Published in final edited form as:

AIDS Behav. 2016 April ; 20(4): 763–767. doi:10.1007/s10461-015-1224-6.

Gay-Related Rejection Sensitivity as a Risk Factor for Condomless Sex

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Abstract

Gay-related rejection sensitivity has been linked to numerous adverse health outcomes, but its relationship to condomless sex remains unexamined. The present study investigated the role of gay-related rejection sensitivity as a predictor of condomless sex. Gay and bisexual men completed questionnaires measuring rejection sensitivity and condom use self-efficacy as well as a timeline follow back interview regarding past 90-day sexual behaviors. Gay-related rejection sensitivity was positively associated with the number of condomless anal sex acts with casual partners, and condom use self-efficacy mediated this association. These findings have important implications for effective HIV prevention efforts among this at-risk population.

Keywords

gay and bisexual men; rejection sensitivity; sexual behavior; condom use; self-efficacy

INTRODUCTION

Gay, bisexual, and other men who have sex with men represent the population most severely affected by HIV in the U.S. and one of the only risk groups in the U.S. for whom new HIV infections continue to rise (1). While this HIV disparity arises from a complex host of biological, psychological, and social factors, stigma, manifested through both structural barriers (e.g., lack of relevant sex education in schools) and interpersonal discrimination, has been identified as a key contributor (1). One pathway through which stigma might operate to influence HIV risk is chronic hypervigilance, especially in the form of expectations of gay-related rejection (2). Although gay-related rejection sensitivity has been associated with a wide range of adverse behavioral health outcomes highly correlated with HIV risk, such as substance use and sexual compulsivity (3, 4), its relationship with risky sexual behaviors has not been directly assessed. Thus, the present study sought to clarify the role of rejection sensitivity as a predictor of condomless sexual encounters among gay and bisexual men.

Defined as the extent to which one anxiously expects and readily perceives rejection, rejection sensitivity was first conceptualized as a biased cognitive-affective schema underlying problematic interpersonal functioning in close relationships. Since then, it has served as a useful construct for understanding some of the unique difficulties faced by members of stigmatized groups. As targets of prejudice and discrimination, stigmatized individuals can be prone to developing expectations for rejection based on their socially devalued identity, which can have significant cognitive, affective, and behavioral consequences distinct from those associated with general interpersonal rejection. For example, African American students who experienced greater anxious expectations of race-based rejection reported greater discomfort during their transition to college, poorer academic performance, and fewer White friends (5).

Pachankis and colleagues (2) extended the construct of rejection sensitivity to gay and bisexual men, who often encounter rejection due to their sexual orientation and are more likely than heterosexual men to experience fear of negative evaluation, social avoidance, and interpersonal distress. Across a series of studies, gay-related rejection sensitivity has been linked to a wide range of adverse mental and behavioral health outcomes, including depression, social anxiety, sexual compulsivity, and substance use (2–4, 6). Although limited research has examined the relationship between gay-related rejection sensitivity and risky sexual behaviors, existing evidence suggests that the two might be closely linked. Specifically, social anxiety, characterized by fear of and apprehension about being negatively evaluated in social or performance situations, has been identified as a risk factor for condomless sexual intercourse among gay and bisexual men (7). Furthermore, anticipation of stigma-related threat can deplete self-regulatory resources: African American college students who were more sensitive to race-based rejection reported a lower sense of academic self-efficacy (8). Given that self-efficacy has been shown to play an important role in condom use decisions (9), we believe that it might serve as an important mechanism underlying the association between gay-related rejection sensitivity and risky sexual behaviors.

The present research extends previous work by investigating associations among gay-related rejection sensitivity, condom use self-efficacy, and condomless anal sex. Specifically, we hypothesized that gay-related rejection sensitivity would be positively associated with the number of condomless anal sex encounters with casual partners in the past 90 days. We further hypothesized that the association between gay-related rejection sensitivity and condomless anal sex would be mediated by condom use self-efficacy, an individual difference measure of self-efficacy for condom use across various situations (10). In our sample of HIV-negative young men recruited before widespread knowledge and uptake of biomedical prevention interventions (i.e., pre-exposure prophylaxis), we specifically chose to focus on condomless anal sex with casual partners as our primary outcome measure. Our sample was also selected for reporting symptoms of depression or anxiety. Given that about 40% of gay and bisexual men report lifetime mood or anxiety disorder diagnoses (11) and that mental health impairment represents a syndemic health condition driving HIV risk among this population (4), our sample represents an important risk group in need of targeted research and interventions.

