Archives of Sexual Behavior (2020) 49:2275–2279
https://doi.org/10.1007/s10508-019-01613-w

COMMENTARY

The Rejection Sensitivity Framework's Promise as a Guiding Force for the Development of Sexual and Gender Minority Mental Health Interventions

Richard T. LeBeau[1]

Received: 29 October 2019 / Revised: 12 December 2019 / Accepted: 14 December 2019 / Published online: 23 December 2019
© Springer Science+Business Media, LLC, part of Springer Nature 2019

Introduction

In the Target Article, Feinstein (2019) makes a compelling argument for increased attention to the rejection sensitivity framework by scholars in the field of sexual and gender minority (SGM) mental health. I agree that although minority stress theory (Meyer, 2003) and the psychological mediation framework (Hatzenbuehler, 2009) have made invaluable contributions to research in this area, complementary frameworks are needed to understand aspects of SGM mental health that are not fully attended to by those models. The rejection sensitivity framework (Downey & Feldman, 1996) makes great sense as a starting point due to its strong empirical support and its established relevance to SGM mental health, both of which Feinstein outlines.

Feinstein (2019) details multiple areas where the rejection sensitivity framework addresses nuances of the relationship between experiences of rejection and subsequent mental health issues that are not addressed (or at least not addressed in sufficient detail) by the other frameworks. Each of the four areas Feinstein highlights (i.e., emphasis on the role of perception, acknowledgment of multiple anticipatory emotions, specification of additional psychological mechanisms, and attention to temporal order) has the potential to guide research agendas in this area. I have little doubt that the specificity of the framework has the potential to be extremely valuable for filling in the significant gaps in our knowledge, but I also believe that the research that has already stemmed from the framework has direct implications for intervention development for SGMs in distress that can be acted upon as ongoing research aims to address these questions.

Based on what is already known from the psychological mediation and rejection sensitivity frameworks, researchers and clinicians have already begun adapting existing interventions and developing new ones that address SGM mental health issues. Some of these interventions, such as ESTEEM (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015), have demonstrated preliminary efficacy. But, given the enormity of the mental health disparities between SGMs and their heterosexual, cisgender peers (e.g., Cochran, Sullivan, & Mays, 2003), a variety of efficacious treatments are likely necessary. One of the many benefits of the rejection sensitivity framework is that it includes several specific mechanisms ripe for modification by psychological intervention. In fact, empirically supported psychological interventions for several mechanisms included in the framework already exist. Nevertheless, data on their use with distressed SGMs are extremely scarce and there are significant theoretical reasons to suspect that most would require significant adaptation for use with SGMs.

In this Commentary, I will first review relevant theoretical considerations regarding the development of novel treatments, and the adaptation of existing psychological interventions, for SGMs. Then, I will move on to specific examples of existing psychological interventions related to the mechanisms identified in the rejection sensitivity framework that hold particular promise for SGM mental health. I will also discuss what aspects of these psychological interventions might require modification for use with SGM populations. Finally, I conclude with some thoughts about the future directions of our field.

This Commentary refers to the article available at https://doi.org/10.1007/s10508-019-1428-3.

✉ Richard T. LeBeau
rlebeau@ucla.edu

[1] Department of Psychology, University of California, Los Angeles, 1285 Franz Hall, Box 951563, Los Angeles, CA 90095-1563, USA

Theoretical Issues in the Development and Adaptation of Interventions for Sexual and Gender Minorities

The question of whether distinct mental health interventions are needed for SGMs is fundamentally an unanswered one. In order to determine that unique interventions for SGMs are truly needed, it needs to be established that existing interventions are not as effective for distressed SGMs as they are for their distressed heterosexual, cisgender peers. Very little data have been published in this area and that which does exist is far from conclusive. The reason for this lack of data is in large part due to the longstanding lack of attention to sexual orientation and gender identity in clinical psychological research. In order to adequately answer the question of whether SGMs respond more poorly to interventions that were developed with heterosexual cisgender individuals in mind, intervention trials need to both (1) measure sexual orientation and gender identity in a conceptually sound and consistent manner and (2) either report pre- and post-intervention data on the variables of interest separately for sexual and gender minority subgroups or conduct appropriate moderator analyses. Historically, sexual orientation and gender identity have rarely been reported in intervention trials and when they have they have been measured using questions that were inconsistent at best and inaccurate at worst. Although some progress has been made with regard to the reporting of SGM status in clinical intervention trials, reporting of these demographic characteristics still significantly lags others such as race and ethnicity (and even variables like income and marital status, which have demonstrated far less of a consistent relationship with psychological functioning than SGM status). Even when the constructs are measured well, however, there is likely to be insufficient sample sizes of sexual and gender minority subgroups in most trials to carry out meaningful analyses (especially when one considers that notable differences between male and female members of these subgroups suggest that an even further breakdown of the groups for analyses may be necessary). Thus, we do not really know if SGMs tend to show a poorer response to psychological interventions than non-SGMs.

