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Lesbians' Constructions of Depression

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Abstract

Lesbians are a marginalized group of women living in a heteronormative society. This study describes lesbians' subjective experiences of depression, and identifies the ways that dominant and alternative discourses shaped their understandings of depression and sexuality. Twelve self-identified lesbians participated in up to three in-depth interviews conducted over a nine month period. Thematic analysis led to themes that explicated their physical and emotional descriptions of depression; identified troubled interpersonal relationships as a primary source of depression; and the means implemented to cope with depression, including taking medication, engagement in therapy, developing social support networks, and discovering their own spirituality. Depression and sexuality were understood within the framework of the dominant discourses of (1) medical model (2) dysfunctional family and (3) organized religion; and the alternative discourses of (1) lesbian identity, (2) alternative families and (3) spirituality. Nurses in clinical practice can assist depressed lesbians clients by bolstering explorations of spirituality and the development of strong support networks within the lesbian and gay communities. Politically, institutionalized heteronormativity must be attacked at every level.

The studies on lesbians and depression conducted thus far have been quantitative and offer important insights into issues believed to underpin depression in lesbians. I employed qualitative methods to gain a deeper and contextualized understanding of lesbians' experiences with depression based upon their narratives. My aim was to identify 1) the themes embedded within lesbians' stories about feeling depressed, and 2) the social discourses underpinning the construction of those themes. This information will assist in guiding future research on depression in lesbians.

Depression rates are steadily increasing globally, despite the billions of dollars spent by government funding agencies and pharmaceutical companies to address the problem. Depression affects 121 million people worldwide and is expected to become the second leading cause of disability worldwide by the year 2020 (World Health Organization [WHO], 2005). Approximately 15% of the U.S. population suffers from an episode of major depression in their lifetime (Kessler et al., 2003). Women carry a disproportionate burden of depression, since they are diagnosed at twice the rate of men (Heifner, 1996; Kaplan & Sadock, 1998). This difference has been explained by many theories, ranging from biomedical hypotheses of hormonal and dimorphic brain differences (Kessler et al., 2003) to feminist social constructionist theory (Stoppard, 2000).

Lesbians' lives parallel those of heterosexual women in many ways, but lesbians in the United States live with institutionalized heterosexism and homophobia. The impact of this marginalization upon lesbians' mental health has not been adequately explored. Most researchers studying lesbians and depression, like those studying depression in the larger population of women, have explored the effects of family social support, social support of friends, relationship status, and relationship satisfaction (Ayala & Coleman, 2000; Mathews, Hughes, Johnson, Razzano, & Cassidy, 2002; Oetjen & Rothblum, 2000). The one variable specific to homosexuality in such studies was sexual orientation disclosure or outness.

However, conflicting or inconclusive results were found. Ayala & Coleman (2000) found that all the above factors significantly affected levels of depression in lesbians, whereas Oetjin & Rothblum (2000) found that the only significant predictor of depression was a lack of social support from friends. Matthews et al. (2002) found that depression in both lesbians (n=550) and a matched community sample of heterosexual women (n=279) was predicted by past traumatic events such as physical and sexual abuse and by coping styles, but that lesbians reported greater rates of sexual abuse as children (30%) than did heterosexual women (16%). The other notable finding was that lesbians reported a higher rate of suicidal ideation (51%) than heterosexual women (38%). Lesbians between 15 and 29 years old were twice as likely as heterosexual women to have attempted suicide (Matthews et al., 2002). Other researchers found that the psychiatric morbidity of gay and bisexual individuals was negatively impacted by perceived discrimination (Mays & Cochran, 2001).

Method

Design

I used critical ethnographic methods to explore and analyze lesbians' experiences of depression. Ethnography is a type of inductive analysis striving to "tell the story" embedded within participants' narratives in a comprehensible way (Janesik, 2000). Critical ethnography is similar to descriptive ethnography in that it studies a particular grouping of people, and identifies patterns in the ways they make meaning within the context of their lives (Agar, 2003). Critical ethnography differs from descriptive ethnography as the identified patterns are examined through a critical lens, delineating the interrelationships between the group being studied and their larger social context. In this study the use of critical ethnographic methods led me to the identification of dominant and alternative discourses underpinning lesbians' vulnerabilities and resistances to depression.

