more conservative actions (Hennessy, 2000, p. 53). Queer activists hope this term will do more than replace gay and lesbian by contesting hegemony at every turn (Duggan, 1992; Jagose, 1996).

Popular Culture: The Prozac Books

A large body of literature exists in popular culture about experiences of depression. The advertising campaigns of pharmaceutical companies found in the popular media have led to a heightened awareness of the existence of the diagnosis of depression. "Prozac" has become a household term and its use is inevitable in any discussion about depression. The books I chose to review all contain the word Prozac in the title and are but a small sample of what is available for general readership. As Wurtzel (1994) states, the huge media campaign that has occurred since the marketing of Prozac reflects the "mainstreaming of mental illness in general and depression in particular." Depression has become trendy with prescriptions of anti-depressants replacing the status once afforded visits to the psychoanalyst's couch.

The array of opinions presented in these few works was striking. *Listening to Prozac* was published in 1993, four years after Prozac received approval by the Federal Drug Administration (FDA) for use by clinicians. Written by a clinical professor in

psychiatry at Brown University, the book purported to offer a "balanced" presentation on what was at that time a new and controversial wonder drug. Written in very simplistic language and with the use of many "case studies," the author, Kramer, depicts mainstream psychiatry's view on antidepressant usage. His voice exemplifies the all knowing beneficiate doctor who truly cares about and understands his patients.

In a rapid and extremely critical response came *Talking Back to Prozac* (1994) by Breggin and Breggin. Their first chapter entitled "Should we listen to Prozac?" offers a devastating blow to the credibility of Kramer's work. The book goes on to shred the idea this drug could be beneficial, purporting its usage to be clinically unsafe and morally unethical with the potential to drive one to suicide or to committing murder.

Prozac Highway (1997) is a fictitious portrayal of a middle aged depressed lesbian. It reflects the darker side of medication usage for the treatment of depression. The protagonist suffers from immobilizing, severe depression but continues to feel ambivalent about the use of medication. She goes off and on her anti-depressants, unsure of the benefits but fearful of the intensity of the pain potentially evoked if off her medication. Wurtzel's novel *Prozac Nation* (1994) recognizes the pros and cons of pharmaceutical usage in the treatment of depression. Her protagonist, a middle class, white adolescent owes her life to Prozac though not without tremendous agonizing over the acceptance of the severity of her mental illness. The book describes the process of trying to control severe and life threatening symptoms of depression without medication and the sense of defeat and acceptance gained when willing to admit the medications' usefulness.

It is apparent that every and any opinion on depression, its causes and treatments, is available for public consumption. Pop culture has demystified the disease state of depression while elevating a potentially lethal condition to celebrity status.

Chapter Summary

This chapter reviewed literature relevant to this study on depression in lesbians. The ideas presented in this chapter represent perspectives circulating in our professional and popular cultures on depression, depression in lesbians, and sexual identities. The literature reviewed offers a description of these varied perspectives providing sociopolitical and historical context to the reader on the phenomena of depression and lesbians.

CHAPTER III

METHODOLOGY

Chapter III contains a description of the method used in this research. This chapter is divided into seven sections: (a) an overview of ethnography including a discussion of critical ethnography, (b) procedures for the protection of human subjects, (c) sampling issues including recruitment, (d) identification of data sources, (f) data management, (g) data analysis techniques, and (h) criteria for insuring validity.

Study Method

Critical ethnography was the methodology utilized in guiding this exploratory study of lesbians and their experiences of depression. Critical ethnography is embedded within the framework of descriptive ethnography with the difference being that critical ethnography questions the motivations of conventional logic (Crotty, 1998; McKewen, 2003; Thomas, 1993). Critical ethnography troubles the relationships amongst lived experiences of a cultural grouping and social discourses, knowledge, power, and politics. (Thomas, 1993).

Ethnography is the study of the ways a particular group of people, or culture, make meaning within the context of their lives (Agar, 2003). Contemporary ethnographers study cultures deeply altered by "global capitalism and a mass mediated world" (Denzin, 2003). Capitalism has led to dramatic changes at all levels and in all aspects of social orders, leading to reformulations of cultures and identities. Cultural and

personal identities are as varied as the contextual factors creating them. The group

studied in this research project, lesbians, potentially shared only one aspect of their

identity, their sexuality. Sexuality is a social construction in our society, and this study

investigated the effects of this shared construct of identity upon experiences and

perceptions of depression.

Cultures are neither isolated nor static but continuously evolving through

technological and economically driven reformulations. Changes in cultural norms and

the world order are occurring with great rapidity at the individual, local, national,

transnational, and global levels. It is necessary for contemporary ethnographers to be

sensitive to these changes (Agar, 2003; Rosaldo, 2001). Denzin (1997) explains that in

our contemporary world "the postmodern is our project not our method" (p. 263). As the

concepts of culture and identity have evolved in the late 20th and early 21st centuries, the

methods for conducting ethnographic studies have also evolved (Christians, 2000;

Denzin, 1997; Gergen & Gergen, 2000; Rosaldo, 2000). No longer do we seek

objectivity in research but rather embrace the understanding that all research ventures are

co-creations amongst participants, researchers and societal discourses. Critical

ethnographic methods afforded me the opportunity to conduct research on lesbians and

depression with the goal of developing nursing knowledge that is empowering and

emancipatory. My hope is that my work fissures the normative approaches to lesbian

nursing research and proves to begin the process of demythologizing much of nursing's

belief systems concerning sexuality.

Procedures for the Protection of Human Subjects

Human subjects' approval was received from the Human Subjects Committee at the University of Arizona before the study began. The approval letter is included in Appendix A. As data collection proceeded, recruitment strategies were altered and amendments to the original proposal were submitted as was necessary and approved by the Human Subjects Committee. Informed consent was obtained from each individual interviewed. A copy of the consent form explaining the purpose of the study, potential benefits, risks, confidentiality, and the informant's rights was provided to each informant prior to their participation in the study. This form is presented in Appendix B. Each participant signed two copies of the consent form, with one copy being given to the participant and one copy placed in a locked cabinet at the University of Arizona, College of Nursing research office. Participation was voluntary and informants were informed that they may abandon the project at any time. One participant chose not to continue participation after the first interview but did not request omission of any data she had already provided. Speaking about experiences of depression was often difficult and one participant requested referrals for therapy that were provided and followed-up with by the participant.

Sample

I approached this study knowing that diversity within the sample is an on-going problem for lesbian researchers (Adelman, 1991; Bernhard & Applegate, 1999; Renaud, 2000; Tait, 1997; Trippet, 1994). Typically white, middle-class, educated lesbians

participate in research studies. In an earlier study I conducted of older lesbians and depression, this proved to be the case (Barnard, 1999). The intent of this study was to include the stories of lesbians of color as well as women whose lives extend across a range of educational backgrounds and socio-economic groups. Participants representing a diverse range of demographic measures were aggressively recruited for inclusion. Demographic information describing the sample's characteristics is presented in Table 1 (see Chapter IV, page 80).

Twelve lesbians participated in the study. The criteria for study participation were (a) born female, (b) self-identified as lesbian or intimately partnered with a woman, (c) 21 years of age or over, (d) English speaking, and (e) the ability to identify some time in their life that they were depressed. English speakers only were interviewed as I was the only interviewer, and I am monolingual. Due to the sensitivity of interpretive data, the use of translation would have jeopardized accuracy.

Twenty five in-depth interviews were collected from the 12 participants. The 25 interviews were collected over an eight month time period. Two women participated in one interview; three women were interviewed three times with the remainder of informants participating in two interviews each occurring several months apart. Data collection was continued until data saturation was achieved. Data saturation occurs when rich points are no longer noted. A rich point is "some expression of the source group, verbal or nonverbal or both, that the researcher cannot make sense of" (Agar, 1999, p.687). Rich points defined the pieces of data needing further clarification. Data collection continued through the dialectic process of data collection – analysis –collection

until no new rich points presented themselves (J. Averill, personal communication,

November 3, 2003). Data saturation was achieved at interview number twenty with

continued data collection occurring to assure no new rich points would present

themselves. By interview number 25 I felt confident that I had captured the story of

depression in this sample of lesbians.

Recruitment

Recruitment was a significant issue to this study as the usefulness of lesbian

health research has been jeopardized historically by the lack of diversity within study

samples. Purposive sampling was implemented in an attempt to recruit a more diverse

sample than is generally recruited for lesbian research. In purposive sampling,

participants are not chosen randomly, but rather for their unique knowledge of

experiences, events and incidents relevant to the research (J. Averill, personal

communication, November 3, 2003). The goal of purposive sampling is congruent with

critical ethnography as it builds patterns about one phenomenon drawn from the

perspectives of different people in different situations (Agar, 1999; Sandelowski, 1999).

Perspective in this regard relates to the relationship between the individual's aspects of

identity to normative social values and discourses. Generalizability which isolates

patterns is not the focus but rather describing the phenomenon in the fullest manner,

seeking out similarities and identifying dissimilarities (Agar, 1999). Six prospective

participants were not chosen for participation as their stories would not have provided a

new perspective on the phenomenon. I intentionally sought women with particular

perspectives such as a young Latina or someone who is employed in a "blue collar" position rather than as a "white collar professional." Demographically the sample seems fairly diverse, however I did not realize that annual income would not adequately reflect class stratification. I ultimately did not achieve sufficient diversity across class although income levels of the participants ranged from being unemployed to earning over $60,000 annually. This issue is discussed further in Chapter VI.

Network sampling utilizing personal connections between individuals was the only successful means of recruitment of participants in this study. Lesbians who were personally known to me or to someone I knew were the only women to step forward as study volunteers. I contacted gate keepers of LGBT organizations not personally known to me but these proved to offer no potential participants. I personally met with and explained the project to three gate keepers connected to LGBT organizations in a variety of settings but though indicating great enthusiasm and support for the project no one volunteered to participate. I was interviewed on a local feminist radio program but did not receive any responses from that 15 minute presentation either, except a call from one mother who wanted me to provide care her depressed gay son. The 12 women who contacted me to volunteer were reached through networking channels such as being the sister of a co-worker of a close friend of mine or a friend of another participant who I had recruited through a workplace relationship. Though conferring some limitations to my sample's diversity this method also proved to overcome another commonly occurring limitation in lesbian research samples. Most studies recruit through advertising at lesbian community settings or businesses frequented by lesbians. I was able to access individuals

who have no such ties. Four women who participated in the study have no links to

lesbian community, and would not consider responding to other recruitment techniques.

Three of the women are currently affiliated with the highly visible lesbian community in

Tucson and the others are known to those in various lesbian social circles.

Data Sources

Multiple in-depth interviews with the participants were the primary data source

for this study. Typically, ethnographic research requires the researcher to engage in

participant observation and extensive field work; however, since no research site exists

and lesbians are not a cohesive identity group, the stories gathered from lesbians provided

the largest and richest source of data for the study. I initially thought spending time at

lesbian community events may provide insight into the lives of lesbians and lend some

relevancy to my study, but I realized early on that this was not the case.

Data sources for a critical ethnography "seem to close in much tighter and

sooner" than non critical research projects (Thomas, 1993 p. 38). Thomas (1993) points

out that including data sources from those whose stories will reproduce the dominant

discourses do not add dimensionally to the understandings sought in critical work. A

focus of this critical ethnography was to deconstruct the discourses discovered within

lesbians' own stories of depression. The available social discourses on depression and

lesbianism have been presented in the literature review. Personal stories of depression

conveyed in a setting of complete privacy provided the most relevant data to achieve the

goals of the study.

At month five of data collection I was feeling that I may not be collecting stories that truly captured the deepest meanings of concepts being presented within the evolving codes. I chose to methodologically triangulate my data sources in an attempt to be confident I was truly grasping the meaning behind their words (Janesik, 2000). I requested that participants create drawings replicating what their depression felt like as well as their feelings about relationships, an identified source of much depression in this group of lesbians. During the next interview, we focused our discussion upon the visual renderings of their stories. Using Van Manen's (1990) ideas for phenomenological data analysis, I queried them about (1) spatiality or the space and spacing, why are things closer or further apart; (2) relationality or why are things grouped a particular way or drawn separately and how they are related to each other; (3) temporality or the ordering and sequencing in the drawing; and (4) corporeality or what is it the image was meant to relay and what do the colors have to say about their feelings of depression. I found this method did not improve my grasp of the concepts and abandoned that data source after three participants engaged in this data collection technique.

One participant is a poet and provided me with copies of a number of poems she wrote about her depression, and another participant had written a short story about an event in her life that she gave me along with some photos of herself. Ultimately it was the narratives of their lives that held the greatest significance to understanding depression in lesbians. By the time data saturation was achieved, I felt I had come to a full understanding of their stories.

Interviews

I conducted up to three in-depth interviews with 12 lesbians using the open-ended method of interviewing described by Taylor and Bogdan (1998). The open-ended style of questioning allowed for the stories to unfold in a natural progression for each woman. Space was made available for the participant to lead me to what she felt was the significant information to be known about her experiences of depression. The most common openings included "Can you tell me about the first time in your life you can remember feeling depressed?" and "What do you do when you are depressed?" or "How did that situation resolve?" I used many prompts such as "Tell me about what was going on in your life at that time" "What do you mean by…?" and "What does that feel like for you?" and "Tell me more about that feeling… or that time in your life… or that relationship." This line of questioning followed the participants' direction as much as possible though I did try to gain information on what contextually underpinned their depressive episodes, how depression felt in their bodies, had they ever been diagnosed and/or treated with depression by a doctor, and what were their belief systems about the phenomenon of depression.

I began the study by conducting a first interview on depression and a second interview on being lesbian with the hope of allowing the participants to tell me about the relationship between these two phenomena. After completing a second interview with three participants on sexuality, I had received no pertinent data linking the two issues. I chose to reformat my interview schedules and integrate information on being lesbian with

the information on being depressed. This proved a better technique and their stories of sexuality and depression became entwined as is their lived experience.

It was my intent to conduct three interviews with each participant, but through the process of data collection-analysis-collection, as well as the unique circumstances surrounding each participant, this did not always occur. For two participants there was only one interview completed, seven participants completed two interviews, and three participants completed three interviews. The interviews were conducted over a time period of approximately eight months. Sandelowski (1999) reminds us that the "temporal shape of life" influences all aspects of a study and as a qualitative researcher I was sensitive to these effects (p.86). Significantly different narratives emerged from the same participant when interviewed multiple times over many months. It was possible to track the ebb and flow of their depressive episodes as well as the effects of depression on their daily lives. Depressive episodes can be intense and describing them while in crisis sounds very different than describing them in retrospect. Many participants experienced major life altering events between interviews such as familial deaths, illness, and relationship break-ups. Prolonged engagement of the participants with the study was essential in collecting rich and thick descriptions of their moods.

The individual interviews were 60 to 90 minutes in length. Each interview was audio-taped. The participants were asked where they would prefer the interviews to be held and at all times their wishes were respected. Three women chose to come to my home while eight requested I interview them in their homes. One participant asked I interview her in the parking lot of her place of employment. Occasionally while in

participants' homes their partner arrived during our interview. In each case I was

introduced joining in a few minutes of small talk, then either the partner retired to a back

room, left the house, or the participant and I moved to another room to continue the

interview. All interviews were completed in privacy which seemed to be important to the

women, despite remarks such as "It's ok if she hears, she knows everything about me."

Journal

A journal is a "reflexive rendering of the researcher's feelings, ideas, and

perceptions," as well as an accounting of the problems arising during the course of the

project (J. Averill, personal communication, November 3, 2003). My journal served to

provide an on-going record of my thinking and feelings about the study including my

frustrations, dead-ended trains of thought, poems I heard that seemed pertinent, and e-

mails I exchanged with my faculty members. I wrote about a number of possible

theoretical perspectives that would explain the phenomenon, but I chose not to include in

my final rendering. Each entry, whether insightful or fruitless, is dated and saved in the

journal, mapping the progressive development leading to my findings and discussion

chapters.

Clinical Experiences

As a practicing psychiatric mental health nurse practitioner I have worked part-

time for five years in a mental health clinic providing care for those enrolled in the State

of Arizona's publicly funded mental health care system. I have treated predominantly

general mental health clients, meaning they suffer primarily from depression, anxiety and

substance abuse issues. The stories I have heard from thousands of clients over those five

years proved to be significant in how I interpreted the participants' stories. Though not a

tangible data source, the effects my clinical practice has had upon my study are

immensely significant.

Data Management

Interviews were the primary data source with each interview being audio-taped at

the time it was conducted. The tape was then transcribed and placed as a Microsoft

WORD document on my office computer (PC) with all proper nouns, whether a person's

name, a place, or a business being changed or omitted. The tape was replayed in its

entirety and compared to the transcription, making any necessary changes to assure the

highest level of accuracy possible. This process maintained confidentiality as well as

allowing me to become more intimate with the data. Participants were initially assigned

numbers with pseudonyms being added later. For example, files were saved as P5I3,

indicating the third interview with participant five. All tapes and transcriptions were kept

in my locked office in my home. The subject consent forms are being stored separately

from the data in a file cabinet in the Office of Nursing Research at the College of

Nursing. The data were shared only with individuals approved through the Human

Subjects Protection Committee at the University of Arizona.

The transcribed textual data were entered into a database using the qualitative

research software Atlas.ti (version 4.2). The software facilitated the processes of coding,

memo writing, and text retrieval. New interviews were added as transcriptions were completed throughout the data collection period and synthesized as part of the on-going thematic analysis. The following section will explain the details of the data analysis process.

Data Analysis

The focus of data analysis in ethnographic research is the recognition of patterns existing within the collected data. Critical ethnography seeks to identify similarities across difference as well as the difference within similarities. Critical ethnography uses macro-analysis to problematize the exceptional cases; anomalies become exemplars (Buraway, 1991; Carspecken, 1996). Analysis moves back and forth between existing theories in which normative values are embedded in the data. In this way, socio-political and historical context is included in the data analysis process. The dominant discourses embraced by the participants become available for discussion.

Data analysis techniques implemented in this study have produced relevant findings available for the (re)construction of nursing theories currently existing regarding depression and lesbians. Inductive analysis strives to "tell the story" embedded within the narratives in a comprehensible manner. The goal of the researcher is to convey the study findings in an understandable and convincing way to the audience (Janesik, 2000). Many systems exist for the purpose of categorizing the data and it must be remembered that these systems serve as a means to an end and are not a means in themselves (Janesik, 2000). I have reviewed a number of systems of categorizing and have implemented one

that has been influenced by DeSantis and Ugarriza (2000), Spradley (1980), and Thomas (1993). This technique moves the analysis from the micro level to the macro level, "structuring the chaos existing within the complexities of lived experiences and providing usable findings" (J. Averill, 2003, personal communication). The terms I use to indicate levels of abstraction from micro to macro are categories, domains, and organizing themes.

Categories are the foundation from which higher levels of abstraction are based. Categories are comprised of the data bits themselves that begin the process of demarcating surfacing patterns. Categories are grouped together into domains. In this study a domain is a conceptualization or sphere embracing a single idea (Thomas, 1993). A domain describes the existing linkage amongst the categories, for example, in this study the domain named *Family* contains categories that address issues regarding mothers, fathers, and perceptions of family interactions.

Domains cluster and form organizing themes. The themes represent the most abstracted level of the analysis. DeSantis and Ugarranza (2000) offer the following definition of a theme: "A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (p. 362). Thomas (1993) concurs with the use of the term organizing theme to delineate the name for a grouping that pulls together "loose threads of data into a clear imaged tapestry" (p. 50).

Identifying Patterns

The inductive method began with a review of a single interview in hard copy with a pen and highlighter after being transcribed and saved on the PC. Initial notations were made and seemingly significant words and phrases highlighted. The transcription was then loaded onto to the Atlas.ti software program and reviewed again while open coding was performed. Open coding is a line by line process of extracting meaning from the individual's perspective. The codes were labeled with words similar to those spoken by the participants (Flick, 1998). After the initial interview with each participant was coded, a *focused network* view was developed from the coded phrases. A focused network views is an option available in Atlas.ti offering a quick snapshot of each participant's interview. In a focused network view all the coded phrases from one individual's interview appear in shortened form and I am manually able to manipulate the phrases on the screen as I formulate ideas on the larger conceptual topics that were presented, such as sexuality, family, or depression. An example of a focused network is presented in Figure 1.

After three interviews were coded, I began to look for commonalties existing within the quotations saved under each code name. Atlas.ti automatically maintains a *code list*. Repetitive review of the codes against and within their original context leads to conceptual refinement. These data grounded descriptive codes were then clustered and synthesized into categories. The codes are regrouped in various thematic schemas with a variety of clustered options before deciding which best describes the phenomenon or experience. Codes were continuously created and merged within Atlas.ti until the code

Figure 1. Atlas.ti focused network view of participant.

list actually reflected developing categories, the next higher level of abstraction. Atlas.ti has no mechanism to separate codes from categories as I defined those terms in this study. Codes and categories shifted and merged as more data were added and the unfolding story emerged.

Domains were formulated that encompassed a grouping of categories. Domains served as an organizational tool to allow for clarification of the direction the data were moving. Focused network views of domains were developed creating a visualization of the domains and the categories contained within its realm. Figure 2 is an example of a focused network view used to organize the categories within the domain of depression management techniques.

The highest level of abstraction is an organizing theme. Four organizing themes emerged from the data that capture the meanings within the narratives of the participants of this study. Theme development was also an evolutionary process as domains were moved and patterned until the organizing themes depicted a holistic representation of the data.

Ensuring Validity

Qualitative research, as an investigation of social and human complexities, is both a scientific and a creative endeavor (Sandelowski, 1986). Based upon the epistemological assumption of social constructionism this study requires a unique set of criteria to determine its merit as valuable research (Guba, 1981; Guba & Lincoln, 1981; Krefting, 1991). Carspecken (1996) offers an extensive listing of strategies specifically

Figure 2: Atlas.ti focused network view of categories.
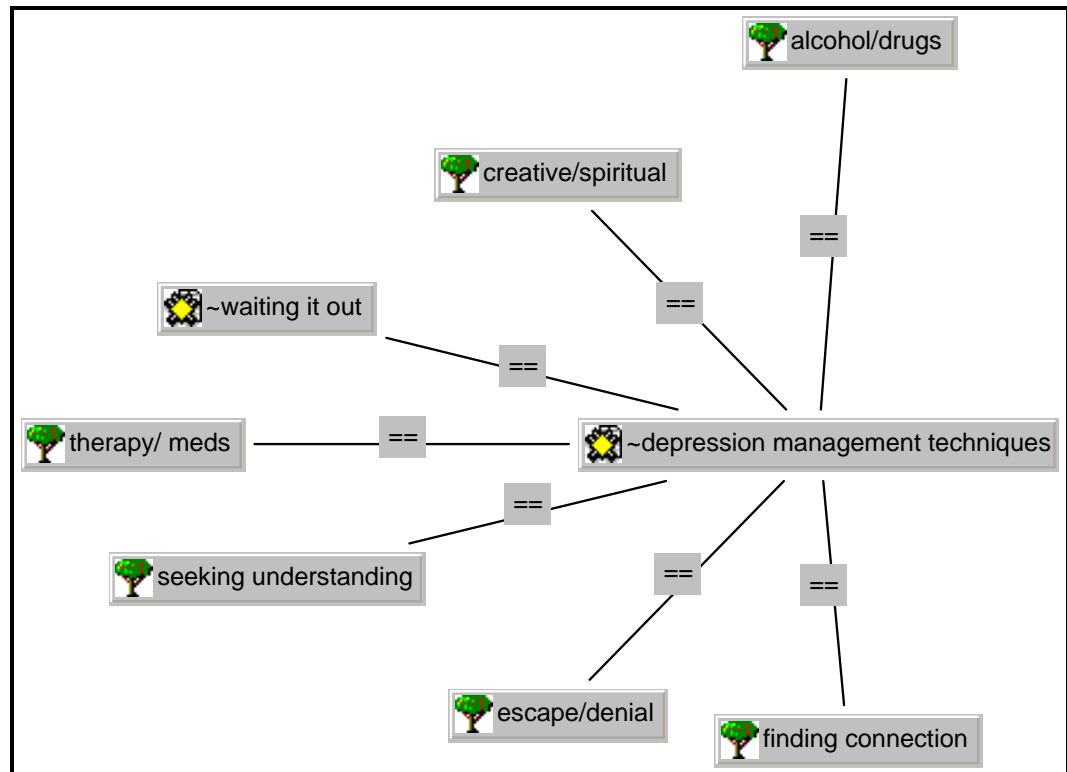
formulated to insure the validity of studies utilizing critical ethnographic methodology.

Validity claims are not the same as "truth claims" of empirical work but rather are based

upon human interactions (Carspecken, 1996). "Truth value" attempts to establish the

authentic and accurate interpretation of the meanings and ignores the effects of discourses

and human interactions within interpretation and representations of truth.

Carspecken (1996) divides the ethnographic project into three distinct stages with

each utilizing a number of procedures to insure validity. The three types of validity

claims are (1) objective validity claims, (2) reconstructive analysis validity claims,

(3) subjective validity claims. Carspecken (1996) acknowledges the influence of Lincoln

and Guba (1985) upon his own work but feels he gives the terms a slightly different

meaning or situates them differently.

Objective Validity Claims

Objective validity addresses issues arising in the earliest stages of the study. It is

concerned with collecting "accurate" data in the sense that what is being collected

represents what is available for collection and is not altered unnecessarily by preventable

data collection errors.

Triangulation. Triangulation traditionally has meant each data bit can be

supported by three sources assuring its authority. Carspecken (1996) suggests the use of

a tape recorder to assure that an objective rendering of data is available for analysis. He

also suggests that written notes be taken by the researcher and another involved research

team member. In this study all interviews were tape recorded in order to provide an

authentic version of the interviews. There were no participant observations contributing to data collection so it was not possible to triangulate data as Carspecken (1996) advocates.