However, there is compelling evidence to suggest that existing psychological interventions are not meeting the needs of SGMs. The first is that the SGM mental health disparity persists despite evidence that suggests that SGMs utilize mental health resources more than non-SGMs (Bakker, Sandfort, Vanwesenbeeck, Van Lindert, & Westert, 2006; Filice & Meyer, 2018). This suggests that it may not be an issue of SGM's ability to access existing interventions or willingness to engage in them, but rather an issue of poorer outcomes following initiation of interventions. The second piece of evidence is that traditional interventions do not address essential features of the widely accepted theoretical frameworks that explain high rates of mental health issues among SGMs (e.g., discrimination, parental rejection, identity concealment). It logically follows that failure to address key factors in the development and maintenance of mental health problems may render interventions less effective.

Assuming that the much-needed research comparing SGM and non-SGM response to traditional interventions suggests that the development of unique interventions for SGMs are, in fact, warranted, it remains unknown to what degree new interventions need to be developed from scratch and to what degree existing interventions can be adapted for use with SGMs. Whereas building an intervention from the ground up allows it to be fully based on theory and empirical data and unencumbered by the limitations of what is already in use, the latter option has the benefit of being significantly less time- and resource-intensive, as the development of a novel treatment often involves years of development prior to being ready for a randomized controlled trial, whereas treatment adaptation can be a much quicker process (although hardly a simple one). It must be noted, however, that treatment adaptation is only a logical option if the following conditions are true: (1) the mechanisms contributing to the development and maintenance of psychological dysfunction are similar between the subgroup for whom the intervention is being adapted and the broader population for whom the intervention was initially designed and (2) effective interventions already exist for these mechanisms. By and large, the rejection sensitivity framework meets both of these conditions.

The framework posits that psychological distress for many SGMs involves processes such as anxious expectation of rejection, the perception of rejection in ambiguous scenarios, and the heightened affective and behavioral responses to rejection. These processes are hardly unique to SGM individuals. As Feinstein (2019) reviews, heightened rejection sensitivity is found across all populations (including individuals with no significant minority identity), as is the association between rejection sensitivity with past rejection experiences and poor mental health. Thus, support is provided for the first condition. Furthermore, each of the processes described by the rejection sensitivity framework has been shown to be modifiable by existing interventions. For example, cognitive restructuring is effective at managing exaggerated expectations of negative outcomes and negative interpretations of ambiguous situations. Furthermore, many techniques related to cognitive behavioral therapy (and particularly dialectical behavioral therapy) have been shown to be effective for maladaptive behavioral responding in response to rejection. Thus, there is support for the second condition as well.

But, if the mechanisms do not differ between SGMs and non-SGMs and effective interventions already exist for the mechanisms, then why would we need to adapt the treatments at all? Why not just deliver the interventions that are known to target key rejection sensitivity processes in their current form

to SGMs? The answer to this question is that even if the processes that need to be targeted by psychological interventions are similar between SGMs and non-SGMs, it does not necessarily follow that SGMs will engage in and benefit from the existing treatments in their traditional format. Multiple types of adaptation might be necessary, including explicitly acknowledging the etiological role of minority stress experiences in the patient's suffering (thus validating the patient's experience and enhancing insight), addressing unique barriers to implementing the skills being taught in the intervention outside of therapy, ensuring patient's safety when applying skills learned in treatment outside of the therapy room in an environment that continues to marginalize SGMs, and making the intervention appear relevant and appealing to patients with a long history of being marginalized by the mental health and medical systems.