Sample and Setting

The inclusion criteria for participating in the study were women self-identifying as lesbian, being at least 21 years of age, and able to recognize sometime in their life when they felt depressed. The broadness of the depression criterion was selected as many depressed women never seek treatment and do not receive a diagnosis of clinical depression (Scattolon & Stoppard, 1999).

I recruited the study sample through purposive and network sampling. Networking or snowball sampling is an effective sampling technique when working with "hidden populations" such as lesbians (Faugier & Sargeant, 1997; Penrod, Preston, Cain, & Starks, 2003). Through personal and professional contacts, I recruited many women who might not have responded to flyers or presentations to groups of lesbians. My implementation of purposive sampling insured diversity within the sample (Agar, 1999; Sandelowski, 1999).

Twelve self-identified lesbians comprised the sample. Of the 12 women, 33% were women of color and 66% were Caucasian. Ages ranged from 21 to 66 years (M=42.5). Incomes ranged from none to over \$80,000 a year (M= \$31,000). Forty-two percent of the women had high school diplomas, less than 1% had an associate's degree, 17% had completed bachelor's degrees, and 33% had completed master's degrees. The study began with 58% of the women partnered and 42% single. During data collection, 17% of the partnered women ended their relationships, while no single women became involved in new relationships. None of the participants had mothered biological children but 33% were co-parenting partner's children, whose ages ranged from 8 to 23 years, with some not living in the home. I conducted all the interviews in a private place of the participants' choosing with only the participant and me present.

A small city in the southwestern United States was the site of the study. The sample was recruited from a geographic area that is considered gay friendly by its residents, although it is not nationally identified as a hub for gay life. The participants either grew up in the area or chose to relocate from areas less tolerant of their sexuality. Publicly available statistics related to sexuality are not considered accurate, as the issue is too sensitive for many people to discuss. The demographic information on the women composing the sample is diverse, but it is unknown how representative it is of lesbians residing in the study setting.

Data Collection

Before collecting data, I sought university institutional review board (IRB) approval for the study. Data were collected in up to three in-depth interviews with participants over a nine month period. Using multiple interviews over an extended period served two purposes. First, the participants developed an increasingly comfortable and trusting relationship with me, assuring rich and thick data. Second, as temporality significantly affects depression, patterns of depression could be revealed within each participant's experience as well as across participants' stories. Of the 12 women, 5 completed three interviews, 5 completed two interviews, and 2 women were interviewed once.

A variety of reasons led to the completion of less than 3 interviews. One woman chose to no longer participate after her first interview, and offered no explanation. The other woman completing only one interview moved a few states away, and when I contacted her by phone she stated she was busy settling into her new residence and had no time for further interviews. She also felt that she had shared the most important information about her experiences with depression in our single extensive interview as her depressive episodes occurred earlier in her life, and she was not dealing with depression at this time. Scheduling issues and feeling they had said all they wished to share were the reasons women only participated in two interviews.

To guide the interview process, I used a series of open-ended questions that went from more general questions about depression to more probing. I intentionally made space available for the participants to discuss the information that they felt was most important. This method allowed the stories to unfold in a natural progression leading to the collection of relevant data that was not dependent upon each participant completing a sequenced series of interviews. The first interview included questions such as, "Tell me about the most recent time you felt depressed." After a participant related a depressive event, I asked, "What were the circumstances occurring in your life at that time?" In the second interview, sexuality was broached if the participant had not mentioned it previously. A typical question was, "How has your sexuality impacted your emotional life?" In the third interview, I asked questions to clarify issues that arose after reviewing their previous interviews. All interviews were audio taped with the participants' written permission, and tapes were transcribed verbatim. The interview schedules approved by the IRB are included in Appendix 1.

Data Analysis

Thematic analysis—The transcribed interviews were reviewed for accuracy and entered onto Atli.ti software (version 4.2). Thematic analysis of the transcripts used a synthesis of methods (De Santis & Ugarriza, 2000; Spradley, 1980; Thomas, 1993) which involved moving the level of abstraction from the micro-level to the macro-level. Data were open coded, categories that clustered into domains were identified, and these domains were organized into themes. Data collection and analysis were ongoing with each added interview, thus ensuring that the development of descriptive codes was grounded in data. This process continued until data were saturated (De Santis & Ugarriza, 2000, Spradley, 1980; Thomas, 1993).