Prolonged engagement. Prolonged engagement refers to the ability of the researcher to blend into the environment or culture being studied in order to minimize the effects of the researcher's presence. In this way the researcher is no longer the cause of alterations in behavior. In this study prolonged engagement was based upon multiple interactions between the participants and me. Many women participated in two or three interviews that were quite lengthy and personal; thus allowing the women to become comfortable. E-mails and telephone calls between scheduled interviews were exchanged over many months. At the time of the interviews many of the participants showed me their homes or introduced me to partners and/or pets. These informal encounters and multiple interviews represented the criteria of prolonged engagement in this study.

Peer debriefing. This is the process of sharing data with other researchers and obtaining feedback on whether they "see" a similar story emerging from the data. I utilized three faculty members for peer debriefing. I shared the transcripts and emerging code lists and requested feedback of my analysis. Discussions with these knowledgeable persons not involved in the study provided alternative insights into the data and critiques of my interpretations.

Reconstructive Validity Claims

Reconstructive validity requirements address issues that arise during the data interpretation process. As the analysis proceeds, meanings that exist beneath the spoken words of the participants are discovered. The following criteria attempt to minimize the misinterpretation of data.

Use of techniques such as interviews and focus groups. This technique helps to facilitate the participants in their reconstructions of their own stories. In this study participants were asked often to clarify and expound upon statements made in an attempt to interpret data as closely to their meanings as possible.

Conduct reconstructions to mitigate power differentials. I often asked participants if they felt that some aspect of my analysis resonated for them. I included in the findings section various reconstructions of the same concept in order to appreciate the variance amongst meanings of similar experiences or descriptions. Involvement of the participants in the analysis of data is essential in qualitative research. The two aforementioned criteria require the participants themselves to determine whether they are being fairly represented.

Peer debriefing. This is the same process as described in the objective validity criteria but it is much more significant to this stage of analysis. Peer debriefing was conducted throughout this study. Carspecken (1996) recommends taping the debriefing sessions and including them as appendices. Tapes of the debriefing sessions were not procured during this study.

Strip analysis. This method is borrowed from Agar's work (1980). Strip analysis compares the emerging organizing themes abstracted through data analysis against a "strip" of data or in the case of my study, actual data bits. If there is congruity, then the themes are appropriate reconstructions. If there is not congruity then either the reconstructions have gone astray, there is another theme not yet identified or this is a negative case and must be explained. Strip analysis was a rewarding process for I felt I had stayed "close to the data" despite the increasing levels of abstraction.

Negative case analysis. Negative case analysis requires that you explain why particular pieces of data do not fit within the organizing themes that have been reconstructed. Negative cases cannot be ignored but must be explained. Offering a variety of experiences within a single category is a method of including negative cases. In this way the same abstracted concept can explain the majority of experiences as well as those *outliers*. Another aspect of negative case analysis is consistent with my use of purposive sampling. It is important to aggressively seek involvement of those who offer a different perspective that may or may not ultimately represent a negative case.

Subjective Validity Claims

Subjective validity claims provide ways to improve the "honesty and accuracy" of the participants' self reporting. Carspecken (1996) states "subjectivity is the realm of privileged access" (p.165). To understand our phenomena under study we trust what we are told by participants. These validity claims strengthen the data generated through dialogical processes.

Review recorded interviews for consistency. It is important to follow up with questions for the participants when contradictions are heard in storytelling. In speaking about their emotional lives many inconsistencies arose in my data that I tried to clarify. Often there is good reason for inconsistency such as feeling ambivalent, but this must be clarified by the participant.

Conduct multiple interviews. Interviewing the same participant a number of times improves the richness and depth of the data. I attempted to interview each participant as often as I could engage them in the research process up to the completion of the three interview schedules approved by the Human Subjects Committee.

Use non-leading interview techniques. It is best to use open-ended interview questions and then ask for clarification as needed. This allows the participant to guide the discussion leading to the disclosure of their priorities surrounding the topic. I implemented open-ended interviewing techniques as outlined by Taylor and Bogdan (1998).

Member checks. It is extremely important to continue to go back to the source. It is suggested that if conducting multiple interviews with a single participant that your reconstruction of what transpired during the previous interview be a starting place for the next interview. Also, summarizing what you have heard is a helpful way to conclude an interview. Invite the participant to challenge your interpretations. I often checked with participants to ask if I had an understanding of what they were telling me. I also presented the developing themes to explore their impressions of what I was reconstructing about depression in lesbians.

Encourage use of terms they use in their naturalistic settings. Participants often will adopt language not ordinarily used to impress or please the researcher. It is important to use language you have determined may be most comfortable for them. Pick up cues from their narratives and mimic their usages. This was an on-going issue for me in this study. The participants desired to use the "proper" medical or therapeutic term when discussing their depression. I repeatedly asked for clarifications when they used a medical term for it was often unclear how it was being used.

Chapter Summary

This chapter discussed critical ethnography as the methodology used to address the research questions of this study. The epistemological considerations leading to this decision were explicated. The methods utilized in data collection, data analysis, data management and evaluation of the validity of the study were described.

CHAPTER IV

STUDY CONTEXT AND PORTRAITS OF THE PARTICIPANTS

The purpose of this chapter is to provide a description of the study participants and to locate them within the socio-political context in which they currently are living. The participants will each be presented through portraits formulated from the information revealed about themselves during the interviews and my impressions of these women. Details within the portraits have been altered at times to insure confidentiality of participants. A table of the aggregated demographic characteristics of the participants is included.

Study Context

The study was conducted in Tucson, Arizona, a city of approximately 500,000 people in the Southwestern United States. Tucson is located in the northern Sonoran Desert, in the Sunbelt region, and because of its warm and sunny desert climate as well as its potential for economic growth, it has become a popular destination for individuals and families to relocate. Tucson experiences 360 days of sunshine a year. The city is ringed on all sides by four mountain ranges, those being the Santa Catalinas, Rincons, Santa Ritas and Tucson mountains. Tucson was once a destination for retirees and those with respiratory diseases, but now is the 30th largest U.S. city and is growing at a rate of 2000 new residents a month. Located in Tucson are Davis Monthan Air Force Base, Raytheon Missile Systems Corporation, IBM Corporation and The University of Arizona. Each of

these entities draws people to the city for employment in an easy going, comfortable environment (City of Tucson, 2004). The 2000 U. S. Census indicates that approximately 62% of the population is white, 30% is Latino, 3% is African American, 2 ½% is American Indian, and 2% is Asian (City of Tucson, 2004). The average household income is $44, 446, the median household income is $36,758 and the per capita income is $26,200 (City of Tucson, 2004). Tucson is 60 miles from the Mexican border and once was a part of Mexico and the home of various Native American tribes. There is a large Mexican population, many of whom live in South Tucson, a community flanking the city of Tucson. South Tucson is a city facing many challenges economically and politically. The majority of the members of the two remaining Native tribes live on reservations that are removed from the city limits. It is quite possible to live in affluent areas of Tucson and never have interaction with the Mexican or Native populations.

There is a state university located in the city, and this college town atmosphere contributes to the area's liberal reputation. It is said that Tucson is a *gay friendly* place, and gay people move here to experience this sense of personal freedom. There has been a lesbian and gay political presence in Tucson since the middle 1970s. A community center opened in the late 1980s and continues to thrive offering a growing number of state and federally funded programs for the LGBT population as well as serving as a social gathering place. The community center also creates a gay visual presence and lends itself as a pivotal point for both the gay and non-gay communities to access information on gay issues. There are over a half dozen bars, coffee shops and eateries that cater to the LGBT population. In November of 2003, gay couples in Tucson were

given the legal rights to register as *domestic partners*. Domestic partnership status affords registered couples the same opportunities as heterosexually married couples on issues overseen by city government. This category does not affect county, state, or federal concerns which at this time do not recognize same-sex unions.

A minority of the participants in this study are natives of Tucson with the others relocating to Tucson anywhere from 30 years ago to four years ago. Many came to attend the university, and stayed on for many years. Others arrived in the 1970s because Tucson offered an alternative lifestyle, and was perceived to be a liberal and progressive place to live. One participant moved out of state during the study, and another participant is planning to leave within six months of completion of the interviews. The majority of participants expressed contentment with living in Tucson, and an appreciation for its comfortable and gay friendly atmosphere.

<center>The Research Participants</center>

Twelve self-identified lesbians participated in this research study. The aggregated demographic characteristics of the participants are described in Table 1. Age and income data indicate a significantly diverse sample. The representation of ethnic groups within the sample is improved over historical lesbian health research studies, but still lacks diversity. Educational levels appeared clustered at high school completion and Master's degree completion. There has been an assumption that relationship status is a determining factor in levels of depression (Ayala & Coleman, 2000; Oetjen & Rothblum, 2000).

Table 1. Aggregated demographic characteristics of participants.

Characteristic	Number of Participants
Age	
21-29	3
30-39	3
40-49	3
50-59	0
60-69	3
Ethnicity	
Women of color	4
White (Caucasian)	8
Education	
High School Diploma	5
Associate Degree	1
Bachelor's Degree	2
Master's Degree	4
Annual Income	
Less than $10,000	1
$10,000 - $19,999	2
$20,000 - $29,999	1
$30,000 - $39,999	3
$40,000 - $49,999	1
$50,000 - $59,999	1
Over $60,000	3
Partnered	
Yes	7
No	5
Children	
Yes	4
No	8

In this study, the distribution of partnered and single lesbians provided the opportunity to investigate this possibility.

It is interesting to note that none of these women were biological mothers. Anecdotally, one may assume that in a sample of this size at least one participant would have birthed a child.

Though not represented in the demographic information, it was also important to recognize the disproportionate number of participants trained and employed in social services and/or medical professions. I attempted to recruit lesbians in the business world and science technologies but though consistently expressing feelings that this study is very important for lesbian health, none were willing to participate.

The goal of the study was to capture the experiences of depression in adult lesbians. The study criteria specified that women only need to be able to identify a personal experience with the term depression. Despite my intentions to reach lesbians who were not necessarily diagnosed or treated for depression, the majority of the participants had long and intense relationships with depression. Table 2 presents the numbers of participants who received treatment both past and present for depression from professionals in medicine and psychology.

Those who seemed willing to speak about their experiences of depression were those who were currently depressed or had histories of severe depression. These issues will be discussed further in the section addressing limitations of the study.

Table 2. Number of participants receiving treatment for depression.

Currently Being Treated for Depression	Previously Treated for Depression
6 Medication and Therapy	1 Medication and Therapy
	4 Therapy only

Portraits of the Participants

The following portraits capture significant characteristics and lived experiences of the twelve lesbians in the study. The goal of these descriptions is to develop a sense of the enormous variance amongst the lives of the participants. The stories contextualize these women's personal experiences with depression.

The participants were each assigned a pseudonym. All names and place names were changed during transcription of the interviews and those changes are reflected in these portraits. Details of their lives have also been altered to protect their confidentiality. The women are presented in alphabetical order by pseudonym. The depth and breadth of the information contained in each story varies for a multiplicity of reasons. Each story is not a portrait of whom each women is but rather a description of what they revealed about themselves and their lives during our interviews. The telling of their stories was influenced by the temporal effects of mood variability, their memories of their experiences relative to existing circumstances, their age and ethnicity, their comfort level with discussing very personal information, their feelings toward me, and their perceptions of what it means personally and politically to be a research participant in a study about depression in lesbians.

Adele

Adele lives with her two dogs and four cats in a small single family home in an established middle class neighborhood. Adele is partnered with a woman who is the mother of a young child. Adele and Adrianna have had a "challenging" relationship over

the past three years. Adele has had a difficult time adjusting to having a child in her life.

She wants Adrianna to be free to go for coffee, go to a movie or go away for a weekend

at will. This is not the case. Adele stated that Adrianna is her perfect mate "but Adrianna

comes with a caboose." The two women and the child lived together in Adele's house

for six months recently but that was disastrous and now Adele lives alone. The two

women are still together but continue to have relationship problems and are "on again/off

again."   Adrianna is a practitioner of Eastern spiritual philosophies. Their relationship

fostered Adele's interests in spirituality. Adele believes that Adrianna "came into her life

to teach her how to love and engage in a sustaining, healthy relationship."

        Adele grew up in a middle class family. She is the middle child of three children.

Her father was a therapist and her mother a stay-at-home mom. Adele states she was

"locked in an eternal struggle" with her mother, always combating her mother's anxiety

and fear. The mother and three siblings argued a lot and "dinner would often be a

screaming match with the father withdrawing to eat dinner alone in another room." She

feels that she did not learn the "tools to be happy from her parents." Her father became

severely depressed while Adele was in college and divorced her mother. He told Adele if

he didn't divorce her mother he was "going to kill himself." Adele is not a depressed

person by nature but also does not know how to find "true happiness." She repeatedly

referred to her family as fear based. She maintains a strained but amicable relationship

with her parents and siblings.

        In high school Adele dated boys and while in college was engaged to be married

to a young man. When she was 23 years old, she and her male fiancé were at a retreat

learning about living a more spiritually based life, when Adele developed an intense

sexual attraction to another female participant. She pursued the woman out of curiosity,

and it was the case that this woman was a lesbian and already in a relationship. Though

unavailable to Adele, the woman she so admired suggested that Adele "may be a lesbian

and should check it out." Adele discussed this possibility with her fiancé and he was in

agreement that she had better "check it out" soon. Upon doing this she determined that

indeed she was "a lesbian." She broke off the engagement and from that day forth has

called herself a lesbian. In retrospect she believes she had crushes on her female friends

throughout junior and senior high school and has always been gay but just didn't know it.

Adele believes "sexuality exists on a bell curve with the tails being those that are

exclusively heterosexual and exclusively homosexual. She is in the tail, absolutely,

exclusively homosexual."

It was not difficult for to tell her parents that she was gay as she was raised by

"educated, liberal, Jewish, parents who were neither bigoted nor prejudiced." Her father

was very supportive of Adele but concerned that she would experience social

stigmatization. Her mother initially thought Adele was gay because of her own failure as

a mother. Adele refused to engage in these conversations and left no room for

negotiation. Adele eventually was able to help her mother recognize that two of her

mother's own friends were actually not roommates but a lesbian couple and this

alleviated some of her mother's apprehensions.

Adele has never suffered from bouts of severe depression. She has however

experienced low points, primarily at the time of relationship break-ups. At these times

she "feels a failure and that she should have done more to save the relationship." She has

never been on medication for depression but has utilized therapists a number of times.

Her depressions have usually been situational and underpinned with feelings of failure,

frustration, or stagnation. For a number of years she smoked marijuana in a subconscious

attempt to numb herself. Emotional extremes of all kinds were avoided during this time

and she felt at that time that this was a wonderful coping mechanism.

Adele hit her "lowest trough" after her relationship ended with a woman she

thought of then as her "soul mate." She then entered into a spiritual journey with a group

of lesbians. She learned there are only two states of being, love and fear, and she was

learning through spiritual awareness to live in love and let go of the fear that was so

ingrained in her being throughout her childhood. This was a turning point for Adele as

she states she never again has experienced depression. She doesn't let it "hang around

for more than a few minutes." She uses her thinking processes to reframe the distressful

situation into a spiritual learning experience. Getting busy and engaging with other

people are other techniques that ward off any feelings of depression.

Cassandra

Cassandra and her fiancé, who she has been in a relationship with for two years,

live with Cassandra's mother in her mother's home. The couple sees this as less than

ideal and want to move into their own apartment but at this juncture it is unclear when

that may happen. Because she is a lesbian she believes "she is different from normal

people and dresses differently, cuts her hair differently than she would if she were

heterosexual." Men find her attractive, and she has intentionally chosen an appearance that she feels is clearly lesbian in attempts to discourage men's advances.

At about the age of 12 Cassandra began to experience sexual fantasies involving women. She did not understand why this was happening to her and became very frightened. She did not tell anyone about these fantasies and prayed to God to make them go away for they would lead to her "burning in hell." Cassandra feels a "freak" and an aberration as her religious teachings adamantly condemns homosexuality. Despite her fears and feelings of shame about being a lesbian Cassandra has been in relationships exclusively with women since becoming sexually active as a teenager. Issues of sexuality are complex for Cassandra. She was molested repeatedly by an in-law at the age of 14. At 16 years old she was gang raped by nine teenage boys. She rages within in response to these events but her feelings become overwhelming and confusing as throughout her life she had first hand knowledge that her father was molesting young girls. Cassandra's relationship with her father was very very deep and intense. She was "his favorite of the four children in her family." He "spoiled her rotten" for 25 years, and she adores him despite the fact that he drank alcohol very heavily throughout his life. Last year Cassandra's father committed suicide one afternoon as he was about to be confronted with charges of molesting a little girl in their neighborhood. Cassandra was a "victim of sexual abuse but also a witness to others being victimized by someone she loved more than the world."

Beginning at around the age of nine, Cassandra began using illicit drugs. Throughout her teen years she used drugs very heavily, including cocaine, marijuana,

pain medications, ecstasy, acid and alcohol. Always feeling like an outcast by her peers

she found acceptance with gangs. She continued abusing drugs and living a very violent

lifestyle until 1996. At the beginning of her senior year in high school, her girlfriend at

that time told Cassandra she was not really gay and was leaving her for a boy. Cassandra

proceeded to enter her father's bedroom, load his gun and was about to shoot herself in

the head when the telephone rang, stopping her in mid-motion. She was admitted to a

psychiatric unit and placed on anti-depressants. She stayed clean for one year and then

began using drugs heavily again. She entered into recovery again, one and one half years

ago. She lives her life by the twelve steps and is whole heartedly dedicated to her AA

program of recovery.

During the time between our two interviews Cassandra was fired from her job,

forced to move out of her apartment and into her mother's house and experienced a

"blackout" for no identifiable medical reason. The blackout left her feeling afraid of

what might have happened to her while she was wandering the streets. She felt

inadequate for she could not carry her "fifty percent of the financial burden in the

relationship and felt sick and tired of being sick and tired." She went into her bedroom

and took what was left in a bottle of anxiety medications in the bathroom cabinet.

Cassandra was brought to the hospital by her fiancé and awoke on a psychiatric unit. I

interviewed Cassandra 30 days after discharge from the hospital. Cassandra hopes to

stop having so many problems and become "normal and hopes the depression will go

away." She is taking anti-depressants and just began work with a therapist the week

before we met. She wants to go to school, and become a social worker so she can help

addicts and girls who have suffered the way she has throughout her life.

Dana

Dana lives alone in a small nicely renovated home in a middle class

neighborhood. She is financially self sufficient. Dana grew up in a family that is not

comfortable with homosexuality. She has always felt she was thought of as "lesser than"

her sister who is heterosexually married. She feels there is "nothing but joy" expressed

for heterosexual family members who bring partners home for holidays but "relationships

with someone of the same-sex are always devalued somehow." Dana appreciates how

difficult life is for lesbians and the pressures to stay "closeted" in the work place to

protect one's job. She is saddened by homophobia but accepts this to be the case in our

society.

Dana moved West to attend graduate school in her early twenties. Shortly upon

arriving out West she met roommates who were "born again Christians." Their influence

led to Dana's conversion to the Christian faith. Her practice is foremost in her life and

her faith guides many life decisions. She realized that altruism is a basis of a "good life"

and attempts to minimize her own selfishness and self-importance. Depression is not a

problem for Dana as she knows that God has a plan for her life, life events are not

random but part of her growth. When sad things happen in her life she feels "humility

and joy for these events are lessons intentionally placed in her path." She does feel

sadness and has had episodes of depression but these are transient and not a "predominant scenario."

Dana's most significant relationship was with a woman who was heterosexually married and parenting two children at the time they fell in love. It was a difficult and conflicted situation that did not resolve without great anguish for everyone involved. The relationship lasted three years and then ended with both women becoming involved with other women. Dana has had many serially monogamous relationships. At the time of the interviews she was single but still seeing her last lover occasionally.

Debra

Debra lives alone in a small, well maintained house. She has been in a relationship with a woman for approximately a year. They lived together from the second month of the relationship through the tenth month when the couple was having a lot of problems, and Debra chose to move out of their rental home and into her own place. The partnership has been troubled throughout most of its existence but it has survived with the help of therapists. Debra most recently said "now we talk about a future together…we make plans like we are staying together."

Debra's childhood was very traumatic and difficult. She grew up with a mother who only desired the "perfect life" meaning the "perfect husband, the perfect daughter, and the perfect home." Perfect for her mother reflects white, upper middle class, heterosexual values. Debra's biological father was illiterate and a drug addict. Her mother married him quite young, and has hated him passionately since their divorce when

Debra was three years old. However, her biological father has joint custody of her, the couple's only child, and throughout her childhood Debra spent weekends with her father often "hanging out in bars." "I was the only kid in the bar playing pool by myself…" Debra speaks very emotionally about only wanting her father's love. She felt badly for him as his situation seems bleak and was willing to love him despite his shortcomings, but her attempts were always rebuffed. She told one heartbreaking story after another of her willingness to forgive him for his meanness and neglect and continued to pursue a relationship with her biological father until a few months ago. At the time of our last interview she had retained a lawyer, and is taking her father to court for owed child support payments.

Debra has a troubled relationship with her mother. Debra was an "overachiever" in high school excelling both in sports and academics. When she told her mother at 16 years old that she was gay, her mother "had a nervous breakdown." Debra's sexuality is the reason her mother was placed and remains on anti-depressants. Debra's sexuality is a disgrace to her family. At 16 Debra moved out of her mother and step father's home and rented an apartment with her girlfriend at that time, also a high school student. Debra dealt with discrimination from family and peers due to her sexuality throughout the remainder of her high school years. She left her home town and moved to Tucson. She feels that her past finally caught up with her and she began to suffer from depression. Debra was unable to do anything but sleep. She was diagnosed with "clinical depression" and now is in therapy and on medication. She understands she has highs and lows and will continue to battle depression for a long time.

Debra has difficulty maintaining friendships as she "has trust issues." She finds it hard to share her feelings and confidences with most people. She has a lot of unstated expectations of friends and when those expectations are not fulfilled she becomes angry with her friend and distances herself. She has only "two close friends and a lot of acquaintances." She has had a series of unfulfilling short term relationships with women, one was mutually physically violent, and another was with an adulterous partner. Debra gets very frustrated and angry with her current partner very often as she doesn't understand why her girlfriend would make a particular remark, or why the partner doesn't understand Debra's position, leaving Debra feeling unsupported. The day before our last interview Debra had a fight with her girlfriend because the girlfriend remarked that Debra was lying on the couch "playing the sick card again." This upset Debra to the point that she "almost blacked out with rage." Debra "yelled and yelled and yelled" at her girlfriend. This event is typical of the way these women relate but Debra feels that "things are getting better between us."

Esther

Esther lives in a large home in a wealthy area of town with her partner of 28 years. Very shortly after the interview her mother died, and Esther and her partner, Rosemary, sold their home and moved out of state. She and Rosemary owned a business for a number of years. Recently the business began doing very poorly and they abandoned their enterprise. The couple had been experiencing severe financial problems that led them to sell their home.

Esther is a very calm woman who speaks positively of her childhood years and very highly of both of her now deceased parents. She has never suffered from chronic depression rather experiencing isolated situational depressions. Counseling is a tool she has implemented when feeling down or anxious throughout her life. She feels that she benefits from speaking to a professionally trained objective person concerning personal issues. In middle age Esther began suffering from panic attacks, she went to a therapist who practiced *in vivo* behavioral therapy. The therapy was very successful and she overcame her panic attacks. Her anxiety never returned and she has been unable to identify its root cause. Esther has never taken anti-depressant medication. She is overweight but does not suffer from medical illnesses except intermittent bouts of arthritis.

Esther has been gay since first becoming sexually active. She had her first sexual encounter with a woman in her early twenties, and she describes that event as the best thing that ever happened to her, stating "it was like coming home." She enjoys being a lesbian. She and Rosemary co-parented Rosemary's now 22 year old daughter throughout the 1980s and 1990s. They had no problems with the schools or with the young girl's friends. Esther and Rosemary are comfortable with their sexuality but do not necessarily flaunt the full nature of their relationship.

In the 1970s, Esther went through a seminar to increase spirituality in her life. This program had a lasting impact upon Esther and she has never felt overwhelmed by life events since that time. She stated she currently "could be very worried about her financial situation as it is dire but knows that worrying won't help the situation and it is

just a part of living." She perceives herself as healthy and in a loving relationship with Rosemary, and the "money issues will work themselves out." When I was interviewing Esther her mother was very ill in a care home. After our first interview, her mother died. I did not interview her again as she was extremely busy dealing with her mother's estate and selling her home and moving. We spoke on the telephone after she had moved out of state, and she said that she had become quite sad and grieved tremendously after her mother's death for she really admired her mother immensely. Esther is "moving on" however and knows she will "be ok with the passage time." She is enjoying her new home, and she and Rosemary are starting a new business venture together.

Lori

Lori lives with her cats in a four bedroom roomy home in a middle class subdivision. Lori has been single for eight years since the break-up of a relationship that had lasted five years. Lori feels "betrayed" by her former lover and has not been able to recover her ability to trust another person in an intimate relationship. She had one short term relationship since the breakup eight years ago and states she "sabotaged" that relationship and behaved in ways she that are "not like her." Lori is ambivalent about relationships at this time but very much craves a high degree of what she refers to as "intimacy in the deepest sense not sexual but true intimacy." Lori likes to have one person in her life at all times where she feels a deep connection, but in recent years this has been missing from her life. Lori has a large circle of friends the majority of whom are lesbians and gay men but is not involved in "the lesbian and gay community".

Lori is a member of a racial minority. She experienced a lot of prejudice growing up. Due to her father's employment, the family moved quite often. Often Lori's family was one of the only families of color in a town. At school she and her siblings were so overtly different they were subject to much discrimination from all and abuse from peers. Lori is middle aged and very comfortable and pleased being of color and being a lesbian.

Lori suffers from a chronic type of depression. She has been in and out of therapy since her teen years. She has been on anti-depressants for the past ten years, and is fearful of ever going off of them for fear she will become very depressed, and never be able to come back from the depression.