METHODS

Participants

Analyses for this paper were conducted using the baseline data from a pilot trial of a stigma coping intervention for young gay and bisexual men. Participants were recruited through advertisements posted to social and sexual networking websites and mobile applications (e.g., sex party listserves, Facebook, Grindr), college campus counseling centers, and community-based organizations. All participants completed a brief screening questionnaire, either on-line or over the phone, to confirm eligibility, which was defined as: (1) being born male and currently identifying as a man, (2) gay or bisexual identity, (3) being between ages 18 and 35; (4) being fluent in English; (5) residing in the New York City area; (6) being HIV-negative; (7) engaging in HIV risk behavior (i.e., at least one instance of condomless anal sex with a casual male partner or with an HIV-positive or status-unknown main male partner), (8) experiencing symptoms of depression and anxiety in the past 90 days, and (9) not currently receiving regular mental health services (i.e., not more than once a month).

Data were taken from the 63 sexual minority men who enrolled in the intervention study and completed all baseline assessment questions. As can be seen in Table 1, the sample was diverse with regards to racial/ethnic background, employment status, and educational attainment. A large majority was gay/queer-identified. Consistent with eligibility criteria, ages ranged from 18 to 35 ($M = 25.71$, $SD = 4.24$).

Measures

As part of the baseline assessment for the trial, participants completed measures of both gay-related rejection sensitivity and condom use self-efficacy via Qualtrics, a popular Internet-based survey platform. Past 90-day condomless anal sex was assessed by an interviewer-administered timeline follow-back (see below).

Gay-related Rejection Sensitivity Scale (GRS) (2)—The GRS assesses anxious expectations of rejection using 14 vignettes that gay and bisexual men rate in terms of the degree to which they would be anxious about being rejected in the situation because of their sexual orientation, from 1 (*very unconcerned*) to 6 (*very concerned*), and the degree to which they would expect such rejection from 1 (*very unlikely*) to 6 (*very likely*). An example vignette is: “A 3-year old child of a distant relative is crawling on your lap. His mom comes to take him away.” For each vignette, participants’ responses to the anxiety scale are multiplied by their expectation scale score and an average of the 14 resulting scores is taken. Internal consistency was $\alpha = 0.91$ in the present study.

Safer Sex Self-Efficacy Questionnaire (SSSE) (10)—The 13-item SSSE assesses self-efficacy for condom use in various situations (e.g., “When you really need affection,” “When your partner says he/she does not want to use a condom”) in response to the prompt, “How confident are you that you could avoid having anal sex without a condom?” using a scale ranging from 1 (*not at all tempted*) to 5 (*extremely tempted*). The SSSE predicts condomless anal intercourse among gay and bisexual men (Rendina, 2014). In the present study, the SSSE demonstrated strong internal consistency ($\alpha = 0.94$).

90-day Time Line Follow Back (TLFB) (12)—Past 90-day condomless anal sex was assessed with the TLFB. In the TLFB, a trained interviewer reviews a past-90-day calendar and life events (e.g., parties, vacations) with each participant to assess participants' engagement in risk behavior during that time. The TLFB demonstrates strong reliability and validity, including agreement with real-time assessments and collateral reports of sexual risk. Each day was coded for sexual partner type (main, casual) and condom use. The total number of condomless anal sex acts with a casual partner over the 90-day period ($M = 5.17$, $SD = 6.50$) served as our outcome variable.