Ensuring Validity—To address validity, I involved participants in the data analysis (member check) and conferred with IRB-approved depression researchers (peer debriefing) throughout the study. Interpretations of thematic data were validated by sharing the content analyses with participants during the second and third interviews and requesting their input about themes that were emerging across participants' stories. Validity of the data analysis was ensured by using Carspecken's (1996) strategies for critical ethnographies. I established trustworthiness through strategies ensuring three aspects of validity. Objective validity addressed issues arising during data collection, reconstructive analysis validity assured faithfulness to the meanings of the participants words, and subjective validity improved the "honesty and accuracy" of the participants' self-reporting (Carspecken, 1996).

Findings

Thematic analysis of the interview transcripts on lesbians' experiences of depression revealed three themes: (1) feeling depressed, (2) relational dissonance as the primary source of depression, and (3) strategies used to cope with depression. Further analysis of the interview transcripts identified 3 dominant (hegemonic) discourses: (1) biomedical model, (2) dysfunctional family, and (3) organized religion; and 3 alternative (counter-hegemonic) discourses: (1) lesbian identity, (2) alternative families and (3) spirituality. These themes and discourses are presented below with supporting excerpts from the interviews.

Feeling Depressed

Most of the participants described depression as a physical manifestation. This theme was best expressed in the words of a 39 year-old woman who self-identified as a Black lesbian:

I don't like depression at all, uh, I don't like how it feels, it's 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 won't be able to get back up again, it's a fear [I have] and I don't think there is anybody who can help me get up again. Depression for me is a whole body experience, and it feels like the joy is draining from your body.

For 7 of the women in the study, feeling depressed was a chronic state of being, described as "a worldview." A 61 year-old Caucasian woman described a life overshadowed by sadness and unhappiness and hoped that one day, "I will figure it out so I can leave this sadness behind." A 39 year-old Caucasian woman with chronic depression stated,

I think for me being depressed is part of my personality, you know, is part of who I am, it is in my soul, and for whatever reason that's how I view the world. So if I shut that part out, you know, I think part of the reason I am so resistant to things like behavior modification techniques or 'just change the way you think' is that [if I did that], I'm isolating, I'm cutting off the major flow to my personality. I want to find what's good [in the depression] for me rather than push it away and pretend it doesn't exist.

Five women experienced depression as an episodic event in response to a specific life event. They had bouts of depression that could be very deep but they didn't "hold onto it for long" and became "bored with being depressed."

Relational Dissonance

Depression was usually spoken about in the context of difficulties with interpersonal relationships. Relationship problems were woven into the women's narratives, particularly troubles within parental-daughter relationships, family systems, and intimate partnerships.

Parents—Many types of parent-daughter problems were not influenced by the participants' sexuality. Parental responses to discovering their daughter's lesbianism ranged from unconditional acceptance to rage, though no parent-daughter relationships were severed due to sexuality. Mothers were particularly reluctant to accept a lesbian daughter. For some participants, their mother's reluctance was an emotionally charged issue that filled much space within their depression narratives. A 21 year-old Caucasian woman depicted a difficult tale that was ongoing in 2004,

My family is upper middle class and they are about, you know, the perfect family and the perfect daughter, who is the scholar and the athlete, and I was that person, but I was gay inside, and I finally told my mom when I was 17 that I was gay. So she made a big hurrah and was screaming and yelling and screaming and yelling at me. I moved out of my parent's house and I moved in with my girlfriend when I was 17. You know, when the depression hits me I feel like everything I felt before is just intensified a hundred times... Ever since I told her I was gay, when I came out to her she got on Prozac and blamed it on me. Her whole depression thing is my fault, because I am gay, and I tell her about my depression and she doesn't seem to understand how bad it is. She just doesn't understand how bad it is. All I ever wanted was my mom to be like a friend, like someone I could talk to. I think most people can call their moms and talk to them and their moms talk back to them. I feel very alone a lot of the time. I feel I can't trust people. I feel alone, like I am fighting the world, and why does this have to happen to me.

A 26 year-old Latina had a similar response from her mother, whereas her father was "ok with it." Fathers' responses also varied dramatically, but most participants did not focus upon their relationships with their fathers as intensely as their relationships with their mothers. Fathers were often described as "distant" and "never home," or "always at work."