Margaret

Margaret lives with her partner of three years in a single family home. She has no dependents, and early-on in her career formulated a plan that would allow her to retire with the resources to travel the world. This plan has been actualized as Margaret has trekked throughout Asia and South America amongst other exotic places in the past decade.

Margaret has been in intimate relationships with women since the age of sixteen when while at a high school event she met a young woman who "after one look" Margaret "knew was the one." The feelings were mutual, and these two women stayed together for 10 years through trying circumstances. Margaret describes those times as difficult "because back then I never heard the word lesbian, there were no role models." When Margaret and her partner's parents found out their daughters were "more than

friends," the girls were separated from each other, and Margaret was sent to see a psychiatrist to help resolve her "confusion around issues of sexuality." The parent's efforts were for naught as when the girls graduated from college they ran away together. The relationship ended after 10 years when Margaret left her first lover for another woman. Margaret has been in relationships most of her life. She has been single only for six to twelve months interludes between serially monogamous relationships.

Margaret is not an anxious or depressed person by nature. She has short bouts of depression but gets "bored" with being depressed, and then gets busy and that resolves her depression. Margaret does not like to speak to anyone about emotions. When she is upset she isolates briefly then will start socializing, and never mention her feelings to friends.

Margaret believes she has a "good life" and says she "walks through the world and sees the cup half full." She has been to therapists occasionally over the years but has never taken anti-depressant medications.

Norma

Norma lives in a townhouse with her elderly mother whom she care gives. Norma is currently single. At the time of our first interview, she was involved in a dating situation that was very confusing to her but between interviews she chose, with the help of her therapist, to end that relationship. Norma is an avid hiker and quite healthy. She has a very busy social life going out almost every evening engaged in various lesbian group activities. Despite Norma's busy social life she is sad and lonely and she "has

gone through life craving a special love that she has never had." She has never received the love she has wanted or needed to feel content but is still hopeful that one day that relationship will happen.

Norma grew up on a farm in the rural Midwest. She had a lonely childhood, spending much of her time when she wasn't working on the farm, alone with her dog Buster. She had a difficult and contentious relationship with her father. Her brother was the favored child, and Norma was disregarded and valueless to her family. One day as a child Norma searched through her parents official papers looking for her adoption papers because she was "sure she could not possibly be a biological member of her family." She has maintained a distant relationship with her brother. The responsibility to care for her mother fell upon Norma after her father's death.

Norma was raised as a Southern Baptist. This religious faith did not extend to her the possibility of being gay. She is gay however, and suffered greatly for many years attempting to find a resolution to this conflict. Although she ultimately did not embrace the religion after childhood she felt for most of her life that lesbianism was shameful. She could never tell her father that she was a lesbian but was able to tell her mother much later in life. Norma had one long term relationship that lasted 15 years. It ended after a slow deterioration in intimacy and sharing of life goals. Since that time she was involved with a heterosexually married woman for a number of years. This was very emotionally draining on her and she finally was able to end this relationship with the help of her therapist. She then became involved with a woman she dated and "on paper she looked

perfect," but Norma was not happy in this coupling either, and chose to end the relationship.

Norma has been in therapy fairly consistently for over 20 years. She hopes one day "to figure it out" and be able to love herself and feel her feelings as these aspects of her emotional life were never acknowledged in childhood and she is only now beginning to move toward self-acceptance. Norma has been on and off of anti-depressants for eight years.

Regina

Regina lives with her dog in a small house that she bought last year in a lower middle class neighborhood. She plans on eventually fixing it up herself, as she cannot afford to hire people to complete the renovations. Regina describes herself as melancholic. She reads extensively about depression, and self-diagnosed herself with dysthymia. She has been on and off medications for depression for eight years. Regina said that only her close friends know she is depressed, and most who know her "would be surprised to find this out as she presents as an outgoing and gregarious person." She has never experienced a successful intimate relationship. Her only two attempts at intimate relationships were both while she was in the armed forces and stationed abroad. Both women were native to the country of Regina's military deployment, non-English speakers, and much younger than Regina. Regina ended both relationships when it became apparent to her that her emotional needs were not being met. She has had two long term romantic attractions to close friends. Both are what she described as

"unrequited love." Regina has loved her high school best friend, Judy, since they met each other at 17 years of age. "It was a long process for over 20 years in which nothing has happened." She has maintained close ties to a small group of lesbians who have known each other for decades. Most recently she thought she had the opportunity to turn one of these close friends into a lover but the woman did not have romantic feelings for Regina, and they maintain a platonic relationship. It was heartbreaking for Regina to watch the object of her desires become involved with yet another close friend with whom Regina had a bad history.

Regina's parents were divorced when she was nine years old. Her biological father taught college history. She describes him as "violent and angry." He was an alcoholic, and treated her mother poorly. She had no contact with him for 20 years, then one day she received a letter from him requesting reconciliation. She disregarded his letter stating "if he is looking for absolution he can look some place else." Her step father is a "real nice guy" and they have a distant but amicable relationship. Regina feels her mother is "slow" and she emotionally care gives her mother, as well as consciously choosing to place no emotional demands upon her. Regina is currently grieving her beloved maternal grandmother's death. Regina made the final decision to stop all life support for her grandmother, as her mother could not completely grasp the situation. This was a very painful and difficult decision for Regina.

Regina's life is lonely at times but she embraces her depression. She feels depression "is in her soul and part of who she is" and feels "it has many life lessons to teach." She currently sees a therapist but between our second and third interviews chose

to stop taking medication. She is confident that she will recognize signs when she needs to start medication again, but feels strongly about taking breaks from the anti-depressants.

Sonya

Sonya lives with her partner of two years in her single family home in a lower middle-class neighborhood. At this time she identifies herself as a *lesbian*; formerly she thought of herself as *bisexual*, and in public spaces used the term *gay* to describe her sexuality. Sonya has been involved in intimate relationships with women since she was 15 years old. *Lesbian* has historically been an uncomfortable descriptor because she has had sexual encounters with men between intimate relationships with women. She only experiences intimacy inclusive of sexual and emotional connection with women but has enjoyed casual sexual encounters with men at various times throughout her life. She believes the term lesbian is threatening for many people due to social stereotyping of "lesbians being mean, angry, men hating, butchy women." She does not want to put people she meets on the defensive. Sonya also "resists any type of labeling or boxing in of the human experience into categories that are artificial and socially determined." Now that she has turned 40 years old, and is in what she hopes is a lifelong and committed relationship, she is comfortable thinking of herself as lesbian.

Her family had some very short term discomfort when she initially told them that she was gay but within a month everyone, except her mother, adjusted to this with ease. Sonya feels very strongly that her sexuality has been a protective factor throughout her

life. She derives her "greatest feelings of safety, connection, intimacy, and comfort from other gay people."

Sonya grew up in a tumultuous household. She refers to herself as *multi-racial* to avoid restrictive labeling while acknowledging both her mother's and father's heritages. She was the youngest of four children. Her siblings are all much older. Sonya's mother was schizophrenic. The family denied her mother's disease, and despite multiple psychiatric hospitalizations her mother was not maintained on psychiatric medication. Alcohol and prescription drugs were her mother's way of coping with her disease. Her mother died when Sonya was 20 years old of cirrhosis of the liver, three days before Sonya was scheduled to fly home for a visit to say goodbye. Not seeing her mother before her death was devastating for Sonya.

Her father "worked all the time," and when he was home, he focused on her mother's problems. His large extended family did not understand what was wrong with her mother and "they let it be known that [her] mother was not welcome in their family." There was much shame and silence about her mother's life, and it was not until Sonya was 34 years old that the family sat down and discussed the consequences of her mother's illness upon their lives. Sonya felt "very alone and very abandoned" throughout her childhood. She has always feared becoming mentally ill, like her mother.

Sonya feels her whole family suffers from depression with each person dealing with it in a different way. Her oldest sister has always been an over achiever; "if you look good no one will ever know." One brother is, and has been for decades, a functioning heroin addict. When Sonya was 12 years old, another brother, who was

going through a difficult divorce, came home to live. He overdosed on heroin one night

and died; it was the first time he had ever used the drug but was so despairing he chose to

try it with his already addicted brother. This event spiraled both Sonya and her mother

into deep depressions. It seems to have been a turning point in the family's life. Blame,

shame and disconnection followed. Sonya developed a "romantic relationship with

depression." It was a "comfortable dark space to escape the pain and chaos of [her]

family life." Sonya believed the world to be an unsafe place, where no one could be

trusted. Depression became a mechanism allowing her to maintain distance. She

eventually began drinking heavily to escape her pain. She was in numerous difficult

intimate relationships. She tried therapy and anti-depressants. She describes her

depression at that time as "a terminal ache, a terminal sense of aloneness."   She found

herself at 31 years old sitting in a room with a loaded revolver pointed at her head. She

called her father to come for her, and entered a psychiatric hospital. In the psychiatric

unit she experienced an epiphany, realizing she "was not crazy at all," and would not

allow herself to be "diagnosed and over-medicated." She laid blame on our mental health

systems for not helping people in need. Shortly after leaving the institution she withdrew

from public mental health services having found a reason to continue living, that being

changing the delivery of public mental health care.

Sonya then pursued an intensive spiritual journey. She "maintains an indifference

towards living but believes if she has to be on this planet she will commit her whole

being to caring for others, especially those most ostracized by our society." She currently

works in social work addressing the health needs of drug addicts, sex workers, HIV

positive people, and the homeless. She no longer lives with the constant pall of

depression. When depression begins to creep into her senses she refuses it entry.

Teresa

Teresa was still in her eight year relationship when I first interviewed her. At the

time of the second interview she was staying with a gay male friend after having just

broken up with Mia, her first and only lesbian partner. Teresa grew up in a small city a

few states away from Arizona. She has a large extended family there with whom she is

emotionally tied, but has chosen to move to a different location "to escape their

alcoholism and dysfunction." She met Mia in college, and upon Teresa's graduation

from college they moved away to live their lesbian lives more freely "away from all the

scrutiny of large families." Their families accepted their relationship at some level, and

have acted as in-laws towards each other, with Teresa's grandmother and Mia's

grandmother spending time together socially. Family is very important to Teresa and she

misses her family.

Teresa's mother died of leukemia when she was two years old. Her mother had

gotten pregnant at 18 years old with Teresa, and was a single mother. The biological

father was not in a relationship with her mother long, splitting before Teresa was born.

There has never been any contact between Teresa and her father. When her mother died,

parental responsibility for Teresa, an only child, went to her maternal grandparents. She

has always had "an emotionally distant relationship with her grandmother." Her

grandfather was an alcoholic during her years at home. At one point in her childhood

both grandparents were drinking, and Teresa was often neglected, being left at home alone at night while they were in the bars. Teresa made a suicide gesture at seven or eight years old. She took a handful of pills, primarily vitamins, but was never taken to the emergency room, for fear child protective services would become involved. Teresa feels her "extended family did not know how severe the neglect was in her home, and also they would not want to draw attention to this," thus nobody in her family interceded on her behalf. Her grandmother stopped drinking heavily quite a long time ago and her grandfather has been sober for ten years at this time. Teresa's relationship with her grandparents is somewhat strained due to her childhood traumas and her sexuality.

Teresa has very "traditional ideas" about how she wants her life to look. She would like to be in a "monogamous committed relationship where all responsibilities are shared." She would like to be "married" and possibly birth her own children one day. Mia did not share that vision with Teresa. Teresa and Mia downplayed their different long term goals, as both were attempting to build careers. Teresa became severely depressed shortly after moving to Tucson. Mia became very frightened, as she had never seen Teresa in such a state. Teresa was treated with an anti-depressant by her PCP, and her mood improved. Depression has been an area of contention in their relationship, as Mia becomes very upset, annoyed and frightened when Teresa lapses into depression. The relationship became very rocky last year for reasons unknown to Teresa. They went to couples counseling to help keep the relationship intact, but to no avail for Mia began having an affair. When Teresa discovered this she was very upset and left town to go home to visit family, and to gain some perspective. Mia called Teresa while she was out

of town, and told her that the relationship was over, and Teresa had two days to get her belongings out of their home. Teresa came back and gathered her property. The break-up has digressed to the point of Mia filing for a protective order of restraint against Teresa, and the retaining of lawyers by both women.

Teresa was very depressed at the time of the second interview. She was barely able to work. Her anti-depressant dose had been doubled by her PCP. She was seeing her therapist three times a week. She was not interested in staying in touch with friends, but her many lesbian and gay friends were watching over her well being.

Tracy

Tracy is a corrections officer, and our only interview was conducted at the visitors' parking lot of the detention center where she is employed full-time. We spoke outdoors in the parking lot leaning against her pick-up truck, following one of her eight hour shifts.

Tracy was recruited for the study by an acquaintance of mine who is a social worker at the detention center. Tracy was amenable to being interviewed, however, upon attempting to engage her for a second interview she chose not to respond to my phone calls. Tracy "does not like to offer a lot of information" about her life. If asked she will answer but she does not talk about herself otherwise.

Tracy lives with her partner, Gloria, and Tracy's adopted child in a single family home. She and Gloria have been together for two years. Tracy spoke very negatively of her partner calling her a "bitch" and "lazy." She said a number of times that if Gloria

"cannot respect her child she does not deserve respect from Tracy." Gloria is also a

corrections officer at the same detention facility. Tracy indicated that the relationship

will probably be ending sometime soon unless Gloria changes her attitude and behaviors

quite a bit. Tracy's family and friends no longer interact with her as Gloria has chased

them all away. Tracy's son was a foster child that she adopted. He has a number of

psychiatric diagnoses and severe behavioral problems, but they "bonded immediately and

[the child] is the center of her world."

Tracy is not "out" to her family. She only has "one family and she does not want

to alienate them for lovers she knows will eventually be gone from her life." Tracy stated

that "there are some things you just don't talk about with your family, and being lesbian

is one of them." Tracy has only suffered from situational depressions. She has never

been to a therapist nor has she been on anti-depressants. She believes depression is a

natural response to life events, and knows with time her moods improve. She was the

most depressed she has ever been following the ending of her first lesbian relationship.

The woman whom she adored had an affair, and this devastated Tracy. During the same

time period, Tracy's mother died. This was very difficult for her, and she feels "it was

the necessity to continue caring for her son that kept her going some days." The

simultaneous occurrence of these two events was life altering for Tracy. She learned

through her ability to recover from these very severe lows that she can emotionally

handle any event with which she is confronted.

Chapter Summary

In Chapter IV, the demographics of the 12 study participants were presented. The socio-cultural context of the city where the participants reside was also included to provide a backdrop for the lives of these 12 lesbians. An appreciation of the socio-political climate of where they live is a crucial factor in understanding their daily life experiences of being gay in a predominantly heterosexual society. Short portraits of the 12 women were presented with the intent to allow the reader a greater sense of the unique circumstances of each life before I begin to synthesize their stories and discuss the patterns of common experience that emerged from the narratives. In the next chapter I will present the four organizing themes that emerged from the findings with an in-depth discussion of each theme, and its domains and categories.

CHAPTER V

FINDINGS

Chapter V presents an overview of the findings of the data analysis and an in-depth discussion of the findings of each organizing theme. Data analysis revealed four organizing themes. Organizing themes identify the most abstracted level of the shared experiences of depression within this sample of lesbians. The organizing themes, domains and categories are presented with supporting exemplars and quotations from the interviews, identifying each as a pattern that emerged from across the interviews.

Overview of the Organizing Themes

Data analysis revealed four organizing themes describing the experiences of depression in the 12 lesbians in the study. The four organizing themes and the domains existing within each theme are presented in Table 3, followed by a brief discussion of each theme.

1. *Being depressed: Describing the experience*. Depression manifested within the participants in a multiplicity of ways. The domains explicate the varied aspects of depression. The domains in this organizing theme are (1) *Duration* and (2) *Intensity*. Categories within each domain provide extensive descriptions of the participants' internal experiences of depression.

2. *The roots of depression: Emotional dissonance*. Depression is a response to relational discord within these lesbians' interpersonal lives. Feeling connected to those they loved

Table 3. Organizing themes and domains.

Theme	Domains
Being depressed: Describing the experience	1.Duration 2. Intensity
The roots of depression: Emotional dissonance	1. Family 2. Peers 3. Intimate relationships
Managing depression: Desire for relief	1.Escape 2. Seeking expert advice 3. Community support
Explaining depression: Needing to know why	1. Biomedical model 2. Familial transmission

is important, and when this connection felt disrupted, absent, or in chaos, depression resulted. The theme's three domains represent the realms in their lives where dissonance was identified as significant. These domains are (1) *Family*, (2) *Peers* and (3) *Intimate relationships*. The categories further detail the nature of their feelings about discordant relationships.

 3. *Managing depression: Desire for relief*. Depression is a very uncomfortable feeling and the participants attempted to find relief from their suffering in a multitude of ways. The domains that presented themselves were (1) *Escape*, (2) *Seeking expert advice* and (3) *Community support*. The categories describe the methods used by the participants to alleviate their suffering within each domain. The women described patterns of effective and ineffective coping mechanisms as well as constructive and self destructive means of managing their feelings.

4. *Explaining depression: Needing to know why*. The participants embraced available discourses that shift the responsibility away from individual's character to other theoretical models of depression. Identifying a cause for their depression also provided hope that there is a cure. The categories (1) *Biomedical model* and (2) *Familial transmission* describes the ways the participants came to understand the reasons why they were depressed. This theme also addresses the participants' experiences with treatments such as taking anti-depressant medications and therapy.

Organizing Theme:

Being Depressed: Describing the Experience

Feeling depressed was an unpleasant experience and contributed to difficulties in functioning in the daily lives of the participants. This theme depicts aspects of the experience as it was described by the participants. The data bits contained within the domains (1) *Duration* and (2) *Intensity* explicate how being depressed is embodied. The participants, with the exception of Tracy, were all very articulate about their experiences of depression. The retelling of their personal journeys through depression revealed stories that are dramatic and at times romanticized. A single participant would describe depression as a very intensely painfully feeling at one point and then later in the same interview describe being depressed as feeling numb. Although there was this range in descriptions within one narrative, there were many commonalties in the ways the women described the feelings of depression. The domain *Duration* addresses the difference between experiences of depression occurring secondarily to a life event and the type of depression that is life long. Table 4 portrays the domain and categories existing within this theme.

Duration

Two distinct types of depression were identified by the participants; these types are situational depression and chronic depression. The difference between the two is the duration of the episode. Situational depressions occur as a direct response to an event. The event could be related to a relationship break-up or a death or the event could be

Table 4. Organizing theme: *Being depressed: Describing the experience*

Being depressed: Describing the experience

Domain: Duration
    Categories: Situational depression
              Depression as a Worldview

Domain: Intensity
    Categories: Terminal sense of aloneness
              No way out: Wanting to die
              Shutting down

---

something occurring in daily life which is upsetting such as financial problems or employment problems. Situational depression is a time limited response to a particular event and as the issue resolves the depression also resolves. The second type of depression is chronic depression. Chronic depression tends to be life long or, at the least, depression is the dominant emotion for many years at a time. Chronic depression waxes and wanes in intensity and may go away altogether for short periods of time. Eventually a new situation will trigger the old and deeply rooted feelings of depression leading to a life lived in the shadows of depression. The two categories are not mutually exclusive as those with chronic depression also suffer from situational depressions, but the reverse is not true. The two categories within this domain are (1) *Situational depression* and (2) *Depression as a worldview*.

Situational Depression

Many women stated they experienced bouts of situational depression that are short lived. The episode is triggered by a life event that either resolves or the women are able to adjust to the occurrence. Those who only experience situational depressions tend to be those with a more positive attitude toward life. Tracy identified financial problems as triggering a recent depressive bout in her life. Adele stated,

> I've never really seen myself as a depressed person. I have had bouts of the blues
> or I would get to a point where I would feel really really crappy about life…but I
> don't hold onto it for longer than, you know, maybe five minutes.

Similarly Esther explained, "I don't fall into depressions easily but I can uh…I can get pretty deep into depression for a short period." Margaret gets bored with depression after a few days and becomes involved in outside activities finding this brings resolution to her depression quite quickly. Situational depressions also occur in the women who suffer from chronic depression. Lori offers this appraisal of whether she suffers from chronic or situational depression, "I indeed do have a predisposition [for chronic depression] I do have a predisposition but my depression is maybe more half and half …." Those experiencing situational depressions represent a group whose life perspective is upbeat and not controlled by a gloomy emotional nature. Many of the women interviewed suffer from chronic depression which is a much more debilitating experience.

Depression as a Worldview

For those women with chronic depression, the phenomenon was described as an approach to life, a perspective, or as Lori said "a worldview." All of the participants with chronic depression were currently on anti-depressant medications. They have all sought help from therapists and doctors as well as being well versed on the literature of depression. These women read books and search the Internet to learn more about depression.

Norma and Teresa are two of the women whose baseline emotional tenor is one of sadness and loneliness. Their chronic unhappiness waxes and wanes with intensity but consistently underpins their lives. Norma has described her childhood and teen years as "lonely." She was 61 years old when I interviewed her and she cried through much of

the interview as she spoke about many of her experiences across her lifespan. She did not use the term "chronic depression" but there is a pall of emptiness and depression that has followed her from childhood to this day. Norma hopes one day to "figure it out" so she can leave this sadness behind.

Teresa also lives with an underpinning of sadness that exposes itself most often when triggered by a situation such as a relationship problems,

> I don't weep uncontrollably unless I'm talking about like really hard stuff like in a therapy session I can weep through the whole thing but it would be about my partnership problems or about you know like my relationship or lack of it that I have with my grandmother and like worrying about losing her and not really having a family because I don't have any brothers or sisters and I don't have any children. I don't have a relationship with my uncles or cousins or anything like that so things like that bring me a lot of sadness…it's hard to tell what was first but it seems that problems with my relationship precede really bad episodes of depression and then once the episodes are on then the problems multiply.

Depression shrouds these women's lives. They break through their depression at times only to revisit the emptiness when a new situation triggers old feelings. Regina refers to herself as an "Eeyore type" invoking an image of the very gloomy and downtrodden Winnie the Pooh character. Sonya is the only participant who has managed to overcome very deep and long term depression. The other women who experience this type of depression continue to suffer greatly.

Intensity

The domain, *Intensity*, refers to the depth and level of suffering depression causes. Suffering is a subjective experience but patterns of descriptions of the intensity of depression emerged during data analysis. Descriptions of the intensity of feelings were vivid and often dramatic. Two categories, *A terminal sense of aloneness* and *No way out: Wanting to die*, capture the passion and power of depression. The third category, *Shutting down*, is antithetical to those, describing depression as numbness and an absence of feeling. Most participants described both experiences at different points in their interviews. Depression can manifest as an excruciatingly painful experience. The pain is a physical aching that is unbearable. For many women this intensity reached such an unbearable level that they wanted to die. Suicidal thoughts occurred when the depression was very severe and it was coupled with a sense of feeling overwhelmed by circumstances and a hopelessness to change anything. Experiences of suicidality are included as the category, *No way out: Wanting to die*.

Just as often as women spoke about their highly charged emotions when depressed they spoke of a desire to escape everything and just sleep. Motivation wanes and they are overpowered with a yearning to withdraw from life. Depression as a numbing experience is described in the category, *Shutting down.*

A Terminal Sense of Aloneness

Lori describes her depression as a physical discomfort,

> Depression is like this kind of black ink being spilled on a piece of paper or cloth just sort of starts spreading and eventually envelops you…depression for me is a whole body experience…it feels like the joy is draining from your body.

Lori has a great fear of depression,

> I don't like depression at all uh I don't like how it feels its really like being really sick and poisoned throughout your body it's a terrible feeling and I feel like I'm gonna get somewhere once in my depression and I won't be able to get back up again…it's a fear and I don't think there is anybody who can help me get up again.

Regina has a recurrent dream that symbolically describes her powerful feelings of depression. She describes the dream in this way,

> I have a fear of drowning. I'm not very good in the water. I don't like to go into the ocean very much…it's a scary dream but the worse scary part is its like black and water is coming up and big waves and I can see this rock jutting up in the water…it has a sharp point at the top I could grab on to but I can't get there and I am struggling against the waves and I can't get to the rock….that's severe depression for me.

Sonya was very articulate in her in-depth descriptions of the level of suffering she

experienced with her depressions. She states, "I was eviscerated by this feeling. There

was nothing left of me. I had no where to go…." Sonya goes on,

> My depression was like a muse right… it mutated into this romantic kind of
>
> relationship almost because it was the only thing in my sense of isolation that I
>
> held on to and then as I got older and I continued to write and then I started to
>
> drinking and there is that whole kind of orientation to being that kind of tragic
>
> poet…a poetic figure that is alone and misunderstood in society. That was a very
>
> appealing image to me and it may be the only thing that kept me alive because
>
> quiet frankly between the violence in my house the disconnectedness I felt from
>
> other people, the unintelligible kind of emotional connections that came and went
>
> with my care givers, uh, and the pressure to go out the front door and pretend
>
> everything was fine made me wanna die.

No Way Out: Wanting to Die

Overwhelmed by intense unbearable feelings of depression and perceiving there

to be no options to change circumstances in their lives, many of the participants

expressed that they either had made actual suicide attempts or had strong desires to die.

Sonya and Cassandra have both spent time on psychiatric units following suicide

attempts. Cassandra attempted suicide and was hospitalized twice in her lifetime with her

second hospitalization occurring between our first and second interviews. Her first

attempt was in her late teens when she pointed her father's loaded gun at her head. A

phone call "snapped her out of it" and at that time she was admitted to a psychiatric

hospital briefly and then to a substance abuse treatment center. Cassandra explains what she was feeling when she attempted suicide most recently with an overdose of benzodiazepines

> Fear, depression, not having a job, getting fired, not having a car, not having money, feeling worthless in my relationship, feeling like I'm inadequate in all aspects of my life…being sick and tired of being sick and tired, tired of battling this blackout and seizures and nobody being able to give me any answers…and feeling totally powerless over them and afraid because I didn't know if someone picked me up when I was on the streets [during the blackout].

Regina realized as she stood in an apartment with a gun to her head that this was not really an option.