Amidst this discussion, it is important to keep in mind that despite the demonstrated relevance of rejection sensitivity to SGM mental health, interventions rooted in this framework are not indicated for all SGMs presenting for mental health treatment. Although minority stress is relevant to all SGMs, the degree to which it is relevant to a given individual's presenting problem varies greatly. Additionally, although heightened rejection sensitivity is commonly found among SGMs struggling with mental health problems, it is not an essential feature experienced by all. As with all individuals presenting for mental health treatment, the selection of the appropriate intervention must be rooted in a theoretically sound, comprehensive biopsychosocial conceptualization of the individual seeking treatment. In the next section, I provide specific examples of how existing evidence-based interventions may be adapted for distressed SGMs with elevated rejection sensitivity.

Examples of Intervention Adaptations for SGM Mental Health

The ESTEEM intervention provides an excellent model for how existing psychological interventions can be adapted to incorporate theoretically grounded, SGM-relevant content (for a description, see Burton, Wang, & Pachankis, 2017). The intervention involves adapting the Unified Protocol (Farchione et al., 2012) through the lens of minority stress theory (Meyer, 2003) and the psychological mediation framework (Hatzenbuehler, 2009) to make the content more relevant to young gay and bisexual men (the target population for this specific intervention). Notably, the specific tenets of the treatment remained the same, with its focus on psychoeducation regarding the interplay between thoughts, feelings, and behaviors; cognitive interventions to modify dysfunctional thought patterns; and behavioral interventions to overcome maladaptive avoidance behaviors. However, the presentation and delivery of each of these facets of treatment were carefully modified based on the frameworks described and feedback from sexual minorities.

Although the development of ESTEEM marks an important milestone in the field of SGM mental health, the work is far from done. Further evaluation of the intervention is needed and, if evidence continues to support its efficacy, ongoing research to apply the intervention to other SGM subgroups (e.g., sexual minority women, gender minorities, older male sexual minorities) is needed. Such research requires careful attention to the complex issue of intersectionality. All SGMs presenting for treatment possess multiple other identities (e.g., race, ethnicity, age, religion, economic status, ability level) and some of these identities may also be stigmatized. In such cases, approaching the individual's distress solely from the lens of their SGM status is likely to be insufficient.

In addition to efforts to address intersectionality, efforts to make such interventions more accessible will also be necessary. It is widely recognized that the need for evidence-based mental health resources drastically exceeds their availability. As such, the field of clinical psychology is actively searching for alternatives to the model of individual weekly psychotherapy with a doctoral-level provider that is utilized by ESTEEM, as well as the majority of existing evidence-based interventions. Efforts to address this issue have included training paraprofessionals to deliver psychological interventions, making interventions briefer and more mechanistically targeted, using stepped care models, and the development of digital interventions. The latter in particular has the potential to drastically increase access to effective psychological interventions. Below, I take a brief look at two interventions that are relevant to rejection sensitivity processes and have a demonstrated ability to be delivered in a digital format. I briefly review each and consider why adaptation may be necessary for their use with distressed SGMs.

Cognitive Bias Modification

Cognitive bias modification (CBM) refers to interventions that aim to alter automatic cognitive processes implicated in psychopathology. Research has primarily focused on attention bias modification (ABM) and cognitive bias modification for interpretation (CBM-I). A recent meta-analysis of meta-analyses found mixed results for their efficacy (see Jones & Sharpe, 2017), but many of the existing studies have significant limitations, including a focus on non-clinical samples as well as heterogeneous administration and outcome measurement. CBM has garnered much attention in the field recently, in large part due to the fact that it is both a mechanistically targeted and scalable intervention.

Both ABM and CBM-I have direct relevance for processes described by the rejection sensitivity framework. Specifically, ABM addresses the biased attention to situational aspects indicative of potential threat when individuals are anxiously expecting rejection or in ambiguous situations where rejection is readily perceived. CBM-I addresses the dysfunctional

thinking patterns that lead individuals high in rejection sensitivity to perceive threat in ambiguous situations, which leads to exaggerated and often maladaptive cognitive and behavioral responses. Although ABM and CBM-I using socially relevant content have the potential to reduce these biases in a manner that can disrupt the negative cycle detailed by the rejection sensitivity framework, there are significant potential issues with applying them in their traditional form to highly distressed SGMs.