Family systems—Dysfunction in one's family of origin was cited as a primary underpinning for depression. Participants often verbalized the reason for their depression as poor role modeling of "healthy ways" to interact within relationships and to cope with emotional difficulties. They also cited role-modeling negativity. For example, one participant stated, "I think I learned a negativistic view of the world, umm, pessimistic view of the world from my mother, I think that kinda sets you up for feeling depressed." Another woman stated, "I was not taught the tools I needed to be happy. My goal over the last few years had been to understand where my negativity comes from, and that mostly I was taught that by my parents." The participants' narratives mentioned code words relating to family 223 times, as reflected in the number of data bits saved in Atlas.ti. In comparison, they used 53 data bits to describe depressive feelings surrounding intimate relationships.

The ability to be out with family members was of great importance to the participants. The roots of the shame surrounding lesbianism were based on family of origin value systems. Five women were not able to come out to their families for much of their lives. For 4 women, religious values foreclosed the possibilities of discussing sexuality with their families. One woman, a 38 year-old corrections officer from a blue collar family knew innately that homosexuality was a forbidden topic. The overarching social stigma against homosexuality underpinned her family's rejection. Although her gender presentation was stereotypically butch and she had lived with two female partners in her adult life, she said, "Why would I tell them [my family]. They just disown you. I just call her my roommate."

Abandonment and neglect—The narratives of 9 participants identified their source of depression as abandonment and neglect. Some participants experienced physical abandonment, whereas others experienced emotional abandonment and neglect. The women who grew up in family systems impacted by alcohol or drug addiction were most severely affected by

abandonment and neglect. Stories of abandonment and neglect were emotionally difficult to retell and often were told through tears. One woman's whose alcoholic mother was mentally ill stated,

The focus of my family became caring for my mother and consequently what happened was I got lost. She had been my primary caregiver and when she no longer did that, and my father was absent, but when he was there he was focused on her... came the awareness that I was very alone and neglected.

The mother of a 29 year-old Latina participant died when she was two years old. Her maternal grandparents, both active alcoholics, raised her. This woman described abandonment as a central theme in her current therapy sessions. She described the following childhood experiences:

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 6 or 7 years old I called the police a couple of times because I was afraid.

Trauma Participants did not discuss childhood sexual and physical trauma often enough to be considered a thematic category. Only one woman described a serious history of sexual abuse. In contrast, 30% of the lesbians in one study sample reported sexual abuse histories (Matthews et al., 2002). Another woman in the present study stated that she had been sexually abused as a young girl by her first cousin but she "loved him very much" and when she realized the abuse was "wrong," she asked him to stop and he complied. She believed that this event never contributed to her depression. Another woman mentioned the word "molestation" once during 3 interviews, but never returned to this topic. Gaining a history of sexual abuse was not a study goal. The reasons the women did not divulge this type of information if it were a part of their histories are not clear since they were forthcoming about many other deeply personal issues.ma

Intimate relationships—All 12 women identified the breakup of an intimate relationship as the precipitating factor for their darkest and deepest depressive episodes. For most of the participants, these episodes were time limited and marked a process of grieving the loss of the partner and the relationship. A 66 year-old Caucasian woman relayed a common thread that ran through many stories:

I've been depressed a number of times in my life, usually over relationships, the ending of relationships, you know, or problems around relationships. I think probably that relationships are more important to me than other things like my career, so I think that's why there are more feelings surrounding relationships. I really hate the breakups.

The idea of life-long commitment in a monogamous relationship was central to the participants' concept of intimate relationships. Most described the depression they experienced following the ending of a relationship as a sense of failure as much as a sense of loss. They felt they should have "done more to save the relationship." An overarching belief clearly delineated by all participants was that intimate partnerships were the most significant relationships in their lives; each was intended to last "forever" and be a loving, supportive and a sexually exclusive arrangement.

Coping Strategies

The participants coped with depression using two primary types of strategies: by connecting to trained professionals for treatment, and by connecting to peers and to deeper aspects of themselves. The latter connections were more effective in lessening the impacts of depression,

whereas reaching out to experts gave them a sense of “doing something about the problem” and a sense of security while feeling vulnerable.

It is important to note that the majority of participants spoke about past substance abuse as a coping strategy. One woman still abused alcohol when her depression exacerbated while the others reported having discontinued substance abusing behaviors through involvement in 12-step programs or through their own efforts.

Medication and therapy—Depression was an uncomfortable and difficult feeling to manage alone. To treat their depression, the women consulted medical doctors, most often primary care physicians, and therapists. Six of the women were taking antidepressant medication and were involved in individual psychotherapy and/or couples therapy during the interviews. One woman had stopped taking medications and participating in therapy several years before the study. Four participants had received only therapy for their depression and only one woman in the study had never sought treatment from professionals.