> At one point in the army I was really depressed but I was really drunk too so I don't know if that counts, but I was at my friend's house, actually she was someone I was seeing and it was messy and icky umm…she was gone for the weekend with her girlfriend and I was feeling guilty because I was you know seeing someone who was supposed to be with somebody else and I just…I wasn't happy, I wasn't getting what I needed and it wasn't going to get any better and I remembered she had a gun, a 9 millimeter and I remember it was loaded and I remember putting it to my head and wanting to shoot myself.

Teresa also tells of a suicide gesture; however for her it occurred as a small child.

> I think I had depression as a child I remember being umm…umm…like seven or eight years old and having a kinda not a very serious suicide attempt but a gesture

like taking a whole bunch of pills….I remember just being really tearful and kind

of curled up in the corner and taking these pills.

Feelings of wanting to die were one response to the misery in their lives but there was

another response as well. Most women depicted times in their life when their depression

manifested as no feeling. They were emotionally numb and only wanted to sleep.

Shutting Down

Closing themselves off to feelings and sleeping a lot was another common

response to depression. Debra states,

I would sleep all day it was like I've been sleeping sixteen hours a day and I

usually sleep six, just this unbelievable thing like I just want to go to bed…I

would lay there and I was suppose to be at work but I didn't care…Its not caring

about any of my friends not really wanting to go out, not wanting to communicate

with anybody… my house was always dark.

Teresa describes a similar response to depression.

Just shutting off and tuning out and you know I think I start to zone out…I just

want to sleep and not want to work and not wanting to think or do anything…I'll

just have this low where I am incredibly depressed and sleepy and just not able to

do much.

For Regina, who suffers from chronic depression, she sometimes wants to "… flee mentally, you know what I mean, I'll just shut down…leave…." Norma echoes this sentiment,

> I have felt like not doing anything and that to me is really depressed and when I don't want to be around people, I don't want to go anyplace, I don't want to do anything that's when I would call it very deep depression.

Depression occupies a large amount of space within the lives of women who suffer from chronic depression. Depression interfered with their ability to function in the world despite its duration. For those who experience short intervals of depression, it still is debilitating and a difficult feeling to endure.

Theme Summary

Depression is articulated within the body as a physical manifestation. Depression is situational evoked or a chronic state. The participants identified three expressions of depression they have experienced in their lifetimes. Depression manifests as an intense pain that can crescendo to a point where it seems unbearable or antithetically, it is an embodied emptiness. The next theme, *The roots of depression: Emotional dissonance*, will describe the sources of depression identified by the participants within their narratives.

Organizing Theme:

Roots of Depression: Emotional Dissonance

The participants framed themselves and their life experiences within a relational

context. The women's emotional well-being hinged upon the nature of the interpersonal

and intrapersonal interactions in their lives. Depression resulted when the participants

perceived a dissonance between the existing emotional make-up of a relationship and

their idea of what this relationship should emotionally provide for them. This difficulty

in feeling emotionally connected to significant others in their lives depicts a thread that

runs through the domains of this organizing theme. Three domains are encompassed

within this organizing theme: (1) *Family*, (2) *Peers*, and (3) *Intimate relationships*.

Table 5 details the domains and categories identified within this theme.

Family

Stories relating to families of origin surfaced repeatedly throughout all the

interviews. Questions within the interview schedules directly asked about relationships

with family members but it is notable how expansive their responses were to these

questions. The women often spoke at length about their relationships with various family

members without my prompts. All participants were raised by their biological mothers

except for Teresa whose mother died of leukemia when she was two years old and she

was raised by her maternal grandparents. Not all the participants were raised by or even

knew their biological fathers. All mothers not living with the biological fathers remarried

at least once, some multiple times. Relationships between participants and their

Table 5. Organizing Theme: *The roots of depression: Emotional dissonance*

The Roots of depression: Emotional dissonance

Domain: Family
    Categories: Fallible mothers
                Distant fathers
                Abandonment and neglect
                Sent to therapy
                Mothers and lesbian daughters

Domain: Peers
    Categories: I am different
                Being ostracized

Domain: Intimate relationships
    Categories: Break-ups
                The bond between women

---

stepfathers varied in intensity but all were harmonious. All of the participants grew up in two parented, heterosexual households. For the two Latina women the cultural value of *familialism* was very important. Both Latinas were very closely connected to their large extended families. Esther grew up in the 1940s in a large city on the East Coast with her immigrant Jewish extended family all living in close proximity to one another.

> …we lived in this big apartment building and I had my aunt and uncle living down on the third floor, next to them were one of their sons and his wife and three children, next to us was my one of my cousins and his wife and their children. So out of six apartments we had four of them and then we had another relative on the other side so it was real close.

Sonya's father was a first generation American of immigrant parents from a Mediterranean country. Her father's side of the family was very closely knit, with their native language spoken in the home rather than English. She had an extensive amount of contact with her paternal relatives though very little with her mother's family who were African-American. Lori who is a woman of color also had minimal contact with her extended family, in part because her father's work caused the nuclear family to relocate many times throughout her childhood. The remainder of the participants was Caucasian and grew up in nuclear family systems. These women spoke occasionally of aunts and cousins but the more significant personal interactions focused upon members of the nuclear family.

Family life was a site of contention for all participants but Esther. Esther spoke very highly and positively of her familial interactions. Conversations about relationships

with families led to the development of the following categories; (1) *Fallible mothers*, (2) *Distant fathers*, (3) *Abandonment and neglect*, (4) *Sent to therapy*, and (5) *Mothers and lesbian daughters*.

Fallible Mothers

The participants spoke about mothers much more often than about other family members. Esther, who is 62 years old, spoke very lovingly and deferentially of her mother. At the time of the first interview she had just recently placed her mother in a care facility after having care given her mother in her home for the previous two years. Her mother died about one month after our interview. The other participants described their mothers as women who were emotionally damaged and often incapable of giving their daughters a foundation of emotional stability or support. Mothers lived difficult lives and suffered greatly and this perception underpinned their daughters' feelings of disappointment, anger, and sadness surrounding their relationships with mothers.

Sonya's and Margaret's mothers suffered from mental illness and alcoholism. Sonya's mother's schizophrenia and its repercussions throughout her childhood served as a major theme within Sonya's narratives. Sonya was depressed throughout her childhood, suffering intensely from loneliness and isolation.

> I had a bizarre relationship with my mother, you know, that was kind of long and
> painful and drawn out and unfulfilling and then ultimately the very realization and
> acknowledgement that my mother was mentally ill and I had tremendous fear of
> becoming mentally ill. There is a lot of chemical dependency in the history of my

family and my mother had so many problems…she'd do interesting things as

people who have conditions like that do, you know, I mean she would close

herself in her bedroom and talk to people who weren't there…and she self

medicated through the use of some alcohol and some prescription drugs.

Margaret states,

So I felt like my mother had deserted me and I thought 'so okay my father drinks

and I can't stand that I hate that, that's disgusting, but at least my mother doesn't

drink', ha, but then she started to also, I felt, you know, that I had been you know,

deserted now there was nobody there but me, you know what I mean? My

mother's condition continued to deteriorate, she was depressed, very depressed,

probably before she started drinking or at least to the point that she was seen by

psychiatrists and she was on medication, she was given shock treatment for

depression, she was given more meds, she tried to commit suicide several times

and she finally succeeded to kill her self when I was about 28.

For Regina and Lori there was sympathy and a sense of responsibility to protect their

mothers. They believed them to be victims of abusive relationships with their biological

fathers. Regina states,

If she were a child today I think she'd have attention deficit disorder, you know

she is not real uh, she is not educated… and I don't want to say slow, but I feel

really bad saying that, but I know its true and my father was just, merciless and he

used to call her stupid and dummy.

Lori feels her mother was once a happier person "but I think by marrying my father she wound up very depressed and I kind of think her life was taken away from her…." Adele maintains a distant and troubled relationship with her mother. She is quite outspoken about her mother's shortcomings; "My mom has got an anxiety disorder of some kind or at the very least she has got a really really low self esteem and she is a real worrier…." Tracy said her mother was a "bitch," Norma was angry with her mother as she was a "doormat" and never defended Norma against her father's verbal assaults. Each woman had something derogatory to say about their mother that contributed to difficult mother and daughter relationships and feelings of being deprived of a positive female role model.

Distant Fathers

Relationships between fathers and daughters varied in nature and intensity but there was a noticeable pattern of distant fathers. Fathers were not a primary source of emotional support for the participants. Dana, Cassandra and Adele had closer relationships with their fathers than their mothers but even with this being the case they consistently reported that fathers stayed minimally involved in their lives. For most participants information about fathers was delivered with much less emotional intensity than information about mothers. Norma and Michelle were exceptions as their inability to gain their father's acceptance was a primary theme in their overall stories of depression throughout their lifetimes. For Cassandra, her father's history of molestation of young girls and his suicide played an enormous apart in her own experiences of depression.

The more typical story is voiced by Margaret whose father was a physician,

> I had a lot of things going for me even though my father wasn't a particularly
>
> warm person he was a nice guy. He didn't do anything bad, he didn't treat us
>
> badly but he it was just a matter of not spending time with us, not really paying
>
> too much attention to us.

And for Lori it was also her father's work and his nature that kept him away,

> Father was very removed he was umm, he was all he did was work and umm
>
> emotionally he was very distant and not a good communicator and ummm as
>
> much as I loved him and admired him I can't really say I really knew him.

Adele often speaks very lovingly of her father but she reiterates this pattern when she states,

> I didn't have a lot of contact with my father before the divorce. I just wasn't close
>
> to my dad. I mean they were living together but most of my contact was with my
>
> Mom just because that was the pattern of my relationship with my parents.

Debra fought against her father's distancing. She anguished over her thwarted attempts

to connect with her biological father. Debra was an outstanding athlete in high school

and she desperately wanted her father to see her play ball but her father did not attend a

single game. Here is a typical depiction of their interactions with her father throughout

her life,

> I was about four years old and I remember running after his Firebird because he
>
> dropped me off a day before he was suppose to and I was like 'Dad, don't go' and

I would run after it all the way down the street like screaming for him and he

would just leave.

For some participants their father's absence was significant, playing a vital role in their

own stories, but for most it was just a fact of their life.

Abandonment and Neglect

Descriptions of feelings of abandonment by primary caregivers occurred in all

participants who were personally affected by alcoholism or drug addiction in their

childhood. The impact the abandonment and neglect had upon their moods throughout

their lifetimes was enormous, with all the participants who lived with addictions as

children having been diagnosed with major depressive disorders as adults. Speaking

about these feelings of abandonment was difficult and often caused them to weep during

an interview. It was not always the addicted parent who caused the participant great

suffering but living within a family dynamic where addictions existed seemed to sensitize

the women to perceptions of abandonment and neglect.

For Sonya and Margaret, whose mothers were mentally ill and alcoholic, there

was no hope of gaining sustainable caring from either the ill parent or the family whose

energy was diverted to caring for the mentally ill family member. Sonya states

The focus of my family became caring for my mother and consequently what

happened was I got lost, and because she had been my primary caregiver and the

person who gave me my most attention, and she no longer did that, and that my

father was absent, but when he was there he was focused on her. I could do

whatever the hell I wanted and with the knowledge that I could do whatever I wanted, came the awareness that I was very alone and neglected.

Teresa's life was afflicted by alcoholism as well. Her grandparents who were her primary caregivers throughout her life were alcoholics. This fact holds great significance to her as she refers innumerable times to the consequences of this upbringing upon the way she relates in the world as an adult. In this statement she speaks to her abandonment;

I would wake up in the middle of the night and no one was… no one was in the house…they [her grandparents] were out drinking together and at six or seven years old I called the police a couple of times because I was afraid.

Teresa also suffers greatly from a sense of being abandoned by her mother who died when she was two years old. Teresa states that her latest therapy sessions, following a recent relationship break-up actually are focusing upon her feelings of abandonment by her mother. She weeps whenever speaking about her deceased mother and her therapist is linking her difficult partner loss to her unresolved feelings of the loss of her mother and the neglect of her grandparents.

Debra's father is a drug addict whose lack of commitment and caring about his daughter has caused Debra significant suffering. Debra says,

Like I'm just crying to him like I want you to care, I want you to talk to me, I want you to be in my life…I am after his love and I am after wanting him to be in my life.

Although Debra's mother no longer lives with her addicted father, Debra also feels abandoned by her mother,

> I wanted to have that support system, you know, that I think most people have where they can call their mom and talk to them and their mom talks back. I felt very alone for a lot of time I felt I couldn't trust people ummm I felt like I was alone, fighting the world like why does this have to happen to me?

For many years Cassandra, whose father was "an extreme alcoholic," was care given by an older sister rather than either parent. When her sister married and moved out of state Cassandra states, "…that's when I started using drugs; I was depressed all the time, I was sad all the time, I missed her and cried myself to sleep.…" Suffering and depression caused by perceptions of abandonment and neglectful parenting is a thread that runs deeply through these women's narratives of their emotional lives.

Sent to Therapy

At some point in time all the participants disclosed their sexuality to their family members with the exception of Tracy. She states,

> Well they don't know we are involved, I told them that she is just a roommate…tell them anymore than you have to and they disown you. Your family is the only one that is gonna ever be there for you, you know, and people [girlfriends] come and go. I figure why would I blow it, I knew that the first one would end, I knew it, I mean she actually was a bitch and this one is a bitch, so

why would I say anything and lose my family over something I know is going to

happen…if I find the right one things might be different.

For some women the decision to tell their parents they were gay led to being sent for

professional psychological help to address what was perceived by the parents as a

pathological condition. Margaret became involved with her first partner in 1958 while in

high school. When in college together they felt comfortable talking to their respective

families about the true nature of their relationship. This is what happened;

> We decided to tell our parents for some reason…we thought you know, surely it
>
> will be okay, but it wasn't okay and they decided to separate us…They weren't
>
> too happy about it so, so one of us had to move from (the university), so I was
>
> moved...but anyway during that period of time my parents sent me to a
>
> psychiatrist. It was during the summer and there was not one in the small town I
>
> lived in, so they sent me away to (name of larger city) on the weekends to a
>
> psychiatrist ummm during that summer.

Debra who "came out" to her parents 41 years after Margaret, in 1999, faced a

similar response,

> I went to therapy in high school when I first came out to my parents and they took
>
> me there and had a therapist tell me that it is just a phase and get over it and you
>
> know and not be a lesbian and blah, blah, blah so ever since then I've had a
>
> negative outlook on therapy.

Life at home became so difficult for Cassandra as a teenager that she went with her parents to a therapist to address "Cassandra's problem."

> We had family counseling and they found out why I was…they were trying to figure out why I was trying to commit suicide, and basically it was part of being a lesbian and not being able to come out to my family and not being accepted and not being able to accept myself.

Lori and Regina also visited therapists as teenagers, though their sexuality was not the matter under discussion. Neither had disclosed nor acted upon their sexual attractions for women at that time. They were sent for help because the parents thought that their daughters were depressed and having difficulties functioning well socially.

Mothers and Lesbian Daughters

Mothers had more difficulty than fathers accepting lesbian daughters. Only Esther's mother fully accepted her daughter's sexuality without issue. Either mothers were part of a parental dyad where both parents rejected their daughter's sexuality or the mother responded more negatively than the father when learning of their daughter's sexuality. Sonya's mother never accepted her daughter's lesbianism, although her father accepted her after a month or so of discomfort with the idea.

> My mother didn't like that I was gay, my mother had a greater issue with me being gay [than my father], but I never talked to her about it and I don't know if it was really that I was gay so much as I was spending a lot of time with my girlfriend and away from her…I was never clear on that, but my mother was a

Roman Catholic so the likelihood is that she had an issue with her accepting my sexuality.

Adele's family dynamic was similar,

I remember telling my father that I was gay, my dad was very supportive about it and just wanted me to be happy. My mom had a hard time with it, but it was her stuff and I recognized that it was her stuff and we had many conversations about it because for her it felt like she had failed somehow and I actually said to her 'You know mom I think it's the opposite, I think that the fact that I can be so comfortable where I'm at and be so confident is an affirmation of your parenting' …I remember having a conversation with my mom where she was very upset I was like 'Mom you know if you don't want to talk about it we don't have to talk about it but it is not going away.'

Cassandra describes her mother's response in this way,

So I moved back home with mom and dad, my dad of course was happy to have me home, he always wanted me to be home. My mom was like miserable, she was mad at me because she couldn't accept my abnormalities as a lesbian.

The domain, *Family*, captures the stories the women told about a variety of negative feelings surrounding their relationships with their families. They spoke about their troubled familial interactions with great emotion and have placed a great deal of emphasis on the effects of this discord on their long term emotional stability. The next group with whom they encountered problems were peers.

Peers

Difficulties between the participants and their families were not the only

troublesome relationships of their lives. The domain, *Peers*, identifies the difficulties

these women had locating themselves as children and adolescents within a social context.

There was a consistent pattern in the women's stories of feeling like an outsider and not

fitting in peer groups.

I Am Different

The category, *I am different*, captures the experience of "othering" for the women

in the study. Although aging mitigated the intensity of the feeling surrounding the

experience of being different than peers, these stories were available for vivid recall

despite the participants' ages. There are two aspects of being othered; this category is

based in a self perception of being different and the second aspect is reflected in the

category, *Being ostracized*, which is based upon external messages of difference. Each

story was rooted in a different reason for being "cast out" (Cassandra's word), but despite

the identifier, it was a painful experience to "be different."

Regina referred to herself as "not being normal" often throughout her interviews.

These perceptions began in high school for her,

> So I'll say probably it started dawning on me that I was not a very happy person
>
> the way other people were, you know, that I perceived them as being happy
>
> around high school, sophomore year, but I always felt that some people went
>
> through like certain stages you know like they had relationships with people

boyfriends, girlfriends whatever, but I didn't go through the same stages, and I

think that kinda made me feel that I wasn't good enough or wasn't normal, you

know, I was different, you know?

It was during high school that Sonya also recognized her difference,

I hated high school, you know, and I felt like an adult all the time. I didn't really

fit in with a lot of peers…I always had the sense that what happened in my home

and my life was different from what other people's lives were like.

This feeling of otherness followed Sonya into early adulthood,

I did a lot of work in the community but I always had the sense, I never had the

sense of being part of life I…I always had the sense of being an observer of it and

I think that was highly correlated to my youth when I would never feel a part of

things. Always separated by you know what I sensed as differences between me

and other people.

For Cassandra her sexuality set her apart from "normal,"

The way I think, the way that I'm sexually with women, makes me wonder if

something is wrong with me…or it makes me feel abnormal, to me normal means

you know being straight and having desire for men you know and I don't have a

desire for men, I don't….I have a very hard time accepting that I am different

because normal people have it easy, lesbians don't have it easy.

Being Ostracized

Another aspect of othering was the actual experience of being ostracized by peers because of a particular character trait or flaw. The reason for their experience of being othered varied with each individual. Despite the reason, the response was similar, with each woman being painfully aware they were being singled out as different by their peers.

Lori is Black and she speaks to the racial prejudice she encountered growing up,

Well my family moved from a town with uh, I was pretty comfortable as comfortable as we were going to be being the only family [of color] like a family that stuck out from other families but I was comfortable in this town but my father needed to move in order to work and he found another job, but the town we moved to was very unfriendly I mean more unfriendly than usual. I didn't have friends and uh I know that I uh I know there was the typical isolation, loneliness at school, uh some of the name calling, I remember eventually not even going to school.

Cassandra said she had a large birthmark removed from her face and it left scars that made her look odd to other children,

At nine I didn't really have any friends at school, I was very much made fun of in school, because I had a scar on my face uh and a scar on the top of my head, that went from the forehead to the back of my head. So I was, uh cast out a lot by the other kids.

For Debra, being ostracized by peers came secondarily to being lesbian as a teenager. She often had to travel as a part of her involvement in her high school sports team and that meant spending nights in motels. Debra was aware that her teammates were very uncomfortable sharing a bed with her and one day confronted her teammates for treating her differently than the other girls,

> They got the rest of the team in the room and I said 'Ok I'm gay, ok if you have issues we need to talk about it because I'm sick of being the person on the couch because nobody wants to share a bed with me, I am sick of being the person who nobody wants to talk to because I'm gay.'

She feels that her confrontation ultimately only led to further discrimination as she then was often "benched by the coach" during games.

Feeling different than peers was commonly experienced by the women in the study. This feeling of separateness from others limited the potential to receive emotional support and increased vulnerabilities to feel depressed.

Intimate Relationships

The final domain of this theme is that of problems with intimate relationships. The nature of intimate relationships was described in any number of ways such as being up and down, being loving and nurturing, being a horrible experience full of jealousy and abuse, but the notable consistency in their stories occurred in discussions of relationship break-ups.

Break-ups

The category, *Break-ups*, describes the most commonly referred to cause of major depressive episodes in this group of women. When asked the context surrounding the deepest and darkest occurrence of depression in their lifetime, without hesitation all the participants responded that it was "break-ups," a term used across all narratives. The response was so universal it felt like a choral refrain.

Even Tracy, who was reticent to speak very openly to me during our interview, cited the end of her first lesbian relationship as leading to a particularly deep depressive episode. She states, "A real deep depression was uh, my first lesbian experience that was somebody I thought I was really in love with and we broke up and it just crushed me…." Margaret, who does not suffer from chronic depression, states,

> I've been depressed a number of times in my life, usually over relationships, the
>
> ending of relationships, you know or the problems around a relationships. I think
>
> probably uh that relationships are more important to me than other things like my
>
> career, you know work, and so I think that's why there are more feelings
>
> surrounding relationships that there are with work or other things in life. I really
>
> hate the break-ups.

For some participants it was the ending of a relationship that triggered a depressive episode that had been brewing for a long period of time. Debra went to her medical doctor at nineteen years old after a relationship break up at which time she was diagnosed and treated with medication first for situational depression then major depressive disorder. Debra explains,

I had a girlfriend, I think we were both going through depression and we didn't

know it. She was living with me and we had broken up and she had moved out of

the house but I think I was suffering from depression way before that and just

didn't know it….it is my own thing, I have a history of it and I have to deal with it

so I went and dealt with it…and we thought you know relationship break up,

school's getting to you, it is just situational so I went on Celexa and then I went

off and the same thing happened again and I went back to the doctor and she is

like no you are more clinical depression, you deal with it everyday all the time.

Teresa was in the process of breaking up during her involvement in the study. She wept

when speaking about the unkind way her ex-partner was orchestrating the break-up. She

describes what was going on in this way through her tears,

I went to (home town) to visit my family…while I was there I got a phone call

from my ex saying that she wanted to end it, it was over, and she that she decided

to tell me over the phone long distance after eight years [together], so I came back

and immediately started planning to leave. I moved into a friend's house and

rented a room from him. I've been out of the house for a month now. It's been

horrible; it's been horrible (choking on tears), a horrible break up because she is

really into controlling all the property…police have been involved, it's been

awful, awful, awful….the symbolic thing that I really really want is to visit with

her dog and a picture, she has not allowed me to leave the house with any

pictures. I have no evidence of like the past eight years of my life…I mean it is

just ugly very very ugly.

Teresa was visiting her therapist three times a week at the time of the second interview, one month after the break-up. Her medical doctor had doubled her dose of anti-depressant and she was having difficulty working as she was suffering from a severe episode of depression.

In trying to understand why relationship breakups are so difficult Lori and Margaret proposed that there is a "scarcity" of potential mates so losing a lover triggers a fear that there will never be another. Lori also believes that in same-sex relationships the partner is a reflection of self and break-ups symbolize a loss of part of oneself. Many women felt that the essential nature of lesbian relationships is a primary contributor to why losing a relationship is so painful. The next category, *The bond between women*, describes this phenomenon.

The Bond Between Women

Many women attributed the pain of breakup to the strength of the bond that exists between two women as well as the innate capabilities of women to experience love intensely. Regina believes there is "more and better communication between two women than between a woman and a man." Adele and Sonya believe women have different abilities for relatedness than men. Adele said,

It's been going on since before the Bible, you know, women are amazing

creatures we have enormous capacity for love and relationship and we're able

to…our hearts are just different I think we have a capacity to love on many many,

many different levels and many capacities because we are women and that's the

way we are made up.

Sonya believes break-ups are more difficult in lesbian relationships than for

heterosexuals because the bond between women has more intensity than the bonds

between men and women.

I don't think heterosexual women connect with men the same way that two

women connect. I think part of it is because they don't share the sense of

common experience as a woman and I mean on a more abstracted level you know

we're both women and our reality as women is similar in that we are women in a

society that has certain expectations about role that we are no longer participating

in so there is some kind of bond I think in that sense of being of being women

together. I think sexually and physically women with other women know women,

you know, I know what a woman feels when a woman is touched and I can only

imagine what men feel. Women can bleed and not die for instance and they can

reproduce. I think they are a different reality. So I mean there are many reasons

that I think that women resonate together in ways that men and women do not.

Theme Summary

The theme, *Roots of depression: Emotional dissonance*, describes the importance

of relatedness to these women. Family, peer, and intimate relationships provide the basis

for their narratives of the underpinnings of their experiences of depression. Depression

ensues when these types of relationships are not meeting expectations of what the women

feel they need for emotional well being.

The two themes reviewed thus far portrayed patterns that emerged relating to the

inner workings of the participants' interpersonal and intrapersonal lives. The two themes

to be presented next deal with the phenomenon itself. These stories describe the various

ways this group of lesbians attempted to deal with depression and explanations as to why

they suffer from depression.

Organizing Theme:

Managing depression: Desire for relief

The participants expended enormous amounts of time, energy, and money trying

to find relief from their depression. At times it was only in retrospect that the woman

identified their intense emotional discomfort as depression, during their emotional travail,

they had only been cognizant of an enormous desire to find relief from suffering.

Discussion of the domains and categories present a number of strategies utilized by the

participants. This theme will illustrate how the same strategy evoked diverse meanings

from participants. Table 6 depicts the domain and their categories within this theme.