Data Analysis

We began by conducting a series of Poisson regression analyses to examine the bivariate associations between demographic characteristics (i.e., age, race/ethnicity, education, relationship status) and past 90-day condomless sex. Given the small number of participants in each of the racial/ethnic and educational categories, these variables were recoded into White (52.4%) vs. non-White (47.6%) and less than college (63.4%) vs. having a bachelor or graduate degree (36.6%). Demographic characteristics that were significantly associated with past 90-day condomless sex were included as covariates in the subsequent analysis. We then utilized *Mplus* version 7.3 to conduct a path analysis to examine our hypothesis that condom use self-efficacy would mediate the association between gay-related rejection sensitivity and past 90-day condomless sex. We opted to use path analysis because past 90-day condomless sex constitutes a count outcome variable, which cannot be accommodated by traditional mediation analyses that rely on linear regression. All variables were treated as manifest (i.e., observed) indicators to achieve an adequate estimated parameters to sample size ratio. The *Mplus* default of maximum likelihood estimation was used to calculate all paths. Unstandardized regression coefficients, along with their corresponding test statistics and p-values, are reported throughout the manuscript.

RESULTS

Preliminary analyses indicated that, of all demographic variables, only age was significantly associated with past 90-day condomless sex, $b = .04$, $SE = .01$, Wald statistic = 10.85, $p = .001$. Thus, we included age as a covariate in the subsequent mediation analysis.

We proposed that gay-related rejection sensitivity would be associated with lower condom use self-efficacy, which would in turn predict a greater number of condomless anal sex acts with casual partners in the past 90 days. We examined these hypothesized pathways using the model depicted in Figure 1, which demonstrated an adequate sample size to number of free parameters ratio of approximately 10:1 (13). Consistent with the idea that anxious expectations of sexual-orientation-based rejection would deplete self-regulation resources needed to avoid sexual risk-taking, gay-related rejection sensitivity was significantly associated with lower condom use self-efficacy, $b = -.43$, $SE = .20$, $t = -2.16$, $p = .03$. Also as expected, lower condom use self-efficacy was significantly associated with more instances of condomless anal sex, $b = -.04$, $SE = .01$, $t = 7.75$, $p < .001$. In line with our mediation hypothesis, there was a significant indirect effect of gay-related rejection

sensitivity on condomless sex through condom use self-efficacy, $b = .02$, $SE = .01$, $t = 2.08$, $p = .04$.

DISCUSSION

The current study examined the role of gay-related rejection sensitivity as a predictor of risky sexual behaviors among gay and bisexual men. In particular, we found that anxious expectations of sexual-orientation-based rejection were positively associated with the number of condomless anal sex acts with casual partners in the past 90 days. Furthermore, this relationship was significantly mediated by condom use self-efficacy: Gay-related rejection sensitivity was associated with lower self-efficacy for condom use, which in turn predicted a higher number of condomless anal sex acts. These findings suggest that, in addition to predicting a wide range of behavioral health outcomes related to HIV risk (e.g., substance use, sexual compulsivity), gay-related rejection sensitivity can also serve as a psychosocial pathway through which stigma operates to influence risky sexual behaviors.

These findings have theoretical and practical implications for stigma research and HIV prevention. Theoretically, whereas race-based rejection sensitivity has been linked to the depletion of self regulatory resources (8) and the experience of identity threat (5), gay-related rejection sensitivity has primarily been conceptualized as an interpersonal process: Anxious expectations of sexual-orientation-based rejection have been proposed to hinder safe sexual practices through their association with unassertive interpersonal behaviors (2, 7). By focusing on condom use self-efficacy as a mediator, the present research highlights a novel intrapersonal mechanism underlying the association between rejection sensitivity and sexual risk. Practically, despite the role of stigma as a major contributor to the HIV disparity experienced by sexual minority men (1), few HIV prevention interventions to date have directly addressed stigma-related stress and the skills needed to cope with such stress. In line with previous research on the relationship between stigma and sexual minority health (2–4, 6), the present findings speak to the importance of addressing minority stress processes, including gay-related rejection sensitivity, in HIV prevention interventions geared towards gay and bisexual men.

The current investigation has several limitations. First, due to the cross-sectional, correlational design, we were limited in our ability to draw definite conclusions regarding the causal relationships among variables of interest. Future research using longitudinal and experimental designs is needed to ascertain the role of gay-related rejection sensitivity as a predictor of sexual risk. For instance, a diary approach can be used to capture the association between baseline or time-fluctuating gay-related rejection sensitivity and daily risky sexual behaviors, thereby minimizing recall bias while accounting for relevant contextual factors (e.g., specific experiences of prejudice and discrimination on any given day). Furthermore, determining whether an intervention designed to alleviate gay-related rejection sensitivity can improve condom use self-efficacy and thereby reduce condomless sex represents another promising direction for future research.