All of the participants understood the biomedical model as an explanatory model for depression. Though the details were at times fuzzy, participants believed their depressions were caused by a “chemical imbalance” in their brain. They considered medical doctors as the appropriate diagnosticians and medications as a plausible treatment since depression was an organic brain disorder. Once on medication, however, none stayed on the prescribed regimen of medications. The women repeatedly went on and off antidepressants because they most commonly felt that they should “be able to handle my life without pills.” When symptoms were exacerbated, they would resume the medications.

Therapists—All participants but one had visited a therapist when feeling depressed at some point in their adult lives. They described therapeutic interventions as a type of interpersonal connection to help them through difficult times. One participant stated,

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.

None used a therapist for ongoing psychological treatment with a goal of changing their moods or behaviors, but rather as an outside resource to assist in traversing a difficult emotional period. This theme is reflected in this passage, “So I probably have seen counselors more at hard times, breakups, and rocky times in relationships.”

Alternative families—Participants identified non-heterosexual friends as the most important source of meaningful, emotional support. Reliance upon gay male and lesbian friends was the primary strategy used during times of relationship difficulties. Many women stated that their gay and lesbians friends would come to their homes and “drag me out of the house, so I wouldn't be alone.” One 40 year-old lesbian who self-identified as being of “mixed racial background” and a social worker described these friends as preventing depression, but most participants related that the friendships mitigated the embodied and emotional suffering caused by the depression of losing a relationship. The 40 year-old lesbian stated,

I believe there is a correlation between my sexuality and not being depressed. I think the people 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 friendships and a safety net that became like family....like an alternative family to the family I had been raised in.

Spirituality—Participants expressed a spiritual connection to the concept of a universal guiding truth as the most effective method of permanently changing the trajectory of depression. An impressive number of participants had some sort of “spiritual epiphany” or “awakening.” Four women described life-altering journeys into spiritual discoveries that changed them forever, 3 women were engaged in New Age spirituality movements, and one had become a “born-again Christian.” Another participant who identified as being on a “spiritual journey,” still struggled with depression but was working to “heal” herself by learning to turn her life over to her “Higher Power.” She was on medication and in therapy but believed that her Higher Power was the most meaningful and effective way to find happiness in her life. One participant said,

I was refusing to be defeated by my depression. I started meeting with this woman who was called a guide. I learned to live by a simple set of beliefs. 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. I always speak my truth, and I live with integrity.

A 56 year-old Caucasian in the medical field was a devout “born-again Christian.” She said that her faith did not conflict with her sexuality as homophobia within the Christian movement did not derive from the Bible but was “the promotion of some people’s personal agendas.” She stated,

In discovering my Faith, in looking at the moment of awakening, I realized I might be on this earth to do something for others. I realized that God is real and is concerned about people, and that was a life changing event for me, my perspective was changed forever.

The four women who described personal spiritual awakenings reported never experiencing debilitating depressive episodes again.

Dominant Discourses

The following three dominant discourses emerged from the interview data and were important in shaping the participants’ stories of depression.

Biomedical model—Participants understood depression to result from maladaptive brain chemistry combined with environmental factors involving families of origin. Because the dominant medical establishment locates depression in the individual brain, medical research and practice focuses upon treating brain chemistry. This discourse has become widely available to the lay public through advertisements by pharmaceutical companies for their antidepressant medications.

Dysfunctional families—The discourse of the dysfunctional family entered the public domain in the 1980s, again through the media. “Dysfunctional family” became a phrase that shared a common cultural meaning to most Americans (Healy, 2000). Many therapists also implement psychodynamic and interpersonal therapies that reinforce the connections between adult feelings and behaviors developed during childhood through relationships amongst family members. When asked to speak about depression, participants integrated these dysfunctional family tales into their stories with great ease. The categories Parents and Family Systems within the theme of Relational Dissonance offer representative data bits describing how participants integrated childhood experiences into their current understandings of why they suffer from depression.