Escape

The desire to escape from their uncomfortable emotional state was a common

experience described in most of the women's narratives. Their mechanisms of escape

make up the categories of this domain and are (1) *Alcohol and drugs*, (2) *Geographic*

Table 6. Organizing theme: *Managing depression: Desire for relief*

Managing Depression: Desire for relief

Domain: Escape
    Categories: Alcohol and drugs
              Geographic cure
              Staying busy

Domain: Seeking expert advice
    Categories: Therapists
              Doctors
              Books and internet
              Spiritual guides

Domain: Creating alternative families

---

cure, and (3) *Staying busy*. Only Tracy regarded depression as an unpleasant but normal part of living and did not speak about attempting to escape her feelings. Her reaction to feeling depressed was markedly different than the other participants. Tracy waited out the feelings knowing that eventually they would dissipate. Age had some influence on the respondents' choices of coping strategy. Excessive alcohol and drug use tended to be a way to deaden feelings in their younger years. Experience proved a good teacher and there was a trend as they aged toward the realization that no matter how much they hurt, they would make it through another bout of depression.

Alcohol and Drugs

It was quite common for the women to report the excessive use of alcohol and drugs at some point in their lives in order to minimize their feelings of depression. Sonya and Cassandra both used alcohol and drugs extensively through their teen years and into their 20s, only achieving "sobriety" by adhering to the philosophy of twelve-step programs. Cassandra was twenty six years old at the time of the interviews and has been "clean and sober" for less than one year, while Sonya was 40 years old and has been "clean" for eight years. Cassandra attends twelve-step programs almost daily and within her narrative were embedded many twelve step catchphrases. Sonya was critical of twelve-step programs and appreciates some of what it offered her but does not embrace much of the "culture" of twelve-step programs.

Adele used marijuana daily from her late 20s into her early 30s.

> I think pot was a great mood elevator, you know absolutely. They don't call it
>
> high for no reason, you feel happier. I started smoking every day and I started,
>
> started smoking every day for a while and then I couldn't do this anymore…about
>
> my 35th birthday I quit smoking pot. I remember having conversations with
>
> people about how the fog was lifting, and I was starting to feel things really
>
> differently. I think all those years I was smoking pot, I was self-medicating or
>
> whatever you want to call it.

Debra also attempted to escape her moods through the use of marijuana but her reaction
was the opposite of Adele's.

> I was using marijuana for a while which was even worse… it makes you worse
>
> when you have depression you know. I was looking for an escape. I got to
>
> college and I started smoking pot but it didn't help, it made everything worse and
>
> I figured in my head I was being like my dad, he's a drug addicted person, he
>
> looks to drugs and alcohol as an escape, and I didn't want to do that.

Regina was the only participant who still abuses a substance when she is very depressed.
She stated that during her most recent bout of severe depression that occurred last year
and lasted three to four months "…I was probably drunk most of the time…I used to just
come home and drink, and listened to music and played tapes and made tapes and drink,
drink, drink…" Regina made no excuses for her drinking and feels it is not problematic
to drink heavily when she is depressed because she is able to stop when her depression

lifts. Many of the women were raised in alcoholic homes but this did not influence their substance abuse behaviors. There was no consistent pattern between being parented by an addict and their own patterns of substance abuse.

Geographic Cure

When it seemed impossible to break out of a depressive episode, some women physically left their surroundings in hopes of finding a happier life elsewhere. Although this was not a means of coping utilized by the majority of participants, for those who chose to geographically relocate in hopes of escaping their pain it held enormous importance. Regina identified geographic escape as one of her primary mechanisms of coping with her depression. Over and over she relocated hoping that a new start will "fix all her problems" and she could then construct a life reflecting what she perceives happiness would look like. Regina used humor when she told me about her frequent moves in search of the better life.

> I did this geographic escape, you know, oooh that was my key to everything. I'm
> telling you it's a good thing they don't have shuttles to the moon, you know
> (laughing) I would be like 'Goodbye I am out of here'

Lori could not break through her feelings of depression after a relationship ended. I asked how the episode finally resolved and she responded "…I moved. I needed to move.…" She moved a few states away and was able to start her life anew and felt much better for a period of time until her next trigger set off another round of depressive feelings. Teresa stated one motive underlying her move to the city where she currently

resides was a desire to escape her family's alcoholism and the subsequent neglect she suffered as a child under their care.

> I'm different from them. They all live in one city very close to each other, they are a close family, but I'm very separate and I guess some of it might have to do with my being a lesbian, but not a lot at all. I think it has more to do with just not connecting you know not bonding with them, and you know being kinda protective and covering myself from feeling…feeling pain, you know given what my growing up was like I don't think they really get it. That it was a bad way to grow up.

Physically moving allowed her a buffer from interacting regularly with her family from whom she already felt emotionally distant. Geographic escape offered a brief respite from depression but all the participants who moved in hopes of finding relief were those suffering from chronic depression and the strategy failed to bring any permanent changes to their moods.

Staying Busy

Staying busy was a common way for participants to avoid thinking about their depression or depressing situations. Maintaining the focus on external events and responsibilities helps them to circumvent experiencing the discomfort that they perceive is awaiting them if they were not distracted. Teresa states,

> When I was a teenager, I was a depressed teenager but the way I dealt with that was to just keep myself so busy that I couldn't have time to be depressed. I was

constantly going out with friends hitting the clubs, taking extra classes, just more, more, more. The first couple of years of undergrad other people can take 12 credit hours, I had to take 18 and join a club and be in the music society and do this and do that. That was my main way of coping, to keep my self so busy I didn't have time for anything else but my commitments and my responsibilities.

When Dana was in graduate school many years ago, her elderly father came to stay with her when he became too ill to care for himself. Moving him to Arizona was a very difficult decision for Dana and one orchestrated by her family not made of her own volition. She spoke about how she negotiated her depressive feelings upon his arrival stating "…my response to any kind of difficulty is to get busy, so I got busy I took more hours at work, I got busy with school, I got busy figuring out where to live …" Dana does not address upsetting situations while they are occurring. She prefers to wait until "the drama" has subsided and she can gain perspective before attempting to understand her feelings. Staying "too busy" while letting her initial emotional response calm down is a pattern of coping she feels is very successful.

Norma's elderly mother was living with her during our interviews. This is very difficult for Norma and she really has very strong negative feelings toward her mother. To avoid having to interact with her mother, she keeps herself very busy with social engagements. She belongs to a number of groups and is almost never home "because why would I want to be at home with Mother, all she does is criticize me." Sonya spoke about her attempts to "manufacture joy" by overachieving.

While for most staying very busy was an avoidance strategy, for Margaret, "getting busy" successfully moves her out of her depression. She stated many times that being depressed is boring and she pulls herself out of an emotional slump by engaging in social events. Her depressive feelings pass without her being cognizant of when that occurs. The excessive use of alcohol and drugs and staying too busy offered two dramatically different means for the women to escape feelings. Substance use frequently leads to a decrease in productivity while staying busy leads to an image of overachieving. Both means were identified as creating only temporary reprieve from facing the "real problem," that of being unhappy and depressed.

Seeking Expert Advice

Participants did not seem to feel they possessed the capabilities or knowledge to deal with their depressive feelings. None reported being able to obtain help from family members or friends and resorted to professionals believed to possess a particular body of knowledge that would be helpful. The level of trust in these experts is noteworthy for even if they were not always pleased with the advice received there was a distinct sense of comfort in knowing professionals are available to help. Experts came in a variety of forms including therapists, doctors, authors and spiritual teachers. The internet was also a common tool for retrieving information on depression. The categories within this domain are comprised of those sources identified by the participants as experts on their depression.

Therapists

The use of therapy was very pervasive amongst these women. Therapy was the most often spoken about coping technique. Only Tracy had never been to therapy. Cassandra was not in therapy at the time of the first interview though had been in therapy as a teenager. During the first interview when I asked her if she was receiving therapy she responded "No, should I be?" After some discussion about this she asked for referral names. I suggested some places she could receive affordable therapy and at the time of the second interview she had followed up with a referral having had one session with a therapist. She was very pleased with this encounter and planned on continuing.

Dana's narrative of when and why she seeks professional counseling help explains why for her an outsider is best.

> I absolutely see a counselor. I am not currently seeing a counselor regularly, I have at different times, and I certainly did when I first brought my dad to stay with me. I've seen counselors most probably, most when I thought I was in unfamiliar waters where I didn't want to… I would much rather not repeat the same mistakes that others have done a million times. I would far prefer to talk to someone who might know that while my scenario was brand new to me it probably had gone on five hundred times before for other people and perhaps there might be navigating tool to help me through that with less turmoil. So I probably have seen counselors more at hard times, break-ups, rocky times in relationships.

Rather than seeking advice Lori recognized she often just needs someone to listen to her.

> I probably have seen half a dozen therapists over the years and out of that half
>
> dozen, a couple of them have been very helpful and then three quarters haven't,
>
> but at the time I probably just needed someone to talk to.

Lori goes on to describe one of her negative encounters this way, "…so I had to see this classic you know classically trained psychoanalyst so and we were like fire and water...it was terrible...it was awful." Esther also recounted one of her unpleasant memories,

> In my teens I saw a psychiatrist and I don't know why I went…I saw him for six
>
> months and I hated this guy, I mean he never said anything I just went and he
>
> asked me to talk and you know I'd talk and I'd sit there and think…what am I
>
> doing here?"

Sonya has been to a number of therapists and recalls "doing therapy off and on for about ten years to recover from well, I was trying to recover from my depression, but really ended up just trying to feel good in my own skin." Margaret visits therapists intermittently stating, "I have done therapy from time to time but not always, sometimes I can handle it on my own…"

The participants collectively have engaged in group therapy, individual talk therapy, cognitive-behavioral therapy and almost all have done couples therapy with a partner at some point in their lives. Some went to therapists only occasionally throughout their lives while others have gone much more regularly. None indicated that they saw one therapist over a very long period of time but instead most saw a number of different

therapists over the years. During the eight months that the interviews were collected the majority of participants had a session with a therapist.

Doctors

Primary care physicians (PCP) played an enormous role in clarifying to the participants that they were suffering from depression. Most of the participants believe depression is a medical condition caused by a chemical imbalance in the brain. Even after speaking to me for hours about the roots of their depression being a response to interpersonal relationships they also firmly held the belief it was a medical condition. The women seemed to perceive no conflict in maintaining both belief systems. Although being diagnosed was received differently amongst the women, doctors were thought to have the authority to make such a determination. Debra's experience with her PCP was a very commonly told story throughout the narratives. She stated,

> I think I had been depressed for a long time and you know, going through this series of not really looking at it and then finally you know totally having these signs I am sleeping through all my classes, like I can't get up, there is no reason, you know, just my whole train of thought was so not like me. I was like I couldn't get out of bed, and had to drop out of school. I went to the doctor and she said I was suffering from depression. So I started on Celexa, and I kept looking for different ways to cure it. I went back to her [my PCP] and she said I was gonna have to be on meds for the rest of my life.

Participants needed their MD to validate the reason they felt badly was because they had

the medical disorder by the name of "depression." The theme, *Explaining depression:*

Needing to know why, will further explicate stories about the diagnosis of depression and

the experiences of taking anti-depressant medications.

Books and the Internet

Most of the women in the study utilized the internet and read books to gain

information on depression. Many read self help books of various kinds. Lori often

referenced her own depression in light of personal accounts of depression she had read

such as William Styron's book, *Darkness Visible: A Memoir of Madness*. Adele

approached educating herself on depression from a different angle, and rather than

reading about depression she highly recommended a book she had recently read titled,

What Happy People Know. It was common for the participants to report "searching the

Web" for information on depression's signs and symptoms, diagnostic criteria, and anti-

depressant medications. After Cassandra was released from her first psychiatric

hospitalization she "read all I could find on depression." Regina could not remember the

title of a book she read recently,

> But it was good, it was good because it described behavior you know feelings like
>
> I could say 'oh yeah that happens to me' instead of…focusing on other sorts of
>
> mental illness and none of them apply to me…I feel like I'm just looking for
>
> some sort of stepping stone, you know formula or something that I would say 'oh

this is what's wrong with me and maybe here is how I could fix it or feel better' you know.

Spiritual Guides

Many of the participants can identify a turning point in their lives when they sought a spiritual teacher to help them find a way out of their depressions. Frustration with failed strategies or just the hope for a happier life led them to seek guidance through a variety of spiritually based teachings. Stories of spiritual awakenings leading to permanent life changes weave through many narratives of those who do not suffer from chronic depression. Although each chose a different spiritual practice, the teachings provided a new foundation from which to base emotional responses. The "awakenings" so profoundly changed women's lives that I pursued a line of questioning with all the participants concerning their experiences with such events. It was apparent that those who still suffer from chronic depression could not resonate with this type phenomenon. When I asked Regina about thinking about the possibility of finding a way to change her approach to her life and not allow depression to be a large part of her world she stated,

> Maybe my ideal vision is maybe something will help me break through to feeling more deeply, because depression is part, you know, part of who I am, it's like you just can't get rid of your arm because you don't like it (laughing) depression is part of me for better or worse. I'm not looking for definition of my life 'oh I want to be happy and open and fulfilled' (said very sarcastically) you know all those things that people say. I want to be passionate and I can be all those things but still be depressed. I sometimes... I …it's very…it's overwhelming but I don't feel

I have the option to just get rid of it, because I would always know that it would

be waiting for me.

But for many, refusing depression a place in their lives is exactly what they have done. Sonya tells the following story,

 I was refusing to be defeated I was refusing to be a statistic of my depression. I

was refusing to become my mother or Anne Sexton….so my desire to survive

overcame my capacity to continue living with depression and I think secondarily

to that was that if I have to be here, this horrible place called the earth that I have

hated my whole life. If I have to be here, then let me do something here that is of

use to somebody else…so I tapered down off my meds, and I go to see people at

[the mental health agency] and I say like, 'I am not crazy you cannot petition me

for not showing up for my case manager appointment. I am not supposed to be

one of these people'…I started to explore some healing work that was alternative

healing. It wasn't about pharmacy, it was about going back and telling the story

and reclaiming your life. I started meeting with this woman and she was called a

guide. It wasn't a cult. It was like a healing system that this woman put together.

The process was you told your story to this person, and they sat and listened and

they validated you and your experiences and at the end of that you were given

other tools to recreate yourself, and to really discover who you were so you do

like a belief system inventory. I went through all of that, and then created a set of

beliefs that I wanted to live by, that were my beliefs, and those are the beliefs I

still live by. They are simple. I will experience joy, I will work to be of service

to my community. There is a very large component of altruism that has served

me in divorcing myself from my depression. You will always speak your truth,

you would live with integrity so if you said you were going to do something you

did it.

Sonya feels that even now depression still underlies her being but she "gives it no power"

in her life. She refuses it entry and keeps her spiritual beliefs forefront in her mind.

Other stories of transformation were very similar to Sonya's. All the women

looked to teachers of Eastern religions or New Age belief systems to learn ways to

reframe their life experiences except for Dana. Dana is a "born again Christian." This is

an unusual choice for a lesbian as this religion espouses homophobia. She does not

perceive this a conflict however as her perception of God is of a benevolent, accepting

God. She believes that homophobia is not a part of her religion but something some

followers have been able to weave into their interpretation of particular passages in the

Bible in order to "promote their personal agendas." Dana states,

In discovering my faith, in looking at the moment of awareness, of awakening,

that I'm not on this earth for everyone else to make me happy, that I might be on

this earth to do something for others. I was very very cynical and negative about

life ….I had a roommate who was I guess "born again," is probably the best term,

sickeningly sweet, but after discussions with her and talking to her and some of

her friends with the challenge of, if you think you know so much why don't you

read the Bible yourself and figure out those answers for yourself. So I took the

challenge… so I did that, I did, I read it, I read the Old Testament, I read the New

Testament, and I was humbled, I was humbled and somewhere in there came that

personal realization that God was real and not only was he real, but he was a

personal God that was concerned about people, and that was a life changing event

for me and you know walls didn't shake. the lightening didn't happen, but I was

changed, my perspective was change, my cynicism was gone.

Dana experiences only situational depressions that are brief in duration and intensity as

she uses her faith and prayer to maintain emotional stability believing all events happen

"for a reason…there is always a lesson…[and] nothing is random." Esther explains what

happened after she attended a spiritual teaching seminar in the 1980s.

I just got a lot of value out of it, it was just kinda a wake up or something on how

to be on the planet and I learned how to contribute me rather than take from

people."

A distinct shift in her perspective toward life occurred that allows her to make the choice

to respond to a situation with depression or not. She is not sure what so profoundly

impacted her but "it has never gone away." Esther also reflected on the fact that,

I know people who have done the same training, and that they don't have this

same attitude, so it is not totally the training. I got a sense of order that works for

me, so I can reach inside myself and kinda latch on to something that has me able

to contain my feelings of fear. So it's like I have tools available to me that I

didn't always have, but they are there now and they just don't go away and

nothing has come to me that I haven't been able to get through.

Creating Alternative Families

Lesbian and gay friends and lovers offered a refuge from difficult family relationships, and their sense of a lack of emotional support from family members. The women spoke of their circles of lesbian gay friends as "family" and "alternative family" while speaking about lesbianism as a protective factor against depression as well as where they turned for solace while depressed. Sonya speaks directly to this issue in the following passage.

> I think there is a correlation between my sexuality and not being depressed. I think that the people that I know that have allowed me to be who I am, whatever that is, have prevented me from experiencing things like depression…after I discovered other women who were lesbians I created friendship, and a safety net for me that became like a family, you know, we would go out partying, hang out, you know, be together and it was like an alternative family to the family that I had been raised in.

Regina has worked in a lesbian run business for a number of years. Her income is low but she states, "I'm not willing to give up my whole network of friends and support for more money." In speaking further about her support system she said, "I realized that being at [business name], in that environment, that is a very caring environment…so I have this community of people that I feel safe with and that I feel like I can relax."

 While speaking about her great sadness over her inability to find support from her nuclear family, Norma stated through her tears, "I wanted that family…ummm… but

then again on the other hand I made my own family you know. I have lots of really good friends to turn to when I am down."

Theme Summary

The theme, *Managing depression: Desire for relief*, describes how these women used a variety of techniques to alleviate the emotional discomforts of depression. Seeing therapists, doctors, and reading educational materials minimized the effects to some degree but did not have long term impacts upon experiences of depression. Following a spiritual path and creating support systems of lesbian and gay friends were the most successful strategies in providing longer term relief for their pain.

Organizing Theme:

Explaining Depression: Needing to Know Why

Depression was not accepted as a naturally occurring experience but rather as pathological event needing a theoretical explanation. Tracy was the only participant who did not explain it through any of the popular theories readily available within our society. The dominant contemporary theories of depression are the biomedical model forwarded by the discipline of medicine, particularly the specialty of psychiatry, and various interpersonal theories posited by the disciplines of psychology, family studies, and social work. Table 7 depicts the domain and their categories within this theme.

Table 7. Organizing theme: *Explaining depression: Needing to know why*

Explaining depression: Needing to know why

Domain: Biomedical model
        Categories: Being Diagnosed
                        Taking medications: On and off

Domain: Familial transmission
        Categories: What I was taught

The Biomedical Model

The biomedical model locates the cause of depression to be within the brain of an individual. The exact mechanism of why people experience depression is being further refined as billions of dollars are being spent on understanding what really is occurring within the brains of depressed people. Though having fallen out of favor in the psychiatric community, the low serotonin theory is popular amongst lay people. The women in this study knew that depression is from something wrong in the brain, and that there are pills to fix the problem. Since it is a physiological problem arising from the brain it takes a doctor to make an accurate diagnosis. Being diagnosed with depression held enormous significance for the participants. These stories will be described in the category *Being diagnosed*. The category *Taking medication: On and off* will present the patterns that emerged from the women's experiences with anti-depressant medication.

Being Diagnosed

The majority of women in this study have been diagnosed by a physician or psychologist with some form of depression at some point in their lives. Primary care providers (PCP) who are medical generalists, not specialists such as psychiatrists, were most often responsible for making this diagnosis. As is the case with the DSM-IV TR, the depressive disorders are many and the participants received a variety of different depression diagnoses. Knowing it was a disease process "just like diabetes" (Debra) that was responsible for their misery was of great importance. Debra was initially diagnosed with situational depression but after the feelings did not resolve with time, her PCP

changed her diagnosis to clinical depression. Regina is diagnosed by her psychologist with Post traumatic stress disorder (PTSD) secondarily to witnessing her mother's rape when Regina was eight years old. Her therapist attributes her chronic depression to this diagnosis. Regina does not agree with this diagnosis and has spent considerable time investigating depression on the internet and reading books, and has self-diagnosed herself with dysthymia. Regina's reflections about her diagnosis capture what the majority of participants said about being diagnosed.

> It gives me a platform to move from you know, if I have no idea what's wrong
> with me I have no idea how to make myself better or feel better you know what I
> mean, if I say, if I identify with being the dysthymic personality I could say 'oh
> okay I've had this feeling of hopelessness or self doubt' whatever the symptoms
> are 'oh okay I'm not a freak' you know 'I'm not a weak-willed person, it's not all
> my fault,' you know, maybe it's something I don't have any control of and maybe
> it's chemical, or maybe I'm just not set up to handle certain situations. I mean it's
> a combination of stuff, but at least I know there is like a kind of category that I
> have a way that I can function, and work my way out of it.

Teresa's and Cassandra's PCP's administered depression inventory tools to indicate to each of them just how severe was their depression. Cassandra states, "He said my depression was off the scale…" Utilizing depression scales transforms an emotion into something tangible and available for treatment. Once diagnosed with depression by the PCP, the next step is being placed on anti-depressant medication.

Taking Medication: On and Off

Being diagnosed with a physiological disorder was a relief for the participants, but treatment with anti-depressants was received with less enthusiasm. There is an underlying fear and discomfort in most of the women about staying on medication for the long term. Debra captures this reaction in the following excerpt,

I went back to the doctor and she is like, 'You are more clinical depression and you deal with depression everyday, all the time' and then like, 'Am I gonna have to be on meds for the rest of my life?' and she is like, 'Probably' and I didn't want to hear that I didn't want to hear that just didn't want to have to rely on medication for the rest of my life to run it the way I usually ran it before. That it was just very hard for me to understand so I still kept trying to get alternative medicine, like I had acupuncture a few days ago, like this is a great struggle for me.

Most of the women have been on at least three different anti-depressants before finding one that is helpful for symptom management. Most participants have gone on and off medications at will, innumerable times. Lori is the exception and says this about being on medication for depression,

It might be in my head, but it really does help, it really does help but you know I really don't want to be on meds forever but I would be terrified if I had to get off them I have been on them probably a good 15 years, yeah, I don't know what they are doing to me you know but I've been afraid to find out but I am afraid to ever go off of them.

All but Sonya report that anti-depressants are indeed helpful in improving moods and allowing them to meet their daily responsibilities. Debra, who was currently on medication at the time of the interviews, says,

> So I started taking some Celexa for a while and I kept looking for different ways of curing depression without having to take medication and I went back and forth and back and forth with the Celexa. I was on it and I stopped taking it and tried to exercise more and it just wasn't the same. For me when I took meds it was a lot better for some reason so I struggle with that.

Regina had weaned herself off her meds over the months the interviews took place.

> My doctor is a D.O., and he gave me Prozac. He was the one that started me about 10 years ago and that really made a difference. I can see the difference and I've recently stopped taking it…yeah well I just stopped, the first time I stopped I had a bad experience. I quit cold turkey and that was bad so I wanted to do it really slow this time.

Regina is confident that she will recognize when her depression is severe enough to warrant starting the medication again. Norma has also been on and off anti-depressants for the past eight years and was taking Zoloft at the time I interviewed her.

> Then I changed to Zoloft and sometimes I take it and sometimes I don't. It helps a lot but I don't mean I feel great when I'm taking it, but that's what worries me. I'm afraid I'm not really feeling my real feelings so then I quit, then I get depressed, and so then I go back on it.

Teresa's PCP doubled her Lexapro dose after her break-up with her former partner

recently. When I asked her if she feels better on the higher dose she responded,

> I don't know really…I think so. I think it makes me have a low in the middle of
> the day versus having that low all day. I think I was just so wrapped up in
> everything that I forgot to take my medication for five days this month and then I
> realized that I hadn't been taking it. I was just not present in my life. I was rock
> bottom. I could see a huge difference, like this stuff is doing something.

 The biomedical model of depression plays a very significant role in these women's

experiences of depression. It is readily assimilated into their understandings of their

feelings and called upon when it fits their needs. A second approach to explaining

depression is to look to their family for reasons why they are depressed. The next

category describes the varied ways their family is understood to be partially responsible

for their depression.

Familial Transmission

Participants often look to their families for an explanation of why they are

depressed. Role modeling of poor coping skills and depressive behaviors was often

sighted as an explanation of their own depression. There was a pervasive belief that

exposure as children to family members' negativity resulted in their own unhappiness.

The category, *What I was taught*, captures these reflections on depression.

What I Was Taught

Many of the women made references to their family members' own unhappiness as being one reason they cannot find happiness in their lives. Lori said of her own depression that a lot of it is,

> …triggered, it is situational, but I also have learned a lot of behaviors. My mother, though she will never confess to it, is depressed. I think my mother is depressed, so it is also in my family…so I think it's in my family, sure I really do and I think, you know, I think a lot of behaviors are learned as well. So you know I think maybe depression too might be a kind of worldview of the way you perceive your world, and I think I learned kind of a negativistic view of the world umm pessimistic view of the world I would say from my mother, and I think that kinda sets you up for feeling depressed.

Adele recognizes,

> I was not taught the tools I needed to be happy. I grew up in a family that was very fear based, very very fear based. My first reaction to a situation that is stressful is fear, anger, panic whatever. My goal over the last few years has been it is to understand where that is coming from and that mostly I was taught that by my parents. Those are the tools my parents taught us.

Norma echoes this sentiment in the following passage,

> I haven't loved myself and I haven't really looked for my good qualities. I keep looking at all the things I don't like about me, you're overweight, you know you

shouldn't say this or what are they going to think about that. Well, I see where I

get it from. My mother moved here to live with me, and I can see where I get it

because my mother constantly worries about what other people think. She is so

full of fear.