ABM and CBM-I are largely based on the assumption that the individual is mistakenly detecting threat in situations that are actually benign. The reality is that despite improvements in conditions for SGMs in recent years, the environment is still a hostile one in many ways. For example, the majority of states in the USA do not have laws protecting workplace discrimination based on SGM status and hate crimes targeting SGM individuals remain prevalent. Thus, training SGM individuals to not attend to indicators of threat or reinterpret situations in a more neutral way has the potential to be inaccurate and invalidating (as very real threats may exist) and, in extreme cases, unsafe. Thus, in addition to including content that is relevant to the social fears of rejection sensitive SGMs, ABM and CBM-I need to be modified to help SGMs distinguish between accurate perceptions of threat that are self-protective versus distorted perceptions of threat that keep many SGMs in a state of isolation and chronic psychological distress.

With regard to CBM-I, one potential modification is to shift the focus away from restructuring the perceptions of another's intention and toward restructuring the patient's internalization of the situation. For example, if a transgender individual is at a work event and overhears a colleague making dehumanizing transphobic jokes, cognitive restructuring focused on the colleague's true intention and the objective presence of discrimination are largely futile (as the evidence clearly suggests that the colleague is bigoted and a discriminatory act clearly occurred). Instead, CBM-I could focus on how the colleague's comments are internalized by the patient. For example, the patient may internalize this experience as further evidence that they are defective or that it is impossible for them to safely be open about their gender identity in any work setting. CBM-I would thus have to validate the painful reality of the discriminatory event while simultaneously helping the individual restructure the dysfunctional internalization of the event.

Behavioral Activation

Behavioral activation (BA) is a goal-oriented intervention that aims to re-engage individuals back into their regular routines when they have been disrupted by stress and mental health issues. Specifically, BA focuses on increasing activities that have the potential to provide positive reinforcement and decreasing escape or avoidance behaviors that provide negative reinforcement (Martell, Dimidjian, & Herman-Dunn, 2013). It is considered a front-line treatment for depression (Parikh et al., 2016) and has demonstrated efficacy for other mental health issues, including anxiety disorders (Kanter et al., 2010). A recent meta-analysis found promising outcomes for behavioral activation when delivered digitally, although most of these studies were conducted in non-clinical populations (Huguet et al., 2018). BA has remained a popular intervention due to its straightforward rationale, goal-oriented nature, and applicability to a variety of mental health issues.

The relevance of BA to the Rejection Sensitivity Framework is somewhat less obvious than that of CBM. However, a common feature of heightened rejection sensitivity is avoidance of situations where rejection might occur. Such avoidance often results in chronic inactivity and social isolation. Thus, treatment for highly rejection sensitive individuals often requires increasing their engagement in a wide variety of activities, particularly those that are social in nature. However, for many distressed SGMs, a straightforward BA protocol may not address key issues related to identity development and discrimination. For example, a lesbian woman who is not "out" to her family and colleagues may face unique barriers when trying to make friends or find dating partners. Similarly, an individual who is in the process of gender transition may face a host of issues while engaging in daily activities that are not experienced by cisgender individuals. Unfortunately, microaggressions and more overt discrimination are a common feature of the social world for most SGMs and psychological interventions will likely need to address them in order to be effective.

The process of applying BA to the unique needs of distressed SGMs likely involves the addition of components not typically included in BA. For individuals who are not "out," the possibility of identity disclosure during activation activities needs to be considered. For those who live in hostile contexts, safety planning may need to be considered for SGMs who are engaging in certain activities. There is also evidence to suggest that BA for SGMs in distress may be enhanced by increasing exposure to SGM-affirmative messages, be it through art and education, increased involvement in SGM community organizations, or some other means (LeBeau & Jellison, 2009; Morris, McLaren, McLachlan, & Jenkins, 2015).

Conclusions

Although concerted, ongoing efforts to improve conditions for SGMs in every domain of life are essential, such societal change is inevitably going to be slow and unlikely to meet the urgent needs of highly distressed SGMs. An improvement in our understanding of how minority stress experiences contribute to elevated mental health problems in SGMs is vitally important, particularly insofar that this increased understanding translates to improved intervention and prevention efforts for the population.

Feinstein (2019) makes a compelling argument that scholars in the field of SGM mental health research should consider integrating the rejection sensitivity framework into their research agendas. I extend this to suggest that the rejection sensitivity framework has direct implications for intervention development for distressed SGMs that can be readily applied. One form that this can take is the adaptation of existing psychological interventions to meet the unique issues with which SGMs present.