Organized religion—The discourse of organized religion was also interwoven into the family of origin stories. The women who grew up in a family system that strictly adhered to

the tenets and practices of an organized religion had more difficulty accepting their homosexuality than those whose families did not rigorously adhere to religious teachings. Shame and guilt were part of participants' depressive narratives when rejection of their lesbianism was rooted in the family's strong religious affiliations. The most extreme story was told by a 62 year-old participant who had lived a closeted and guilt-ridden life for over 20 years. She did not come out to her mother until she was in her mid-fifties and her father had already died. She stated,

I was raised in [state] and pretty much the buckle of the Bible belt, very, very religious and very rural. When I first realized I was a lesbian I was 30 years old....I didn't have anyone to turn to and least of all the church...I had nobody to turn to...it was horrible, so I was totally alone and I had totally had to work it out so what I wound up saying was "so what if I go to hell?"

Another woman came out to her family at 17 years old, but she too was tortured by her religious upbringing and stated,

I started to know I was gay like in seventh grade and I would pray and I would ask God to stop me from thinking about women in that way. I knew something was wrong with me because I was raised Catholic and I'm Hispanic so I mean I was so freaked out and started to cry in my bedroom because I thought about women in that way and I thought I was going to burn in hell.

Alternative Discourses

Some participant's constructions of their sexual identities included alternative discourses that resisted social homophobia and heterosexism. If these alternative discourses were well integrated into their sense of identity, sexuality was not a part of their depressive narrative. These women were able to separate their positive feelings about their lesbianism from others' negative attitudes. The roots of these alternative discourses were in feminisms and the lesbian identity political movement of the 1970s.

Lesbian identity and feminisms—Many women navigated their sexual identity by embracing a form of feminism that reverses the dominant binary discourse of male/female and essentializes the loving, caring, and compassionate nature of women. This discourse is theoretically complex, but the public discourse took shape for many lesbians as a female dominant world, as reflected in this participant's passage: "Women are amazing creatures. Our hearts are just different. I think we have a capacity to love on many, many levels and in many different ways because we are women together and that is the way we are made." The majority of the women's stories showed a strong and proud lesbian identity discourse that gained popularity in the 1970s.

An assumption that prevailed across the narratives was the existence of a centralized and tangible lesbian community, an important aspect of the identity political movements. Participants either explained their relationship to the "the lesbian community" or their reasons to maintain distance from "the lesbian community." A 29 year-old woman going through a breakup referred many times to what "they" would think or be saying about her and the ex-partner. When I asked her to clarify who "they" were, she responded, "You know, the community. They always have something to say about you, they usually end up siding with someone during breakups." She then went on to explain how the community was supporting her because her ex-girlfriend had been unfaithful and "there are moral judgments in the community against that kind of behavior."

Alternative families and spirituality—As discussed above, the discourses of alternative families and spirituality were coping mechanisms for the participants. These alternative

discourses empowered these women to resist negative impacts of the dominant discourses of dysfunctional family and organized religion described above.

Discussion

The results of this critical ethnographic analysis of 12 lesbians' narratives on their experiences of depression show that they drew from both dominant and alternative social discourses to explain their experiences. Generalizations cannot be drawn from this small sample, but the narratives of this diverse group of lesbians offer insights into the ways sexuality is woven into lesbians' depressive experiences, augmenting the existing body of knowledge on depression in lesbians. Lesbian research has been plagued by over representation of white, middle-class, well-educated women. I attempted to address this issue, but met with only partial success. Attitudes about sexuality vary enormously based upon geography. The effects of geography are unknown but it can be assumed these may greatly impact stories of their experiences. Family support, support of friends, relationship status, relationship satisfaction, trauma histories, and outness are some of the variables identified in prior studies as impacting depression in lesbians (Ayala & Coleman, 2000; Matthews et al., 2002; Oetjen & Rothblum, 2000).

The lack of support from family of origin was described as a primary source of depression in this group of lesbians, consistent with previous findings (Ayala and Coleman, 2000). The narratives of this group of lesbians expand upon this idea and identify parental rejection of lesbianism, particularly mothers' rejection, as causing the most sadness. Support of friends positively impacted mood, and helped mitigate symptoms of depression, which also is consistent with previous findings (Ayala & Coleman, 2000; Oetjen & Rothblum, 2000). Relationship status did not contribute to depression in this study, whereas relationship satisfaction did. An essential aspect of relationship satisfaction was the quality of the interactions between partners. Satisfaction was linked to the depth of commitment, often in reference to monogamy and fidelity. Participants identified relationship difficulties as the primary reason to see a therapist.