Sonya says that "because there is a history of depression throughout my family on my

mother's side predominantly" all of her siblings suffer from chronic depression. When

Regina was speaking about her inability to have loving and intimate relationships she

stated,

Maybe it's because it was just part of my upbringing, you know the whole don't

show too much, don't be too angry, too sad or don't let anybody see you be

emotional. They weren't exactly warm and fuzzy kind of people. The messages

weren't overt, but I never saw my stepfather really being affectionate with my

mother you know, sort of superficial, you know, kiss goodbye, kiss hello…those

kind of messages.

A further validation of the familial transmission of depression is evoked when

participants explain the ways their own help seeking behaviors mimic their mother's

behaviors. Lori stated her mother has been in therapy in the past for her depression and

Regina and Debra mention that their mothers are both taking anti-depressant medications.

Theme Summary

The theme, *Explaining depression: Needing to know why*, portrays the theoretical models embraced by the participants as they attempted to come to terms with being depressed. It was necessary to have an explainable cause in order to feel there is hope for a cure. A medical or behavioral reason for depression also lifted moral responsibility dispelling ideas that depression may be a malady of the weak willed or emotionally inept.

Chapter Summary

Chapter V presented an overview of the thematic analysis of the data collected in this study. The findings were structured into organizing themes, domains, and categories. Depression is rooted in both emotional and physiological causes. It is an emotion that carries much significance with it for many of the participants. Much energy is expended addressing depression and its consequences. A few of the women only experienced situational depressions but the majority of women in this study have suffered greatly from depression. The collective narrative of depression in this sample of lesbians has been described through a thematic analysis. Chapter VI will provide a discussion of these findings and the implications of this study to nursing.

CHAPTER VI

DISCUSSION AND CONCLUSION

The final chapter identifies relevant discourses underlying the narratives of the

participants as they spoke about being lesbians and being depressed. A discussion of the

effects of class membership upon narratives of depression is presented followed by

sections on limitations of the study and implications for nursing education, practice and

research. Study conclusions complete the chapter.

Introduction

Critical ethnographic work seeks to explain the participants' experiences in

relationship to existing discourses and the power dynamics occurring within the social

order. It is through dialogical processes that discourses are negotiated and produced.

Chapter V identified the patterns that emerged across the narratives. In this chapter I will

discuss some of the discourses that underpin these identified patterns. The findings

revealed no organizing themes emerged relating sexuality to depression. For some women there were connections between sexuality and depression but in these cases this relationship was a part of a greater picture of depression already existing within their lives. Discourses of identity describing how these women negotiated being lesbian in a heteronormative world and being female in a male dominated society are interwoven with depression discourses and are explicated in this chapter. Many more discourses exist within these narratives that will not be identified in this text but left for discussion in the future.

<div align="center">Constructing Depression</div>

Constructions of depression in this study bring together discourses of family with psychodynamic theories and the biomedical model of depression. The organizing theme, *The roots of depression: Emotional dissonance*, described the difficulties the participants experienced coping with discordant familial and intimate relationships. There are two factors influencing the importance placed upon the quality of their interpersonal interactions; the first is that women in our society are the cultural bearers of emotions, and the second is that there are socially constructed expectations of the ways a family functions.

The women in this study perceived themselves as relational beings as Margaret identifies in this excerpt,

"Well I think probably that relationships are more important to me than other things. You know there are more feelings surrounding relationships than there

are….I had a career, work, career that for the most part I enjoyed. It was a good job, it gave me a lot of flexibility and freedom and variety but I never felt that I was career oriented."

The importance of finding happiness within the spheres of emotionality and interrelatedness is reinforced throughout popular culture and reflected in television, movies and advertising (Doane, 1987; Laplace, 1992). In speaking about female protagonists in Hollywood films Laplace (1992) states,

"The woman's film is distinguished by its female protagonist, female point of view and its narrative which most often revolves around the traditional realism of women's experience: the familial, the domestic, the romantic---those arenas where love, emotion and relationships take precedence over action and events" (p. 139).

The representation of women as the emotional foundation underlying the structure of the "All American Family" is proliferated widely. While the males in the family protect and provide, women are the caregivers. It is of great importance to the current hegemonies to perpetuate an image of the typical American family as being a nuclear family system dedicated to upward mobility, heterosexuality and religion. The nuclear family as the cornerstone of the "American Dream" has been disseminated as a social "norm" since the post WWII era (Zaretsky, 1986). Popular culture and professional discourses maintain the potency of this image. The middle class family life portrayed in the 1960s television programs such as "Leave it to Beaver" and "Ozzie and Harriet" do

not reflect the lives of the majority of Americans; however, these images have been sustained for almost fifty years. Women are depicted as loving and devoted mothers, wives, and caregivers who address the family's emotional well being. These images continue to be viable and continue to be reflected in the television series such as "The Cosby Show," "Everybody Loves Raymond" and "Home Improvement." Hollywood movie actresses such as Julia Roberts portray women as sensitive and caring humans while also being beautiful and charming. Certainly the ways that participants described themselves and their biological families did not measure up to these standards. The categories *Fallible mothers*, *Distant fathers*, and *Abandonment and neglect*, depict their dismay with their own childhoods. Images of families more representative of the participants', including those with alcoholic and negligent or abusive parents, are also commonly portrayed in the contemporary media but as pathological.

Although none of the participants in this study are biological mothers nor are they heterosexual it was other expectations of nuclear family values that were clearly reflected in the narrative as underlying feelings of depression. Although able to transcend the heterosexual roles, the participants fostered expectations that home life is tranquil and parents are inherently responsible and reasonable human beings whose primary concern is for the welfare of their children. It is through the perpetuation of this mythological family that contemporary American society has established *family* as a site of expectation, and ultimately a site of disappointment (M. Joseph, personal communication, April, 2002).

Through social production there is a perpetuation of the belief that emotional competencies and incompetence are learned as children through interactions within nuclear family systems. It is believed that the troubles children encounter as they interact emotionally with parents lead to on-going emotional difficulties in all adult relationships. The concept of the "dysfunctional family" as the root of interpersonal shortcomings was perpetuated in popular culture and pop psychology throughout the 1980s and 1990s.

The majority of women interviewed were deeply disturbed and hurt by what they perceived as less than ideal childhood circumstances, unsupportive parental interactions and the ending of intimate relationships. Eleven of the 12 participants sought relief from their suffering at the therapist's office. However, therapy as a part of dominant psychological discourse is complicit in the maintenance of the normative myths of family as a site of expectation, supporting the normative ideals of what constitutes a healthy relationship between child and parent.

Psychological Discourse

In our fast paced world of HMO medicine, traditional psychoanalysis is not often a viable therapeutic modality. Therapy today is often based upon psychodynamic and interpersonal theories of psychology. However, Marcuse (1966) describes the theories of these neo-Freudians as only a reframing of Freud's psychoanalytic tenets. Marcuse (1996) states, "psychoanalytic therapy aims at curing the individual so that he can continue to function as a part of a sick civilization without surrendering to it altogether" (p. 245). As was described in Chapter II, many neo-Freudian theories of depression

circulate but this paraphrasing of one aspect of classic psychoanalytical thought reflects

these underpinnings (Becker & Schmaling, 1991).

> The depressives' fixations to severe injuries to their self-esteem resulted from
>
> multiple disappointments in their early parental relations. Because the love
>
> objects of adults tend to be partly identified with the adult's own parents the
>
> hostility of adult depressives toward their current significant others partly reflect
>
> their earlier dissatisfying relations with their parental figures. In the depression
>
> prone this partial identification of current with past significant others becomes
>
> even more pronounced after disappointment-induced regression (p.133).

Issues surrounding the emotional qualities of family life and their effects imparted

later in life upon intimate adult relationships greatly impacted the participants. Families

were further implicated as the cause of the participant's depressions as is described in the

category, *Familial transmission*. This category offers data bits describing a belief that

depression was also passed on to them from their families. This transmission took the

form of role modeling of behaviors as well as genetics.

Although genetics was not clearly explicated often enough to be included as a

category many participants implied they were depressed because their mothers and

sometimes grandmothers were depressed. The idea that depression is genetic is

purported by the bio-medical model of depression. The participants solidly embraced the

bio-medical model of depression as will be discussed in the next session. The bio-medical

model of depression is contemporary society's dominant discourse on depression,

squarely placing the responsibility for depression upon faulty brain chemistry. Within

the medical literature is an acknowledgment of the impact environment has upon physiology thus providing a rational link between the psychodynamic/interpersonal theories of depression and the biomedical model. However, this information would not have been available to the participants, and without this information believing in both the bio-medical model and the psychodynamic theories is conflicting. When asked for clarification on how they can believe in both I received many glossed over responses such as Margaret's, "I don't know. I think it is probably a combination of both the environment and the brain. I don't have a theory on depression." Regina became annoyed with me and flustered when I asked her to explain how she could support both models.

Biomedical Model of Depression

The participants embraced the biomedical model of depression with as much enthusiasm as the interpersonal theories of psychology. The theme, *Explaining depression: Needing to know why*, includes data bits identifying the significance of this model for the participants. Moral weakness, socio-political factors, and environmental/ familial factors are absolved and depression is explained to be, as Debra said, "a disease like diabetes." This very simplistic explanation has spread far into the popular culture with amazing voracity. Healy (2004) states the *psychobabble* of the 1980s, has been replaced by the *biobabble* of the new millennium. The once popular phrase "I grew up in a dysfunctional family" is now reframed as "I am depressed because I have a chemical imbalance in my brain."

The benefits to the maintenance of current social power structures by the perpetuation of this model are enormous. Medical discourse remains unchallenged as one of the most powerful discourses in our society (Kleinman, 1988; Stoppard, 2000). The medical profession is having difficulty establishing boundaries slowing the encroachment of pharmaceutical companies' influences upon medical research and practice (Angell, 2004). Physicians speaking out against pharmaceutical company influences are presenting more and more evidence that studies conducted and the findings reported are not at the level of objective scientific inquiry practitioners depend upon to make clinical decisions (Angell, 2004; Healy, 2004).

Since the marketing of Prozac in 1989, the number of cases of major depressive disorder diagnosed by physicians yearly in the United States has increased a thousand fold (Healy, 2004). It seems strange and antithetical to medical research that in the case of anti-depressants, the cure preceded the disease. As the SSRIs became available the medical literature emphasized the problems created by the underdiagnosing of depression (Davidson& Meltzer-Brody, 1999). Articles appeared in medical journals encouraging psychiatrists and primary care physicians to carefully elicit information from patients leading to a proper diagnosis of depression, for now it was possible to treat this disorder with safer and more effective medications (Panzarino, 1998). Healy (2004), however, documents enormous gaps in standard procedures assuring public safety occurring during the research and development phases of the SSRIs. In the past year articles questioning the safety of SSRIs began to emerge with regularity in the medical literature (Culpepper, Davidson & Dietrich, 2004; Kondro, 2004; Meek, 2004).

The New York Times published an article by Shultz (2004) titled, "Did

Antidepressants Depress Japan?" The author writes,

> If you lived in Japan for the past five years, you would know by now that your
>
> *kokoro* is at risk of coming down with a cold….Your *kokoro* is your soul, and the
>
> notion that it can catch cold was introduced to Japan by the pharmaceutical
>
> industry to explain mild depression to a country that almost never discussed
>
> it….Now, a huge campaign by the pharmaceutical industry is publicizing mild
>
> depression, which most Japanese didn't realize existed until recently.

Japan's experience mirrors the United States' with depression now being a

buzzword in Japan with a proliferation of books and internet chat rooms dedicated to

discussions on depression. Sales of anti-depressants quintupled between 1998 and 2003

in Japan. GlaxoSmithKline reported 110,000 people consulted their physicians

concerning depression during a seven-month long ad campaign (Shultz, 2004).

Observing this phenomenon abroad assists in clarifying what has happened in the United

Sates over the past 15 years, since Prozac became available to clinicians.

Feelings of severe depression do lead to suicide, and these feelings warrant

aggressive treatments. However, it seems more and more apparent that the current

worldwide pandemic of mild to moderate depression is in part a marketing endeavor

benefiting the pharmaceutical companies. Ten billion dollars is currently spent annually

on anti-depressants worldwide. In 1999 in the United States, 84 million prescriptions for

SSRIs were filled and $5.5 billion dollars spent on these drugs (Healy, 2004).

Along with the manipulation of the medical profession into partnering with the pharmaceutical companies in this endeavor, these companies have done a remarkable job of educating the public about depression. These drugs are advertised widely on television, in magazines and newspapers. The advertisements offer simplistic and inaccurate information explaining the chemical changes in the brain that underlie symptoms of depression along with promises of full remission. Typical marketing ploys are utilized to sell their product, such as portraying individuals after treatment with their product as beaming, happy people, enjoying their middle class lives with their circle of loving friends and family members. In my clinical practice I have had countless requests by clients for a particular medication seen advertised on television.

An interesting aspect of widespread SSRI use is the realization of how often full remission of symptoms is not achieved. These medications offer partial remission at times, and often no relief of symptoms. Their benefits are subjective and often subtle, and it is sometimes impossible to identify why a client may feel better for a period of time. Intolerable side effects are very common including sexual dysfunction and emotional blunting, a condition where an individual no longer feels depressed but is not capable of feeling anything intensely. Each SSRI has its own side effect panel and it is unpredictable how a patient will respond to a particular drug. Prescribing is a guessing game based upon some basic guidelines and clinical experience. Unlike diabetes where blood sugars are measurable or treating an identifiable bacteria with a specific antibiotic, the prescribing of anti-depressants has no objective parameters to establish efficacy. As is described in the category, *Taking medication: Off and on*, the participants, like my

clients, reported going off and on these medications at will. Many were on three or four different anti-depressants before settling on one or giving up on them altogether. Marketed as safe and effective drugs that raise serotonin levels and "fix" the depression, this is not the truth. The biomedical model's relationship to pharmaceutical company profits is problematic in itself but its maintenance of hegemony goes further.

The biomedical model and the interpersonal theories of depression serve to maintain the social hierarchies by locating the problem of depression within the individual and the family system. This individualized focus veils the responsibilities that social policies created and enforced by government have upon the creation of a depressed citizenry. Larger social issues such as poverty and racism that are critical in some narratives of depression are circumvented, and dissent and social activism are suppressed (M. Joseph, personal communication, September 26, 2004). The current depression discourses trap individuals into cycles of depression as neither psychotherapy nor medication necessarily offer relief. Many of the study participants exemplify how, despite utilizing all available resources, depression lingers.

Constructing Lesbianism

The findings of the study revealed no overarching connection between lesbianism and depression. The majority of lesbians in this study were very comfortable with their sexual identity, deriving a strong sense of self from their lesbianism. Some alluded to problems with dealing with a heteronormative world but most were able to gain support and comfort from their sexual identity. Their strength was drawn through the

embodiment of two counter hegemonic discourses, those of radical-cultural feminism and lesbian identity.

Radical-Cultural Feminism

Radical-cultural feminism is one of the perspectives that developed during the second wave feminist movements of the 1960s and 1970s. Radical-cultural feminism exalts what is defined as the essential nature of women. Love, compassion, sharing, and caring are essential feminine qualities (Tong, 1989). It was discussed earlier that the participants identified as relational beings, and this brand of feminist discourse frames those traits into a positive self affirming female identity. This belief echoed throughout the narratives. The category, *The bond between women*, presents data bits reflecting the participants' belief in the inherent relational capabilities of women. A quote of Adele's speaks to the group's sense of what being female means,

> It's been going on since before the Bible, you know, women are amazing creatures, we have enormous capacity for love and relationship and we're able to…our hearts are just different, I think we have a capacity to love on many many, many different levels and many capacities because we are women and that's the way we are made up.

This idea that "that's the way we are made up" dominated the thinking of these lesbians. One participant is so well versed in radical-cultural feminist writings that she referenced Gilligan (1982) during our second interview. She utilized this particular

feminist perspective to explain the huge impact relationship break-ups had upon her emotional state.

Expressions of emotion and the desire for connectedness are perceived as weaknesses in the dominant culture, while individuality and independence are strengths. Radical-cultural feminism reverses this paradigmatic model and claims women's desire and ability to connect is her strength and identifies male attributes of emotional isolation and competition as the roots of all that is wrong in the world. These feminists claim that male attributes underpin our political systems of power through physical might and lead to social problems and wars (Jack, 1999; Stoppard, 2000, Tong, 1989).

Second wave feminisms, including the radical-cultural brand, have been widely criticized for reflecting the realities of life for white, heterosexual, middle class women of Northern European descent (Baker, 1996). The feminist movements of the 1970s were organized and maintained by women with these characteristics. Poor women, minority women, and lesbians were marginalized by the second wave feminists. Rising up against the authority of patriarchy can only be attempted by women with economic, educational, and class privilege. The political goals of second wave feminisms were those issues germane to women of privileged backgrounds.

White, middle class, and educated lesbians broke away from the mainstream feminist movement only to reinstate a similarly oppressive lesbian feminist movement addressing the interests of class privileged lesbians. Lesbian feminists, an outgrowth of the radical–cultural movement, felt that lesbianism was "feminism in action" (Abbott & Love, 1973. p. 136). Lesbianism is a natural expression of love and frees women from

the patriarchal belief that women who have sex with women are deviant, abnormal, sick or bad (Tong, 1989). The political organizing of lesbians of the 1970s successfully developed into counter hegemonic discourses of lesbian identity embraced by the participants of this study.

Lesbian Identity

Lesbian identity is a set of discourses that create *lesbian* as a unique grouping of women with their own cultural identity. Culture is used in this context to indicate a group of women who share common meanings within their constructions of sexual identity (Denzin, 1997). These shared meanings have evolved over the past thirty years but lesbian identity discourses have continued to offer lesbians the ability to construct positive self- affirming sexual identities. Lesbian identity is a malleable concept that has adapted to evolving historically contextualized settings. Renderings abound depicting the multiplicity of diverse lesbian and gay identities that have existed in contemporary American society (Faderman, 1991; Jagose, 1996; Kennedy & Davis, 1993; Mumford, 1996). Race, class, geography and changing social mores come together and create a number of unique identities that are particular to historical moments and circumstances. Lesbian history in the United States has been one of conflict amongst these varied identity movements; however they all serve in "generating self-esteem and solidarity" as

well as "claiming a social space and breaking the silence around lesbians" (Kennedy & Davis, 1993, p. 373).

The lesbian identity discourse most significant to the participants in this study has its evolutionary roots in the early days of radical-cultural feminism. In the early 1970s these feminist lesbians rejected the butch-femme identities of working-class and Black lesbians, maintaining these roles served to reinstate heterosexual roles, and offered no resistance to sexism (Kennedy & Davis, 1993). The lesbian feminists used social privilege to establish themselves as the legitimate lesbian identity, and created a visible middle-class version of lesbianism to counter heterosexual dominance. This brand of radical-cultural feminist lesbianism was the predominant identity embraced by the participants. Being identifiable to each other and others is important in building a visible presence (Esterberg, 1994). The majority of the women in the study were identifiably *lesbian.* For some it is important to be able to identify each other in order to increase their sense of belonging, while for others identifying publicly as lesbian is "being a rebel" (Phelan, 1993, p. 9).

Another aspect of lesbian cultural identity is the coming out process, meaning a woman first recognizes within herself that she is sexually attracted to women. Eventually lesbians come out to some people in their social sphere identifying themselves as a lesbian (Cass, 1974). At the time of coming out, finding other lesbians and finding a lesbian community for support often becomes a priority in a *newbie's* life.

The lesbian community is a very powerful concept, creating the image of lesbians as a cohesive force countering oppression. Lesbian community was a visible and tangible

reality in the 1970s. Since the 1970s diversity amongst lesbians has been recognized and actualized. The result of this decentering process is that *the* lesbian community has become impossible to locate (Stein, 1992). In many cities traditional lesbian institutions closed such as bars and bookstores to be replaced with specialized interests groups. Groups exist for lesbian mothers, Orthodox Jewish lesbians, and Latina lesbians. There are lesbian twelve-step support groups, lesbian dinner and theatre groups, groups for lesbians who practice S&M sexual practices, and on and on goes the lists of decentralized lesbian organizations that have responded to the desire of lesbians to spend time with other self-identified lesbians who share common interests (Stein, 1992).

There is an LGBT community center in Tucson that continues to provide a focal point for lesbians as well as all non-heterosexual people to gather and organize events and procure services. Businesses and bars draw patrons belonging to specific population groups including lesbians, allowing for the on-going sense of community.

Significance of Lesbian Identity to the Participants

Lesbian identity was enormously important to this group of women. It is an integral part of their sense of self. The identity discourse was powerful enough to mitigate constructions of being a marginalized and oppressed group by mainstream discourses. Lesbianism was not a determinant of depression in the participants' stories, indicating the level of empowerment this discourse affords. Esther, who is older and *came out* when she was in her early twenties, stated, "…there wasn't anything hard…I never ever experienced being a lesbian as a problem." Sonya spoke extensively of the

ways her lesbian friends and the lesbian and gay communities were her salvation from an impossibly painful home life. Degrees of openness in different settings varied amongst participants, but none identified lesbianism as a negative part of their identity except Cassandra. In her case she spoke with great shame about her sexuality, but at the same time lives a very open lesbian life. She stated that she intentionally dresses and cuts her hair in ways that identify her as a lesbian and she is formally "engaged" to a woman. Despite her internal struggle she garnered enough support from lesbian discourse to live openly as a lesbian.

It is interesting that all the lesbians in this sample stated that they first recognized attractions to women while in their teens. I am suspect that some may have reframed their adolescent sexuality after actually identifying themselves as lesbians. As teenagers a number of the women dated boys. However, none had ever been heterosexually married, and very few described having any sexual encounters with men in their adult years. As was mentioned previously, none in this group had birthed babies. It is well documented that lesbians come to this sexuality after a wealth of different life experiences (Kehoe, 1989). It is common for lesbians to have been heterosexually married and have children before they begin engaging in relationships with women. It is unclear and very puzzling why this sample was composed of those who have identified as lesbian throughout their adult lives. It is unknown if this influences their need/ability to embrace lesbian identity discourse.

Lesbian community played a vital role in these women's lives. When asked about their relationship with the lesbian community it was not uncommon for most of the

women to speak negatively about *the* community. Remarks included Teresa's comment, "I dreaded what would be said about us, you know how they gossip..." and Adele's, "Notice I said a *feminist* organization not a *lesbian* organization;" and then Sonya's, "I think the lesbian community may be imaginary." However, these women derived great support from lesbian camaraderie. Emotional connections to other lesbians is an important part of the lesbian identity discourse, and omnipresent in these narratives. The following excerpts are indicative of their dependence upon lesbian support systems. Sonya stated, "Most of my friends throughout my life have been lesbians" and Regina, "My workplace (a lesbian run business) is my safety net."   The stories of lesbian bridge partners and lesbian clubs and organizations of all sorts comprise the majority of the social networks of these women.

Each woman spoke of their lesbian identity as if it was *the* lesbian identity. Many times I had to ask for clarification about statements because they were made with an assumption I would understand their meaning, since the participant and I are both lesbians. They often appeared confused when I asked for clarification. When speaking about her recent relationship break-up, Teresa spoke about the values propagated in the lesbian community. When I asked her for clarification, she stopped and had to think for a moment, and said "well *you* know, monogamy and idealizing relationships and I think you face backlash from the community if you cheat on your partner.…" Tracy spoke about the restrictive nature of her current relationship saying that she no longer goes out with her lesbian friends to socialize. When I asked where she would go she stopped and looked at me in amazement for a moment, and said "well the bars of course."

Although the negative impacts of heteronormativity and homophobia were not prevailing themes, there were stories identifying difficulties being lesbian in our society. The influences of religion were the most formidable challenge to these women's strong lesbian identities.

Influences of Religion

Three participants had a difficult time dealing with the influences of mainstream religious beliefs, one that traditionally castigates homosexuality. Cassandra, a Roman Catholic, stated that she is afraid she "will burn in hell" because she is a lesbian, and she "wonders why God made her a freak." Cassandra speaks about wanting her family to accept her, but she believes her hardest challenge is to accept her own lesbianism. Cassandra is left conflicted, and is having great difficulties internally reaching a level of comfort with her sexuality.

Norma grew up a Southern Baptist and attended church on a regular basis as a child. She stated,

> I was pretty lonely, lonely, I even went to GA which is girl's auxiliary with the Southern Baptist church, mainly just to be social because I wasn't interested in the teachings of the Bible and stuff, I never did learn the Bible very well….I always had to go to Sunday school and church and training union.

When asked if she felt there was a relationship between her sexuality and her depression she thought "there probably was some." She describes her childhood by

saying "I was raised in (name of Midwestern state) that's pretty much the buckle of the Bible belt, very, very religious and very rural …" Norma correlates her lonely childhood and her difficulties with her family members with her family's very religious practices. She was never able to tell her father before his death she was a lesbian, and she only told her mother about her sexuality when Norma was in her 50s.

Dana is a *born again Christian* who was raised in a religious family in the South. Dana holds the belief that heterosexuals "have it easy" with their families and "celebrations for gay relatives are just not as happy."   Though comfortable with her sexuality now that she is living in a liberal college town, there is a clear undercurrent in her stories that she feels the negative influences of heteronormative discourse.

However, religious upbringings did not negatively impact all participants, indicating the varied ways that aspects of identity come together within individuals. Many clients grew up in homes where a variety of religions were practiced. Most of the women were able to leave behind homophobic teachings, and become quite comfortable with their sexuality.

Second wave feminism, lesbian identity, and lesbian feminism contribute greatly to this group of women's self-identities. The level of incorporation of these feminist ideas into the participants' self-identities led me to begin to understand the class implications within stories and experiences of depression.

Depression as a Class-Mediated Construct

Data analysis revealed a plethora of commonalities in the ways the participants constructed their sexual identities and their experiences of depression. I was initially very surprised at this finding as their life stories are very diverse. Their demographic information indicates a range of characteristics that I expected would lead to a more varied expressions of depression. I was particularly awed when women with very different demographic characteristics used identical wording within their narratives. I then began to wonder if these women shared another trait that I had not discovered. As I listened again to their stories I realized the power of the influences of class strata upon the interpretations of their lives.