In addition to providing a nuanced consideration of how the rejection sensitivity framework can complement the minority stress theory and the psychological mediation framework, Feinstein (2019) also more broadly provides a model for how we can integrate other theoretical frameworks into research agendas for the advancement of SGM mental health research. The rejection sensitivity framework is a great place to start, but it is hardly the only theoretical framework that can be integrated into SGM mental health research to improve intervention and prevention efforts. Hopefully, my Commentary encourages scholars to consider other theoretical frameworks that can be leveraged to address this urgent public health need.

Undoubtedly, systematic programs of research incorporating numerous theoretical frameworks are sorely needed to move our field forward (for a review of vital research questions in this area, see Pachankis, 2018). However, the field of SGM mental health is most likely to benefit not from a lengthy, sequential process in which theoretically driven laboratory research eventually progresses into the development, evaluation, and dissemination of interventions but rather from the close integration of basic research in experimental psychopathology and applied research in clinical science (for a conceptual review of the relationship between the two fields, see Waters, LeBeau, & Craske, 2017).

Compliance with Ethical Standards

Conflict of interest Dr. LeBeau has no potential financial conflicts of interest relevant to this work.

References

Bakker, F. C., Sandfort, T. G., Vanwesenbeeck, I., Van Lindert, H., & Westert, G. P. (2006). Do homosexual persons use health care services more frequently than heterosexual persons?: Findings from a Dutch population survey. *Social Science and Medicine, 63*(8), 2022–2030.

Burton, C. L., Wang, K., & Pachankis, J. E. (2017). Psychotherapy for the spectrum of sexual minority stress: Application and technique of the ESTEEM treatment model. *Cognitive and Behavioral Practice, 26*(2), 285–299.

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53–61.

Downey, G., & Feldman, S. I. (1996). Implications of rejection sensitivity for intimate relationships. *Journal of Personality and Social Psychology*, *70*, 1327–1343.

Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J. R., … Barlow, D. H. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy, 43*(3), 666–678.

Feinstein, B. A. (2019). The rejection sensitivity model as a framework for understanding sexual minority mental health. *Archives of Sexual Behavior*. https://doi.org/10.1007/s10508-019-1428-3.

Filice, E., & Meyer, S. B. (2018). Patterns, predictors, and outcomes of mental health service utilization among lesbians, gay men, and bisexuals: A scoping review. *Journal of Gay & Lesbian Mental Health, 22*(2), 162–195.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730.

Huguet, A., Miller, A., Kisely, S., Rao, S., Saadat, N., & McGrath, P. J. (2018). A systematic review and meta-analysis on the efficacy of internet-delivered behavioral activation. *Journal of Affective Disorders, 235,* 27–38.

Jones, E. B., & Sharpe, L. (2017). Cognitive bias modification: A review of meta analyses. *Journal of Affective Disorders, 223,* 175–183.

Kanter, J. W., Manos, R. C., Bowe, W. M., Baruch, D. E., Busch, A. M., & Rusch, L. C. (2010). What is behavioral activation?: A review of the empirical literature. *Clinical Psychology Review, 30*(6), 608–620.

LeBeau, R. T., & Jellison, W. A. (2009). Why get involved? Exploring gay and bisexual men's experience of the gay community. *Journal of Homosexuality, 56*(1), 56–76.

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2013). *Behavioral activation for depression: A clinician's guide*. New York: Guilford Press.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.

Morris, S., McLaren, S., McLachlan, A. J., & Jenkins, M. (2015). Sense of belonging to specific communities and depressive symptoms among Australian gay men. *Journal of Homosexuality, 62*(6), 804–820.

Pachankis, J. E. (2018). The scientific pursuit of sexual and gender minority mental health treatments: Toward evidence-based affirmative practice. *American Psychologist, 73*(9), 1207–1219.

Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology, 83*(5), 875–889.

Parikh, S. V., Quilty, L. C., Ravitz, P., Rosenbluth, M., Pavlova, B., Grigoriadis, S., … CANMAT Depression Work Group. (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: Section 2. Psychological treatments. *Canadian Journal of Psychiatry, 61*(9), 524–539.

Waters, A. M., LeBeau, R. T., & Craske, M. G. (2017). Experimental psychopathology and clinical psychology: An integrative model to guide clinical science and practice. *Psychopathology Review, 4*(2), 112–128.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.