Two types of social discourses within the participants' stories were identified: dominant discourses that reflected the prevailing beliefs of society, and alternative discourses that resisted prevailing beliefs. Depression was explained by two dominant discourses or explanatory models, the biomedical model and the psychodynamically based therapeutic model. The biomedical model identifies the source of depression as existing within the individual brain. The participants understood that antidepressant medications rebalance brain chemistry in similar ways that "insulin fixes diabetes." This model relinquished individual responsibility for depression, freeing participants from a sense of inadequacy and guilt, while simultaneously failing to recognize social responsibilities for depression. This explanatory model does not implicate other factors as causes of depression, e.g., the marginalization of populations and socioeconomic inequities.

It is interesting to note that only one woman described using any alternative treatment for depressive symptoms although lesbians have been reported to use complementary and alternative treatments (Matthews, Hughes, Osterman, & Kodl, 2005). One woman stated that she had tried acupuncture briefly but abandoned it for antidepressants. Eleven participants had previously taken or were currently taking antidepressant medication produced by pharmaceutical companies and prescribed by medical doctors.

These participants interpreted psychodynamically based therapeutic models into lay language as the *dysfunctional family* discourse. This model identifies the roots of depression as within family of origin dynamics. These women's depressive narratives show that this model can become a mechanism for individuals to avoid change. Some participants resigned themselves

to the fact that depression was an inevitable result of their upbringing. The category family systems identifies how the participants felt helpless to change behaviors or feelings as they believed depression was programmed into them since childhood.

Though depression was framed within the parameters of dominant discourses, sexuality was understood through alternative discourses that resist homophobia and heterosexism. These alternative discourses allow lesbians to move past “political agendas that assume gay citizenry’s affective fulfillment reside in assimilation, inclusion and ‘normalcy’” (Cvetkovich, 2003, p. 11).

To counter the negative impacts of familial rejection and discord, the participants identified strong emotional bonds with other lesbians and gay friends. The development of alternative families was a key component of coping with depression. Lesbian identity has served over its long history to “generate self-esteem and solidarity amongst lesbians” as well as to claim “a social space and break the silence around lesbians” (Kennedy & Davis, 1993, p. 373). The data indicate that the positive effects of the lesbian identity and feminist political movements of the 1970s have maintained a place within the lives of lesbians today. Feelings of lesbian pride, and appreciation for the positive aspects of their sexual difference from heterosexual society enabled many of these women to successfully offset the influences of institutionalized homophobia. It is unclear why some participants successfully embraced this alternative discourse while others did not embrace a strong lesbian identity.

Capturing the stories of lesbians speaking of their depression has added depth and breadth to our current understanding of this issue. It is very clear from the women’s narratives that a strong spiritual life, separate from religious life, and a strong social support network of lesbians and gays are potent factors in developing resiliency against the negative impacts of depression within lesbians. Practitioners can best assist lesbian clients by encouraging the exploration of these two possibilities in their lives. Discussions of spirituality within therapeutic settings may open new vistas to women who have not previously considered this aspect of their being. Negative experiences with organized religions may have foreclosed opportunities to pursue alternative spiritual approaches that bolster self concept.

Practitioners cannot generalize about the impact of sexuality upon lesbian clients’ moods. Sensitive inquiries based upon available knowledge will guide practitioners to effective areas of focus within therapeutic settings. Awareness of community resources available to help lesbians develop non-heterosexual support networks is important. Understanding the links amongst the acceptance or rejection of their sexuality by their family of origin, their development of an alternative family structure, and the client’s depression offers direction for the clinician.

The participants clearly indicated that a strong sense of lesbian identity was important as a mechanism in resisting the dominance of a heteronormativity. This identity politic implies the need to support legislation that normalizes the understanding of sexuality upon a continuum, rather than as a binary system. Nurses need to work at all legislative levels to recognize the rights of humans regardless of their sexuality and work toward the deconstruction of policies that limit freedoms based upon sexuality.

Conclusion

The relationship between depression and lesbianism is a complex interplay of several factors underpinned by shifting power struggles between dominant and alternative discourses. We now have a glimpse into understanding how lesbians conceptualize causative and palliative mediators of depression. Further critical research is needed into the areas of the social production of sexual identity and family systems, as well as investigating the factors allowing

some lesbians to embrace alternative discourses that resist the negative effects of heteronormativity and homophobia upon depression. As the body of knowledge about lesbians and depression continues to grow, practice and policy decisions must be based upon these research findings.

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