Class is a very complex concept to discuss, and extends beyond the scope of this project. I am using the term *class* as it is described by American sociologists. Class is an "abstract stratification construct" (Baker, 1996, p. 17). Ross (1938) states prestige is the basic criterion determining class hierarchy. Prestige comes through inheritance (Page, 1964). Many factors contribute to positioning within a class stratification system including property ownership, financial assets, occupation, and educational background (Muntaner, Eaton, Diala, Kessler & Sorlie, 1998). Grusky (2001) offers the following inclusion of assets as significant in determining class membership: (1) Economic assets attained through ownership of business and property as well as total financial worth, (2) Political assets referring to personal authority within the household, authority within the work setting such as a managerial position, or a significant role within the political world, (3) Cultural assets that include having social privilege, living an extravagant lifestyle and/or being a celebrity of some type, (4) Social assets referring to the social

circles in which one travels. This includes club memberships, organizations of high social

rank, as well as maintaining friendships in these circles, (5) Honorific assets are afforded

those individuals who are engaged in honorable professions such as law, medicine, and

religion, and (6) Human assets include educational levels, knowledge, and identifiable

areas of expertise. These assets joined by issues of inheritance coalesce in any number of

ways to bestow a class placement upon a socially derived hierarchal system. Prestige and

social privilege conferred on individuals through class membership leads to particular

constructions of one's life. Bourdieu (1984) describes the ways that class membership

influences one's "taste" or appreciation for the arts, including visual arts, theatre, music,

foods, etc. Cultural competence is learned, often through inheritance, as a code allowing

a particular form of decoding to occur within the individual. Bourdieu (1984) states,

> In fact, through the economic and social conditions which they presuppose, the
>
> different ways of relating to realities and fictions, of believing in fictions and the
>
> realities they simulate, with more or less distance and detachment, are very
>
> closely linked to the different possible positions in the social space and
>
> consequently, bound up with the systems of dispositions (habitus) characteristics
>
> of the different classes and class fractions. Taste classifies, and it classifies the
>
> classifier (pp. 5-6).

Hochschild (2001) has identified differences between the emotional socialization

of middle class children and working class children. Parents prepare children in a class-

appropriate manner for their future roles in society. Based upon the work of Kohn (1963)

and Bernstein (1971), Hochschild describes how emotional management styles are passed

through the generations. Middle class children are controlled through "appeals to feelings and the control is more of feeling" (Hochschild, 2001, p. 152). Middle class children are punished for inappropriate emotional intention or displaying inappropriate emotion for a particular situation. A working class child is more often punished for behaviors, and the control is more behavioral (Kohn, 1963). Working class children are being socialized to physically act upon feelings with outward displays of emotion, while middle class children are learning to manage feelings without action.

In this study it has become clear to me that the vast majority of participants are members of America's middle class. Through inheritance the majority of these women were distanced from economic necessity, and made personal life choices based upon desire or philosophical and political beliefs. Class was a commonality that transcended racial, ethnic, and age differences. During purposive sampling I attempted to diversify occupation and socio-economic status (SES). In determining SES, I only considered their annual incomes. This measure gave me no information as to the participants' placement upon a social stratification system that in turn influences constructions of identity.

It was difficult to recruit women who were not employed in some capacity in helping professions as these women seemed most comfortable speaking about emotions, but also it may be that, as Hochschild (2001) has described, middle class women are more familiar with discussing feelings and management of feelings as a result of their class privilege and upbringings. I did not consciously attempt to diversify my sample by class. This is not an unusual omission in academic pursuits. Hennessy (2000) argues that neoliberalism has effectively eliminated the primacy of discussions of class in academic

cultural analyses to the advancement of its own ideology. Health research is certainly

guilty of minimizing considerations of class status upon health and rather focuses upon

SES (Jenkins, Kleinman, & Good, 1991). Upon my revelation that class was an

important demographic characteristic within my sample, I conducted a literature search

on depression as it relates to class membership within some of the prominent health

databases. I discovered only a handful of studies conducted with consideration of class

issues existing within the enormous body of literature on depression (Jenkins, Kleinman,

& Good, 1991; Muntaner, Eaton, Diala, Kessler & Sorlie, 1998).

    As I reviewed the life stories of the participants, I came to see how various factors

of class inheritance and assets as Grusky (2001) delineates them indeed placed the

majority of participants firmly in the middle class. Many women had revealed

information about parents' occupations and family values and lifestyles that along with

their own educational and life experiences identified them as women of privilege.

Annual incomes were sometimes low by choice such is the case with Regina whose

annual income is $18,000.   Regina has a bachelor's degree but chooses to work as a

lower paid employee in a lesbian owned business, as her workplace offers her social

support she is not willing to forgo. Regina stated that she would love to earn more

money as she has problems meeting her monthly expenses, and does not have the

financial resources to renovate her newly acquired home, but she loves her work

environment and won't leave that "for any amount of money." Sonya is earning in the

$30,000 a year range because she too loves her work and chooses to receive a lower

income than she is capable of generating. Sonya spoke of owning extremely successful

business ventures in her 20s that brought her large sums of money, but now is very content working in social services. Esther dropped out of college, but is a business owner and a home owner. Each story is unique, but as I realized how each placed the participant into the middle class, I understood why their stories sounded so similar to each other.

There were many clues to their class standing, such as the focus upon the self and the seeking of self-fulfillment within their lives that are strongly associated with Western, middle class values (Jenkins, Kleinman, & Good, 1991). The resources available to these women and their comfort with utilizing these resources are another reflection of middle class life. Almost all participants have engaged in therapy. Although now available in some forms within the public sector, therapy is generally expensive and a luxury available to those who have the time, money, and desire to attempt to understand their inner beings in greater depth. All the participants had health insurance and access to primary care doctors. They often mentioned their use of the internet to retrieve information. A reliance upon and accessibility to the internet is a class privilege.

After recognizing the class issues embedded within my study, I re-examined the findings, and determined that Cassandra's and Tracy's stories were unique amongst the others. Cassandra is struggling to appear middle class, but comes from lower class roots, and this is evident in her dialogue. Tracy is representative of a working class lesbian, and constructs depression in a very different way than the other participants. These two narratives will be examined more closely as *outliers*. As Buraway (1991) describes, the

differences found within the stories of outliers are significant in understanding power relations within our society.

Cassandra was unemployed at study's end. She had lost her job during her time enrolled as a participant in the study due to an emotional outburst where she swore and yelled at a customer where she was employed. At the time of our last interview she was enrolled in the public assistance programs available to her, and receiving mental health services in the public sector. Cassandra grew up in a violent world where power was measured through physical dominance. She was sexually assaulted innumerable times by family members and strangers. Cassandra was not raised to value education, and although graduating from high school she spent most of her teenage years "on the streets, doing drugs, and running with the gangs." Her father was an alcoholic, and although owning a home, the family assets were few.

As has been discussed, being a lesbian has been difficult in many ways for Cassandra. Her family, and particularly her mother, disapprove of her sexuality. Cassandra perceives her sexuality as being deviant but an essential aspect of her being. She is saddened that she is "a freak" but has no doubts that she loves women and always has since she "started having sexual fantasies about women at the age of 12." Cassandra draws from the dominant heterosexual discourse, and has not had the access to counter hegemonic discourses available to the majority of the participants through university educations and personal involvements in the feminist and lesbian political movements, already described as consisting of primarily middle class women.

She and her partner are engaged and Cassandra wears a diamond engagement ring. The two women bought a Cadillac together. Cassandra stated she is happiest when she is independent and "…independence for me is making enough money to fend for myself, having a nice job, having nice car, having the things I want. I guess its material for me." She stated that when she has money she forgets all her problems and is not depressed. When she has money she takes care of everyone in her environment except for herself. She buys things for her fiancé, her friends, and her family. These times have been short lived, and are followed by serious bouts of depression as when she loses her financial independence she is overwhelmed with her sense of powerlessness and dependence. Cassandra wants to become an art therapist, birth a child through artificial insemination and raise it with her partner. Cassandra has the dreams of a middle class woman, but at this time in her life lacks the agency to achieve this goal. Victimization and loss of control over her life permeate her stories, while she struggles to construct a life that appears to be middle class.

Tracy was the only participant who did not embrace either the interpersonal theories of depression or the bio-medical model of depression. She has she never been to therapy nor taken psychotropic medications. When I asked her about the increased rates of depression in our society she said she did not know a lot of depressed people. She stated,

"I think everybody has their own personal problems as to what makes them depressed. I guess it can be money, it can be a spouse, you know, whatever, I

don't think depression is any bigger a problem than it's ever been. People have

their reasons."

Tracy had very little to say about depression. She tended to sum up her stories about life

interactions in very succinct fashion. She stated her current partner is a "bitch" and she

had better get a job, or she will have to move out. There were no long sentimental stories

to tell, though Tracy did identify her deepest depression as resulting from the loss of her

first true love. The descriptions throughout Tracy's interview were concrete and without

a lot of psychological analysis. Tracy linked a lack of money to bouts of depression three

times in her interview, indicating that financial woes as source of depression seems a

viable option to Tracy. This is in sharp contrast to Esther, who had this to say,

I mean, like right now my life sucks, but I don't think I'm depressed, I get

stressed out about the whole financial thing it's been going on for a good seven or

eight months and uh and I could lose my only investment if I, you know, if I don't

get enough money to pay the mortgage, but I'm not…I'm not dying or anything

(chuckling) even if I lost the house I could live with that…and I'll do anything I

can to not lose the house…but the economy just killed us and we haven't

recovered, uh, but I don't know its kinda like I made a choice to live in certain

way, I could actually get really depressed and not want to get out of bed everyday,

but I'm choosing to do it some other way and I think I have the power to do that.

The middle class sense of personal authority over circumstances represents a different

construction than Tracy's more working class approach. Tracy expects untoward events

to occur in her life. She does not react emotionally to these occurrences, but rather seems

to be more accepting of life's ebbs and flows. She does not feel she is sheltered from

negativity as are middle class individuals. Her lack of a need to explain and analyze life

events was a unique trait amongst the 12 women.

Tracy, like Cassandra, has more difficulty negotiating her lesbianism than the

majority of the participants. Her family does not know she is lesbian as she sees no

reason to tell them. She has a very *butch* appearance but she says this about being

lesbian,

> "I don't really deal with it in any different way, than my everyday life, I don't tell
>
> everybody, um, I don't think its anybody's business, I don't offer it, I don't see
>
> that I have to put things on the back of my vehicles to tell everybody."

Like most of the women, she denies that being lesbian is really a difficult issue, but she

does not feel the need to come out to people to validate her sexuality. Although

Cassandra and Tracy in no way can represent whole classes of people, they offer

glimpses into alternative constructions of depression and lesbianism, and the possible

linkages between class, lesbianism, and depression.

Another influence upon my thinking along class lines is my clinical work in the

public sector. As a psychiatric nurse practitioner I have heard thousands of people of the

lower classes tell me about their experiences of depression. The stories are constructed in

vastly different ways than those of the participants. Just as I identified a schema of

common patterns within my data I have recognized many similarities amongst the stories

of my clients. I have not conducted any type of formal study on this population, but the differences between the groups are striking.

The participants spoke of emotional discord as the primary root of depression, while my clients speak of being overwhelmed by life circumstances. My clients speak about inadequate housing, unemployment, and a lack of resources on every level as the causes of their depression. Both groups describe depression as manifesting the same symptoms, those of difficulties sleeping, not wanting to get out of bed in the morning, crying a lot, and being very irritable with everyone in their environment. The difference is my female clients are attempting to support themselves, raise children, and have relationships while living in poverty. Although eligibility for public services is based solely upon SES measures, and I have stated class is not determined by income alone, it can be extrapolated that most of my clients are members of the lower classes. They most often are not well educated, do not come from families with privilege, and cannot have financial assets or they would not qualify for services. The women I treat in my practice conceptualize their sense of agency very differently than the participants. They feel powerless at home and in society, describing themselves as victims of the systems from which they seek assistance. The participants' depression narratives are about managing uncomfortable feelings; for my clients they are about survival. The participants primarily described experiences of emotional neglects and abuses experienced as children. My clients describe experiences of repeated severe physical and sexual abuses perpetrated upon them by family members, lovers, and strangers. Violence and problems with the law are a part of daily life for my clients.

The disparity between stories of depression told by members of different social classes is an interesting finding of the study that warrants further investigation. I believe this study tells us very little about experiences of depression in lesbians, but rather about depression in middle class lesbians, and I would venture to guess about depression in middle class women.

Limitations of the Study

The study was based upon the analysis of 25 in-depth interviews collected from 12 self-identified lesbians. As the primary data source the sample's unique characteristics create the parameters of the information I received about lesbians' experiences of depression. The limitations are based in issues of the sample's characteristics, issues of volunteerism, and data generating techniques.

The Sample

Recruiting lesbians for research studies has already been identified in this text as being a significant problem for researchers. Historically, white, middle class, middle aged, well-educated women recruited from within the lesbian community participate in studies. I was able to move past the limitation of community affiliation and through the utilization of purposive and network sampling techniques I recruited a group that demographically appeared diverse. As was discussed however, this sample was overwhelmingly middle class and brought social constructions of depression and self-identity that are unique to this class of women. The sample also over represents those in

helping professions. The reasons for this over representation are unknown, and I have already speculated as to why this was the case. Although I recruited from the greater Southern Arizona area, all of the participants live in Tucson. Tucson is considered a very *gay friendly* place and this factor must be significant to the findings. Many of the participants moved here from varied geographic locations including urban settings as well as rural settings, with many having grown up in the Northeast, Midwest and Southern parts of the United States. Those drawn to settle in Tucson may share qualities that I cannot determine. Identifying limitations of the study are endless, but suffice it to say that any characteristic a majority of participants share can be identified as another limitation of the study.

Volunteerism

The second limitation may be framed by the following two questions; (1) Who ultimately volunteered to participate? and (2) What were their motives for participating? It is unknown exactly why these particular 12 women chose to participate while so many others who heard about the study through recruitment strategies did not volunteer. I have already suggested some reasons including the possibility that those in helping professions speak about feelings with ease, and are comfortable narrating their personal stories of depression. It is significant that 11 participants have been involved in therapy, and maybe only those who are accustomed to speak to strangers about their feelings volunteered. Although it was made clear that my role was as a researcher, it was known by the participants that I am a certified psychiatric nurse practitioner. Possibly they felt

they were receiving some free therapy. Some participants told me they felt a sense of relief after having the opportunity to speak about their lives.

During recruitment I stated very emphatically to gatekeepers that the participants do not currently need to be experiencing depression, but no matter how I tried to emphasize this fact the majority of women who called had very intense life experiences with depression. Half of the sample was currently being treated for a depressive disorder at the time of the study. I believe the most telling indicator as to why a group with extensive stories to tell about depression volunteered is explained by the most common reaction I received from the general population to my area of study. Many people over the past few years have asked about the focus of my dissertation work, and when I stated that it is a study about depression the most common response was, "Ohhh that must be depressing. Why would anyone want to talk about that?" I believe that many of those people may not currently be depressed and reflect the thinking of the lesbians who were aware of but did not volunteer for the study. Possibly only depressed people are willing to speak about their experiences. A few of the women who were not depressed and did not suffer from chronic depression stated they thought that this project has political significance. They stated they were glad to "help me out" if it will forward the cause of improving lesbian health care.

Data Generating Techniques

The questions asked during the interviews shaped the responses, and ultimately the findings of the study. In my previous study (Barnard, 1999) I asked directly about the

relationship between episodes of depression and being lesbian during the first interview. In this study I pursued questions asking for more general information about their experiences of depression. With no prompts to move into discussions of sexuality, they did not indicate that it was related to depression. I waited until the middle of the second interview to ask about relationships between the two phenomena. The lack of connection made by the participants between their sexuality and depression was a significant finding as will be discussed in the implications section. This finding might have been lost had I begun the interview with a question about their experiences of depression as a lesbian. The formulation of questions, the order they were asked, the tone of my voice, and the words I chose to use all shaped and limited the responses I received.

I attempted to allow participants to tell their stories as freely as I was able. My interviewing techniques improved over the months as I became more adept at moving participants through their stories with less and less interference. I had constructed interview schedules at the proposal phase, and generally followed those guidelines for questioning. As interviews were the primary data source, all influences upon the interviews pose potential limitations of the study.

Implications for Nursing

The study identified the influences of social discourse upon the constructions of lesbians' experiences of depression. This study is based upon social constructionism and critical social theories actualizing White's proposition that nursing embrace a fifth way of knowing, that of sociopolitical knowing (White, 1995). White states that "it is in the

culture that 'self' is located. This cultural location influences each person's understanding of health and disease causation, language, identity and connection to the land" (p. 84). The most significant findings of this study are related to the ways these lesbians constructed themselves, and their ideas about their own mental health. By "going to the source" I found that contrary to mainstream nursing assumptions, being a lesbian is not a reliable predictor of depression, and these lesbians do not perceive themselves as vulnerable and marginalized individuals simply because they are lesbians.

Identity constructions are based upon a number of aspects including influences of class, race, sex, age *and* sexuality. Nursings' perspective toward lesbian health care thus far focuses upon the vulnerability of the population secondarily to a perception of a lack of agency lesbians experience within our society. I had no sense while interviewing the majority of the participants that they feel powerless because of their sexuality. This stereotyping of lesbians as a vulnerable and oppressed minority is perpetuated by nursing education, practice, and research approaches. This stereotyping of lesbians in nursing is complicit in the maintenance of heteronormativity. The stories of the majority of participants in this study portray women that are confident and comfortable being women who love women. They are proud of their lesbian identities, and realize that if lesbianism is a problem it is society that has created this problem. Rather than concluding this study with suggestions for the development of interventions for treatment of depression in lesbians the study implications call for a reformulation of nursing's approach to lesbian health care through changes in nursing education, practice, and future research.

Implications for Nursing Education

Nursing teaches sexuality to be binary, either one is heterosexual or homosexual. Normalizing other expressions of sexuality should be the goal of nursing education. As the participants of the study demonstrated, nonheterosexuals do not live a life of fear and personal shame. Their lives are constructed through a variety of discourses that come together in a multiplicity of ways allowing for the potential of self acceptance.

Nursing has the potential to become a site of emancipation for marginalized sexualities including lesbians. Basing understandings of sexuality upon difference from a norm further oppresses nonheterosexuals. Nursing has the opportunity to move society toward much needed change. Nursing educators instruct those who will practice in hospitals, clinics, community health centers and in schools reaching large numbers of people. Nurse educators must begin to teach sexuality based upon the concept of normalization rather than marginalization and upon acceptance not difference.

Implications for Nursing Practice

Nursing practice must take similar steps as were suggested for nursing education. Nurses must forgo assumptions about lesbian clients, how lesbians feel about themselves and their preconceived notions about "cultural ways" of lesbians. Lesbians are simply women living their lives, and they rely on nurses for care and advice as any woman might. The goal for practice should be to normalize lesbian sexuality by posing questions in a manner that does not impart privilege to heterosexuality. For example, ask a woman who she lives with and what is the nature of their relationship, without preconceived

ideas or judgment. Do not make assumptions that lesbians do not have children, or that the children are from previous heterosexual marriages. Lesbians are birthing mothers through artificial insemination in greater and greater numbers (Renaud, 2000). Do not assume you have any idea what "roles" two women in a lesbian relationship may play as appearance and life roles often do not simulate heterosexual couples. In psychiatric settings, nurses must not assume that being lesbian may be a part of the patient's construction of depression. Lesbians are comfortable with themselves, and it is a nurse's responsibility to be comfortable with lesbians.

Implications for Nursing Research

Lesbian health research continues to focus upon comparative studies of lesbians to heterosexual women and is based upon a deficit model. A recent CNN article of June 21, 2004 titled, "Lesbian health: Emerging specialty" built an argument for increasing research funding for lesbian health upon beliefs such as "lesbians appear to have higher rates of obesity, smoking and alcohol use when compared to heterosexual women and this may be linked to the stress of feeling targeted by prejudice" (CNN, 2004). The perpetuation of this type of thinking amongst lesbian health researchers themselves only supports dominant paradigms and defeats their intended goal. The issue underlying the call for increased lesbian health research is that lesbians are invisible in our society. The way to achieve recognition and acceptance is not to set lesbians apart from heterosexuals and identify all their potential unique maladies, but instead to focus upon changes in nursing education and practice.

Renaud (2000) conducted a critical ethnography researching lesbians who are biological mothers with similar findings as my study in that these women embraced a number of counter hegemonic discourse allowing them to comfortably "navigate and negotiate mainstream discourses" (p. 215). Research methodologies such as critical ethnography, discourse analysis, and participatory action research are dedicated to emancipatory goals and will further the normalization of lesbianism. Studies that minimize differences based upon sexuality and maximize understandings of the ways dominant discourses maintain the status quo to the benefit of the powerful, and to the detriment of all others are productive projects.

The idea that class may be a determinant to expressions of depression emerged from this study. It was interesting to note that in the CNN article on lesbian health, the researchers commented that "Many lesbians are in excellent health and, particularly if affluent or well-insured, readily find doctors they like." This reinforces the belief that class is the issue in poorer health outcomes, not sexuality. The relationship of class stratifications to health and mental health is an area for researchers to pursue with the goal to identify changes within the sociopolitical context that would prove to minimize feelings of depression.

Conclusions

This study approached the problem of depression in lesbians from a critical perspective with the goal of identifying the sociopolitical underpinnings of their experiences. This approach differs from the majority of health research projects as critical work does not identify the problem and the solution as existing within the

individual, but rather implicates social realms. The study findings indicate that the

dominant discourses of family, psychology, and medicine all partner to create a social

norm of discontent and inadequacy surrounding life experiences that we have come to

identify as "depression." Exposing social discourse as the underpinning of depression

shifts nursing's thinking about this diagnosis and its treatments. Treating depression

requires resisting current social policies, policies that limit possibilities based upon race,

ethnicity, and sexuality; policies that maintain an underclass. Treating depression

requires resisting the dominant discourses of psychology and medicine that identify the

individual as the problem, and fail to connect the personal to the social and the political.

My hope is that this study will provide an incentive for other nursing researchers to

implement critical approaches and involve themselves in social activisms and issues of

social policy.

APPENDIX A

HUMAN SUBJECTS APPROVAL

(with Periodic Review Form)

APPENDIX B

SUBJECTS CONSENT FORM

REFERENCES

Abbott, S. & Love, B. (1973). Sappho was a right-on woman. NY: Stein and Day.

Abraham, K. (1955). Notes on the psycho-analytic investigation and treatment of manic-depressive insanity and allied conditions. In Selected papers on psycho-analysis. London: Hogarth Press.

Adelman, M. (1991). Stigma, gay lifestyles, and adjustment to aging: A study of later-life gay men and lesbians. In J.A. Lee (Ed.), Gay midlife and maturity. (pp. 7-32). NY: Hawthorn Press.

Adler, A. (1958). What life should mean to you. NY: Capricorn Press.

Agar, M. (1980). The professional stranger. NY: Academic Press, Inc.

Agar, M. (1999). How to ask for a study in qualitatisch. Qualitative Health Research, 9 (5) 684-697.

Agar, M. (2003). Ethnography. Symposium conducted at the meeting of the Advances in Qualitative Methods, Banff, Alberta, Canada.

Agger, B. (1998). Critical social theories: An introduction. Boulder CO: Westview Press.

Angell, M. (2004). The truth about the drug companies: How the deceive us and what to do about it. Random House.

Averill, J. B. (1997). Health care experiences of elderly rural Latinos (Dissertation University of Colorado Sciences Center, 1997). Dissertation Abstracts International, 56, 9804623.

Ayala, J., & Coleman, H. (2000). Predictors of depression among lesbian women. Journal of Lesbian Studies, 4 (3) 71-86.

Badger, T.A. (1993). Physical health impairment and depression among older adults. IMAGE: Journal of Nursing Scholarship, 25 (4) 325-330.

Baker, N.L. (1996). Class as a construct in a "classless" society. Women and Therapy,18 (3 /4) 13-23.

Barnard, A.G. (1999). A life apart: The experience of depression in older lesbians. Unpublished master's thesis, University of Arizona, Tucson, AZ.

Bebbington, P.E. (1998). Sex and depression. Psychological Medicine, 28 1-8.

Bebbington, P.E., Dunn, G., Jenkins R., Lewis, G., Brugha, T., Farrell, M., & Meltzer, H. (1998). The influence of age and sex on the prevalence of depressive conditions: Report from the National Survey of Psychiatric Morbidity. Psychological Medicine, 28 9-19.

Beck, J.S. (1995). Cognitive therapy. NY: The Guilford Press.

Becker, J. & Schmaling, K. (1991). Interpersonal aspects of depression from psychodynamic and attachment perspectives. In J. Becker & A Kleinman (Eds.), Psychosocial aspects of depression. (pp.131-168). Hillsdale: NJ: Lawrence Erlbaum Associates.

Behar, R. (1993). The translated woman: Crossing the border with Esperanza'a story. Boston: Beacon press.

Behar, R. (1996). The vulnerable observer. Boston: Beacon Press.

Berlant, L. (1997). The queen of America goes to Washington city: Essays on sex and citizenship. Durham, NC: Duke University Press.

Berlant, L., & Warner, M. (1998). Sex in public. Critical Inquiry, 24 547-566.

Bernhard, L.A. & Applegate, J.M. (1999). Comparison of stress and stress management strategies between lesbian and heterosexual women. Health Care for Women International, 20 (4) 335-347.

Bernstein, B. (1971). Class, codes and control. NY: Schocken.

Blackbridge, P. (1997). Prozac highway. Vancouver, Canada : Press Gang Publishers.

Bourdieu, P. (1984). Distinction: A social critique of the judgment of taste. Cambridge, MA: Harvard University Press.