Additionally, because participants in the current study were recruited for an intervention trial, the sample was relatively small, homogeneous, and limited in its representativeness. Specifically, although the sample was diverse in terms of race/ethnicity, employment status,

and educational attainment, consistent with eligibility criteria all participants were young adults living in New York City, engaging in HIV risk behavior, and experiencing depression and anxiety symptoms during the past 90 days. These sampling characteristics provide us with a unique opportunity to test our hypotheses with those gay and bisexual men who were particularly at risk for HIV infection, especially considering that young adulthood represents a developmental period during which behavioral patterns are formed, mental health problems for gay and bisexual men are prevalent, and identity-related stress is particularly likely to impair health. Nevertheless, considering that internalizing mental health symptoms are closely linked to gay-related rejection sensitivity and sexual risk (6, 7), future research should carefully examine the generalizability of our findings to gay and bisexual men without elevated depressive and anxiety symptoms. Furthermore, although our path model does not contain any latent variables and has an adequate sample size to parameters ratio of 10:1, our results should be regarded as preliminary given the small absolute sample size. As such, the present findings warrant confirmation by future studies with larger samples, which would not only yield more precise results but also allow a more comprehensive examination of how gay-related rejection sensitivity might interact with other known risk factors (e.g., substance use, intimate partner violence, number of sexual partners) to predict condomless sex.

Lastly, we acknowledge that condom use self-efficacy, which served as our hypothesized mechanism underlying the association between gay-related rejection sensitivity and condomless sex, was not a direct measure of self-regulation; rather, it captured participants' perceptions of their own ability to engage in self-regulation in a very specific behavioral domain (i.e., condom use). Future experimental research could productively examine the effect of gay-related rejection sensitivity on self-regulatory resources by using lab-based measures of attentional and physical self-regulation, such as the Stroop task and the physical exertion paradigms in response to direct threats to one's stigmatized identity (8). In sum, the present study contributes to our understanding of how gay-related rejection sensitivity, an important individual-level stigma process that has been linked to numerous adverse health outcomes, might operate to influence HIV risk among gay and bisexual men. Additionally, it provides a starting point towards a more fine-grained understanding of the intrapersonal processes (e.g., self-regulation) underlying the association between stigma and sexual minority health.

Acknowledgments

This project was supported by a research grant from the National Institute of Mental Health (R34-MH096607; PI: John E. Pachankis). Katie Wang was supported by a training fellowship from the National Institute of Mental Health (T32-MH020031). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. We thank Trace Kershaw and members of the Center for Interdisciplinary Research on AIDS, HIV Prevention Training Fellowship, for their feedback on an earlier version of this manuscript.

We would also like to acknowledge the contributions of the ESTEEM research team: Evie Arroyo, Aliza Boim, Demetria Cain, Michael Castro, Chris Cruz, Sitaji Gurung, Ethan Fusaris, Ruben Jimenez, Douglas Keeler, Alexa Michl, Brett Millar, Chloe Mirzayi, Theresa Navalta, Luis Nobrega, Brian Salfas, Martez Smith, Laurie Spacek, Rachel Proujansky, Anita Viswanath, Jonathan Warren, and Thomas Whitfield.

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Figure 1.
Gay-Related Rejection Sensitivity Predicting Sexual Risk

Table 1

Sample Demographics

	<i>n</i>	%
Race		
Black/African American	10	15.9
White	33	52.3
Asian/Pacific Islander	5	7.9
Other/Multiracial	15	23.9
Hispanic/Latino		
Yes	23	36.5
No	40	63.5
Sexual Orientation		
Gay, queer, or homosexual	58	92.1
Bisexual	5	7.9
Employment Status		
Full-time	25	39.7
Part-time	20	31.7
Student (unemployed)	10	15.9
Unemployed (including disability)	8	12.7
Highest Educational Attainment		
High school diploma or GED	8	12.7
Some college or Associate's degree	32	50.8
Bachelor's or other 4-year degree	17	27.0
Graduate degree	6	9.5
Relationship Status		
Single	52	82.5
Partnered	11	17.5