Breggin P.R., & Breggin, G. R. (1994). Talking back to Prozac. NY: St. Martin's Press.

Buraway, M., Burton, A., Ferguson, A.A.. Fox, K.J.; Gamson, J., Gartrell, N., Hurst, L., Kurzman, C., Salzinger, L., Schiffman, J., Ui, S. (1991). Ethnography Unbound. Berkeley, CA: University of California Press.

Burr, V. (1995). An introduction to social constructionism. NY: Routledge.

Butler, J. (1990). Gender trouble. NY: Routledge.

Cabrera, B. E. (2001). Lesbian gender identity. Dissertation Abstracts International ,61   8B. (University Microfilms No. 2001-95004-421)

Carlston, E.G. (1993). Zami and the politics of plural identity. In S. Wolfe & J. Penelope (Eds.), Sexual practice/ textual theory: Lesbian cultural criticism. (pp. 226-236). Cambridge, MA: Blackwell Press.

Carrion, V.G. & Lock, J. (1997). The coming out process: Developmental stages for sexual minority youth. Clinical Child Psychology & Psychiatry,2 (3) 369-377.

Carspecken, P. (1996). Critical ethnography in educational research. NY: Routledge.

Cass, V.C. (1979). Homosexual identity formation: A theoretical model. Journal of Homosexuality,4 (3) 219-235.

Cass, V.C. (1984). Homosexual identity: A concept in need of definition. Journal of Homosexuality, 9 (2-3) 105-126.

Castillo, R.J. (1998). Meanings of Madness. Cambridge, MA: Brooks Cole Press.

Chodorow, N. (1978). The reproduction of mothering: Psychoanalysis and the sociology of gender. Berkeley: University of California Press.

Christians, C. G. (2000). Ethics and politics in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 133-154). Thousnad Oaks, CA: Sage.

Clayton, P.J., Herjanic, M., & Murphy, G.E. (1974). Mourning and depression: their similarities and differences. Canadian Journal of Psychiatry,125. 309-312.

CNN (2004, August 17). Lesbian health, emerging specialty. Retrieved September 15, 2004 from coalition@lgbthealth.net.

Cochran, S.D., Keenan, C., Schober, C., & Mays, V.M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the US population. Journal of Consult Clinical Psychology, 68 1062-1071.

Cochran, S.D. & Mays, V.M. (1988). Disclosure of sexual preferences to physicians by black lesbian and bisexual women. Western Journal of Medicine, 149 616 - 619.

Cochran, S.D., Sullivan, J.C., & Mays, V.M. (2000). Prevalence of psychiatric disorders, psychological distress, and treatment utilization among lesbian, gay, and bisexual individuals in a sample of US population. Journal Consultant in Clinical Psychology, 68 1062 – 1071.

Corey, G. (2001). Theory and practice of counseling and psychotherapy. Belmont, CA: Brooks/Cole Thomson Learning, Inc.

Crotty, M. (1998). The foundations of social research. Thousand Oaks,CA: Sage.

Culpepper, L., Davidson, J.R. & Dietrich, A.J. (2004). Suicidality as a possible side effect of anti-depressant treatment. Journal of Clinical Psychiatry, 6 (2) 79-86.

Davidson, J.R. & Meltzer-Brody, S.E. (1999). The under recognition and under treatment of depression: What is the breadth and depth of the problem? Journal of Clinical Psychiatry, 60 (supp 7) 4-9.

Denzin, N. K. (2003). Performance Ethnography. Symposium conducted at the meeting of the Advances in Qualitative Methods, Banff, Alberta, Canada.

Denzin, N. K. (1997). Interpretive ethnography: Ethnographic practices for the 21st century. Thousand Oaks, CA; Sage.

Denzin, N. K. & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp.1 -29). Thousand Oaks, CA: Sage.

Doane, M.A. (1987). Clinical eyes: The medical discourse. In The desire to desire: The woman's film of the 1940s. (pp. 38-68). Bloomington, IN: Indiana University Press.

Dowd, L. (2001). Female perpetrators of partner aggression: Relevant issues and treatment. Journal of Aggression, Maltreatment & Trauma, 5 (2) 73-104.

Dreier, O. (2000). Psychotherapy in clients' trajectories across contexts. In Mattingly & Gatto (Eds.) <u>Narrative and the cultural construction of illness and healing</u> (pp. 237-258). Berkeley, CA: University of CA Press.

Drevdahl, D., Kneipp, S., Canales, M.K., Dorcy, K.S. (2001). Reinvesting in social justice: A capital idea for public health nursing? <u>Advances in Nursing Science, 24</u> (2) 19-31.

Duggan, L. (1992). Making it perfectly queer. <u>Socialist Review, 92</u> 155-172.

Ellis, A. (1962). <u>Reason and emotion in psychotherapy.</u> NY: Lyle Stuart.

Esterberg, K. (1994). A certain swagger when I walk. In S. Seidman (Ed.) <u>Queer theory/Sociology</u> (pp. 259 – 279). Blackwell Publishers.

Faderman, L. (1991). <u>Odd girls and twilight lovers.</u> NY: Columbia University Press.

Falco, K.L. (19950. Therapy and lesbians: The essentials. <u>Psychotherapy in Private Practice, 13</u> (4) 69-83.

Finfgeld, D. L. (2001). New directions for feminist therapy based on social constructionism. <u>Archives of Psychiatric Nursing, 15</u> (3) 148-154.

Flick, U. (1998). <u>An introduction to qualitative research.</u> Thousands Oaks, CA: Sage.

Floyd, F. & Stein, T.S. (2002). Sexual orientation identity formation among gay, lesbian and bisexual youths. <u>Journal of Research on Adolescence, 12</u> (2) 167-191.

Foucault, M. (1978). <u>History of sexuality volume I: An Introduction.</u> NY: Random House.

Foucault, M. (1985). <u>The use of pleasure: The history of sexuality volume II.</u> NY: Random House.

Foucault, M. (1986). <u>The care of the self: the history of sexuality volume III.</u> NY: NY: Random House.

Freud, S. (1915). Mourning and melancholia. In <u>Complete psychological works: Vol. 14.</u> London: Hogarth Press 1957.

Fuss, D. (1991). <u>Inside/out: Lesbian theories, gay theories.</u> NY: Routledge.

Gaines, A.D. (1992). From DSM-I to III-R; Voices of self, mastery and the other: A cultural constructivist reading of U.S. psychiatric classification. Social Science Medicine, 35 (1) 3-24.

Gammell, D. J, & Stoppard, J. M. (1999). Women's experiences of treatment of depression: Medicalization or empowerment? Canadian Psychology, 40 (2) 112-128.

Gamson, J. (1991). Silence, death, and the invisible enemy: AIDS activism and social movement "newness". In M. Buraway (Ed.), Ethnography unbound: Power and resistance in the modern metropolis. Berkeley, CA: University of California Press.

Geets, E., Bouhuys, S.A., & Bloem, G. (1997). Nonverbal support giving induces nonverbal support seeking in depressed patients. Journal of Clinical Psychology, 53 (1) 35-39.

Gergen, K. J. (1973). Social psychology as history. Journal of Personality & Social Psychology, 26 309-320.

Gergen, K. J. (1994). Realities and relationships. Cambridge MA: Harvard University Press.

Gergen, K.J. (2001). Social construction in context. Thousand Oaks, CA: Sage.

Gergen, M.M. & Gergen, K. J. (2000). Qualitative inquiry: Tensions and transformations. In N. K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp.1025-1046).

Gershon,E.S. (1983). The genetics of affective disorders. In L. Grinspoon (Ed.), Psychiatric Update: Vol. 2. (pp. 434-457). Washington, DC: American Psychiatric Association.

Gilligan, C. (1982). In a different voice. Cambridge MA: Harvard University Press.

Gilman, S.E., Cochran, S.D., & Mays, V.M. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. American Journal of Public Health, 91 (6) 933-939.

Gramling, L.F. & McCain, N.L. (1997). Grey glasses: Sadness in young women. Journal of Advanced Nursing, 26 312-319.

Grusky, D. B. (2001). Social stratification: Class race, and gender in sociological perspective. Boulder, CO: Westview Press.

Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. <u>Educational Communication and Technology: A Journal of Theory, Research and Development, 29</u> (2) 75-91.

Guba, E.G. & Lincoln, Y.S. (1981). <u>Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches</u>. San Francisco: Jossey-Bass, Inc.

Guba, E.G. & Lincoln, Y.S. (1986). Judging the quality of fourth generation evaluation. In <u>Fourth generation evaluation</u> (pp. 228-251). Newbury Park, CA: Sage Publications, Inc.

Hagedorn, S. (1995). The politics of caring: The role of activism in primary care. <u>Advances in Nursing Science, 17</u> (4) 1-11.

Halperin, D. M. (1995). <u>Saint Foucault: Toward a gay hagiography.</u> NY: Oxford University Press.

Harding, S. (1995). The method question. In Anna Omery, Christine Kasper & Gayle Page (Eds.), <u>In search of nursing science.</u> Thousands Oaks, CA: Sage Publications.

Healy, D. (2004). <u>Let them eat Prozac: The unhealthy relationship between the pharmaceutical industry and depression.</u> NY: New York University Press.

Heifner, C.A. (1996). Women, depression, and biological psychiatry: Implications for psychiatric nursing. <u>Perspectives in Psychiatric Care, 32</u> (3) 4-9.

Heim, C., & Nemeroff, C.B. (2001). Childhood trauma, depression and anxiety. <u>Biological Psychiatry,49</u> 1023-1039.

Heim, C., Newport, D.J., Heit, S., Graham, Y.P., Wilcox, M., Bonsall, R., Miller, A.H., & Nemeroff C.B. (2000). Pituitary-adrenal and autonomic responses to stress in women after sexual and physical abuse in childhood. <u>Journal of the American Medical Association, 284</u> (5) 592-597.

Henderson, L. (1999). Simple pleasures: Lesbian community and Go Fish. <u>Signs: Journal of Women in Culture and Society,25</u> (1) 37-64.

Hennessy, R. (2000). <u>Profit and pleasure: Sexual identities in late capitalism.</u> NY: Routledge.

Hochschild, A.R. (1983). <u>The managed heart: Commercialization of human feeling.</u> Berkeley, CA: University of CA Press.

Hochschild, A.R. (2001). Emotion work, feeling rules, and social structure. In A. Branaman (Ed.), Self and society. (pp. 138-155). Malden, MA: Blackwell Publishers.

Howarth, C. (2002). Using the theory of social relationships to explore difference. Thousand Oaks, CA: Sage.

Hughes, T. L. (1999). Sexual identity and alcohol use: A comparison of lesbians' and heterosexual women's patterns of drinking. Paper presented at New Approaches to Research on Sexual Orientation, Mental Health, and Substance Abuse Conference. September 1999, Rockville, Md.

Jack, D. C. (1999). Ways of listening to depressed women in qualitative research: Interview techniques and analyses. Canadian Psychology, 40 (2) 91-101.

Jacobson, E. (1971). Depression. NY: International Universities Press.

Jagose, A. (1996). Queer theory: An introduction. NY: New York University Press.

Janesik, V. J. (2000). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N. K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp.379-400). Thousand Oaks, CA: Sage.

Jenkins, J.H., Kleinman, A., & Good, B.J. (1991). Cross-cultural studies of depression. In J. Becker and A. Kleinman (Eds.), Psychosocial aspects of depression. (pp.67-100). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Jordan, J. (1997). Women's growth in diversity. NY: The Guilford Press.

Jordan, J., Walker, M.; & Hartling, L. M. (2004). The complexity of connection. NY: The Guilford Press.

Kaplan, H.I., & Sadock, B.J. (1998). Mood disorders. In Synopsis of psychiatry (8th ed., pp.524-580). Baltimore: Williams and Wilkins.

Karasu, T.B. (1990a). Toward a clinical model of psychotherapy for depression: Systematic comparison of three psychotherapies. American Journal of Psychiatry, 147 (2) 133-147.

Karasu, T. B. (1990b). Psychotherapy for depression. Northvale, NJ: J. Aronson.

Kaschak, E. (2001). Intimate betrayal: Domestic violence in lesbian relationships. Women and Therapy, 23 (3) 1-5.

Katz, J. & Joiner, T.E. (2002). Membership in a devalued social group and emotional well-being: Developing a model of personal self-esteem and group socialization. Sex Roles, 47 (9/10) 419-431.

Kehoe, M. (1989). Lesbians over sixty speak for themselves. NY: Harrington Press.

Kendler, S.K., Bulik, C.M., Silberg J., Hettama, J.M., Myers, J., Prescott C.A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women. Archives of General Psychiatry, 57 (10) 953-959.

Kennedy, E.L. & Davis, M.D. (1993). Boots of leather, slippers of gold: The history of a lesbian community. New York: Penguin.

Kessler, R.C., McGonagle K.A., Swartz, M., Blazer, D.G., & Nelson, C.B. (1993). Sex and depression in the National Morbidity Survey: Lifetime prevalence, chronicity, and recurrence. Journal of Affective Disorders, 29 85-96.

Kitzinger, C. (1987). The social construction of lesbianism. Newbury Park, CA: Sage.

Kipnis, L. (1998). Adultery. Critical Inquiry, 24 289-327.

Kleinman, A. (1988). Rethinking psychiatry: From cultural category to personal experience. NY: Free Press.

Klerman, G.L., & Weissman, M.M. (1985). Depression among women: Their nature and causes. In M. Gutentag, S. Salasin, D. Belle (Eds.), The mental health of women (pp. 57-92). NY: Academic Press, Inc.

Klerman, G. L., & Weissman, M. M. (1986). The interpersonal approach to understanding depression. In M. Theodor and G. Klerman (Eds.), Contemporary directions in psychopathology: Toward the DSM-IV. pp 429-456.

Kohn, M. (1963). Social class and exercise of parental control. In N. Smelser & M. Kohn (Eds.), Personality and social systems. (pp. 297-313). NY: Wiley.

Kondro, W. (2004). UK bans, Health Canada warns about anti-depressants. Canadian Medical Association Journal, 171 (1) 23-24.

Krakauer, I. D. & Rose, S.M. (2002). The impact of group membership on lesbian's physical appearance. Journal of Gay and Lesbian Social Services, 6 (1) 31 – 43.

Kramer, P.D. (1993). Listening to Prozac. NY: Penguin Books.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. The American Journal of Occupational Health, 45 (3) 214-222.

Kuiken, K. (2001). Derrida, Kristeva, and the dividing line: An articulation of two theories of difference. Canadian Review of Comparative Literature, 27 (1) 316-121.

Laplace, M. (1992). Producing and consuming the woman's film. In C. Gledhill (Ed.), Home is where the hart is: Studies in melodrama and the woman's film. (pp.138-166).

Lather, P. (1993). Fertile obsession: Validity after poststructuralism. The Sociology Quarterly, 34 (4) 673-693.

Lindemann, E. (1944). Symptomatology and management of acute grief. American Journal of Psychiatry, 101. 141-148.

Lorde, A. (1984). Zami: A new spelling of my name. Freedom, CA: Crossing Press.

Levine, H. (1997). A further exploration of the lesbian identity development process and its measurement. Journal of Homosexuality, 34 (2) 67-78.

Lincoln, Y.S. & Guba, E.G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 163-188). Thousand Oaks, CA: Sage.

Marcuse, H. (1955). Eros and civilization. Beacon Press: Boston.

Massumi, B. (1995). The autonomy of affect. Cultural Critique (3) 83-109.

Matthews, A.K., Hughes, T.L., Johnson, T., Razzano, L.A., & Cassidy, R. (2002). Prediction of depressive distress in a community sample of women: The role of sexual orientation. American Journal of Public Health, 92 (7) 1131-1139.

Mays, V.M., & Cochran, S.D. (2001). Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the U.S. American Journal of Public Health, 91 (11) 1869-1876.

McGarth, E., Keita, G.P., Strickland, B.R.,& Russo, N.F. (1990). Women and depression: Risk factors and treatment issues. Washington DC: American Psychological Association.

McEwen, M.M. (2003). Mexican immigrants' understanding and experience of tuberculosis infection. Unpublished Dissertation, The University of Arizona, Tucson, AZ.

Medscape (2004). Retrieved on 8/31/04 from http://www.medscape.com/pages/editorial/resourcecenters/public/depression/rc-depression4.

Meek, C. (2004). UK psychiatrists question SSRI warnings for under18s. Canada Medical Association Journal, 170 (4) 455-456.

Miller, N. (1995). Out of the past: Gay and lesbian history from 1869 to the present. NY: Vintage Books.

Miller, D.H., Green, K., Causby, V., White, B.W., & Lockhart, L.L. (2001). Domestic violence in lesbian relationships. Women and Therapy, 23 (3) 107-127.

Moraga, C. & Anzaldua, G, (eds.) (1981). This bridge called my back: Writings by radical women of color. NY: Kitchen Table Women of Color Press.

Morris, J.F. & Rothblum, E.D. (1999). Who fills out a lesbian questionnaire? The interrelationship of sexual orientation, years out, disclosure of sexual orientation, sexual experience with women and participation in the lesbian community. Psychology of Women Quarterly, 23 (3) 537-557.

Mullen, L.M. (1999). Metaphors in the talk of "depressed" women in psychotherapy. Canadian Psychology, 40 (2) 102-111.

Muntaner, C., Eaton, W.W., Diala, C., Kessler, R.C., & Sorlie, P.D. (1998). Social class, assets, organizational control and the prevalence of common groups of psychiatric disorders. Social Science and Medicine, 47 (12) 2043-2053.

Nemeroff, C.B. (1998). The neurobiology of depression. Scientific American (6) 42-49.

Nestler, E. J., Barrot, M., DiLeone, R. J., Eisch, A. J., Gold, S. J., & Monteggia, L. M. (2002). Neurobiology of depression. Neuron, 34 13-25.

Newmann, J.P. (1984). Sex differences in symptoms of depression: clinical disorder or normal distress. Journal of Health and Social Behavior, 25 (6) 136-159.

Nolen-Hoeksema, S. (1990). Sex differences in depression. Stanford, CA: Stanford University Press.

Oetjen, H., & Rothblum, E. (2000). When lesbians aren't gay: Factors affecting depression among lesbians. Journal of Homosexuality, 39 (1) 49-72.

Page, C. H. (1964). Class and American sociology. NY: Octagon Books.

Panzarino, P.J. (1998). The costs of depression: Direct and indirect; treatment versus nontreatment . Journal of Clinical Psychiatry, 59 11-14.

Parker, P. (1985). Jonestown and other madness. Ithaca NY: Firebrand Books.

Parks, C. (1999). Lesbian identity development: An examination of difference across generations. American Journal of Orthopsychiatry,69 (3) 347-361.

Pezet, S., Malcangio, M., McMahon, S. P. (2002). BDNF: A neuromodulator in nociceptive pathways? Brain Research Review, 40 (3) 240-249.

Phelan, S. (1993). (Be)coming out: Lesbian identity and politics. Signs: Journal of Women in Culture and Society, 18 (4) 15- 41.

Pillard, R.C. (1991). A genetic study of male sexual orientation. The Archives of General Psychiatry, 48 1089-1096.

Ponse, B. (1978). Identities in the lesbian world: The social construction of self. Westport, CN: Greenwood Press.

Remafedi, G., French, S., Story, M., Resnick,M.D., & Bl;um, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. American Journal of Public Health, 88 57-60.

Renaud, M. (2000). A critical ethnography of lesbian families with biological born babies (Doctoral dissertation, University of Washington, Seattle, 2000). (University Microfilms No. 9995428).

Reynolds, A.L., Hanjorgiris,W.F. (2000). Coming out: Lesbian, gay and bisexual identity development. In R. Perez & K. DeBord (Eds.), Handbook of counseling and psychotherapy with lesbian, gay and bisexual clients. (pp. 35-55).

Rosaldo, R. (2001). The anthropology of globalization. Blackwell.

Ross, E. A. (1938). Principles of sociology. NY: Appleton-Century.

Rothblum, E. D. (1990). Depression among lesbians: An invisible and unresearched phenomenon. Journal of Gay and Lesbian Psychotherapy,1 (3) 67-87.

Sadek, N.A., & Nemeroff, C.B. (2000). Update on the neurobiology of depression [On-line] http:/www.medscape.com/Medscape/psychiatry/Treatmentupdate/ 2000/tu03/public/toc-tu03.html.

Sandelowski, M. (1986). The problem of rigor in qualitative research. <u>Advances in Nursing Science, 8</u> (3) 27-37.

Sandelowski, M. (1999). Time and qualitative research. <u>Research in Nursing and Health, 22</u> 79-87.

Sandoval, C. (2000). <u>Methodology of the oppressed.</u> Minneapolis, MN: University of Minneapolis Press.

Saphira, M. & Glover, M. (2001). The effects of coming out on relationships and health. <u>Journal of Lesbian Studies, 5</u> (1-2) 183 – 194.

Schulz, K. (2004, August 22). Did antidepressants depress Japan? *The New York Times*, Magazine Desk.

Schwandt, T.A. (2000). Three epistemological stances for qualitative inquiry. In N.K. Denzin and Y.S. Lincoln (Eds.), <u>Handbook of qualitative research</u> (2nd ed. pp. 189-213). Thousand Oaks, CA; Sage.

Schwartzberg, A. Z. & Schwartberg, K. W. (1990). Short term group psychotherapy with adult children of alcoholics. <u>Psychiatric Annals,20</u> (7) 391-394.

Seafstreom, C.A. (1999). On the postmodern curriculum theory: moving the question of unity to the question of difference. <u>Studies in Philosophy and Education, 18</u> (4) 221-236.

Shugar, D.R. (1999). To(o) queer or not? Queer theory, *lesbian community,* and the functions of sexual identities. <u>Journal of Lesbian Studies, 3</u> (3) 11 – 20.

Shweder, W. (1990). Cultural psychology—what is it? In J. Stigler, R. Shweder & G. Herdt (Eds.), <u>Cultural psychology: Essays on comparative human development.</u> Cambridge, England: Cambridge University Press.

Singer, E. (1998). The interpersonal approach to psychoanalysis. In R. Langs (Ed.), <u>Current theory of psychoanalysis</u> 73-101.

Smith, B. (ed.) (1983). <u>Home girls: A black feminist anthology.</u> NY: Kitchen Table Women of Color Press.

Spanier, C. & Frank, E. (1998). Maintenance interpersonal psychotherapy: A preventive treatment for depression. In J. Markowitz (Ed.), <u>Interpersonal psychotherapy: A review of psychiatry series.</u> 67-97.

Spradley, J.P. (1980). <u>Participant observation.</u> Orlando, FL: Holt, Rinehart & Winston.

Stein, A. (1992). Sisters and queers: The decentering of lesbian feminism. <u>Socialist Review, 22</u> (1) 33-56.

Stein, E. (1993) Evidence for gay genes: An interview with Richard Pillard. <u>Gay and Lesbian Quarterly</u> (1) 93-110.

Stevens, P.E. (1992). Lesbian health care research: A review of the literature from 1970 – 1990. <u>Health Care for Women International, 13</u> 91-120.

Stevens, P.E. (1994). Lesbians' health related experiences of care and noncare. <u>Western Journal of Nursing Research, 16</u> 639-659.

Stoler, A.L. (1995). <u>Race and the education of desire.</u> Durham, NC: Duke University Press.

Stoppard, J.M. (2000). <u>Understanding depression: Feminist social constructionist approaches.</u> London: Routledge.

Strickland, B. R. (1988). Sex-related differences in health and illness. <u>Psychology of Women Quarterly, 12</u> 381-199**.**

Stuart, G. (2001). <u>Principles and practice of psychiatric nursing.</u> St. Louis, MO: Mosby.

Szewczyk, M. & Chenault, S.A. (1997). Depression and related disorders. <u>Primary Care, 24</u> (1) 83-101.

Szymanski, D. M. (2002). Lesbian internalized homophobia in relation to same-sex relationships, feminist attitudes, and coping resources. <u>Dissertation Abstracts International, 62</u> (8A). (University Microfilms No.2691)

Tait, D. (1997). Stress and social support networks among lesbians and heterosexual women: A comparison study. <u>Smith College Studies in Social Work,67</u> (2) 213-224.

Taylor, S., & Bogdon, R. (1998). Introduction to qualitative research methods. (3rd ed.). NY: Wiley & Sons.

Teichman, Y. (1986). Family therapy of depression. <u>Journal of Psychotherapy and the Family, 2</u> (3-4) 9-39.

Thomas**,** J. (1993). <u>Doing critical ethnography.</u> Newbury Park, CA: Sage.

Tong, R.P. (1998). <u>Feminist thought</u>.(2nd ed.).Boulder, CO: Westview Press.

Trippet, S.E. (1994). Lesbians' mental health concerns. <u>Health Care for Women International, 15</u> 317-323.

Van Manen, M. (1990). <u>Researching Lived Experience</u>. London, Ontario, Canada: The State University of New York.

Walters, S.D. (1996). From here to queer: Radical feminism, postmodernism and the lesbian menace (or why can't a woman be more like a fag?). <u>Signs: Journal of Women in Culture and Society, 21</u> (4) 832-868.

Warren, B.J. (1993). Explaining social isolation through concept analysis. <u>Archives of Psychiatric Nursing,7</u> (5) 270-276.

Waxler, N. (1974). Culture and mental illness. <u>Journal of Nervous Mental Disorders, 159</u> 379-395.

Weiss, L. & Fine, M. (2000). <u>Speed bumps: A student friendly guide to qualitative research.</u> NY: Columbia University Press.

Weston, K. (1991). <u>Families we choose: Lesbian, gays, kinship.</u> NY: Columbia University Press.

White, J. (1995). Patterns of knowing: Review, critique, and update. <u>Advances in Nursing Science, 17</u> (4) 73-86.

World Health Organization (2000). Depression. Retrieved July 28, 2004 from http://www.who.int/mipfiles/1956/Depression.pdf.

Wurtzel, E. (1994). <u>Prozac nation.</u> NY: Houghton Mifflin Co.

Zaretsky, E. (1986). <u>Capitalism, the family and personal life.</u> NY: Harper & Row.