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Rejection Sensitivity and Minority Stress: A Challenge for Clinicians and Interventionists

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Minority Stress Theory (MST) makes a simple argument: stigma and prejudice that are directed at sexual and gender minorities (SGM) in our society bring about a variety of stressors (Hendricks & Testa, 2012; Meyer, 2003b; Testa, Habarth, Peta, Balsam, & Bockting, 2015). Stigma and prejudice, thus, are unique sources of stress that add to the stress that is ubiquitous in our society and to which everyone is exposed. Minority stress, like all stress theory, also recognizes the important roles of social support and coping in moderating the impact of stress (more recently, the term *resilience* has been preferred, but it has a similar meaning in the stress process, see Meyer, 2015). Because of the added exposure to stress, MST predicts that, all else being equal (e.g., at the same level of social class), SGM will experience more stress than heterosexual cisgender people. In turn, because of the role of stress in health, minority stress leads to adverse health outcomes among SGM and accounts for the resultant health disparities between SGM and their cisgender heterosexual counterparts. Although minority stress describes stress processes, including mediators and moderators, as they impact health outcomes, a broader perspective shows that the entire minority stress model is itself a mediator of the relationship of social status and health outcomes (Meyer, 2003b; Meyer, Schwartz, & Frost, 2008, see Fig. 1). The contribution of MST has been to explain how social structures characterized by homophobia and transphobia impact the health of SGM. I believe that the importance of minority stress has been in articulating a framework that identifies the cause of disease in anti-LGBT prejudice. This framework contrasts with the idea that pathology is inherent in sexual and gender minority identity, something opponents of LGBT rights have been trying to convey, with echoes of this argument reverberating from the debates on the classification of homosexuality as a mental disorder (Bayer, 1981). In developing MST, I did not aspire to describe all of the many factors that can contribute to individual variation in health outcomes. Minority stress does not account for many causes of health disorders—it does not include familial dynamics, personality, genetics, neurological, and other factors, except if they are related to homophobia or transphobia.

In his Target Article, Feinstein (2019) proposes to add a new element, rejection sensitivity, to the minority stress model. Rejection sensitivity has been identified as an important process to address in treating mental health problems among LGBT people in clinical settings

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(Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). When we consider adding additional elements to the minority stress model, we need to consider the implication of the addition to the original framework of minority stress as a social process. As Feinstein notes, rejection sensitivity is an individual variable that focuses on the person's interpretation of stress rather than the objective stressor that the person was exposed to—that is, stress is understood as a subjective, interpretational experience. The notion of *stress* as a subjective, or an *appraisal*, process has as solid a background as does the view of stress as objective, most importantly in the seminal book by Lazarus and Folkman (1984), titled *Stress, Appraisal, and Coping*. Describing their concept of stress and the importance of the appraisal process, Lazarus and Folkman (1984) used a striking quote from Shakespeare's *Hamlet* to exemplify the importance of appraisal: "There is nothing either good or bad, but thinking makes it so" (p. 24).

But this view of stress differs from the stress perspective I have been promoting. As I have described before, following Dohrenwend (1998) and Pearlin (1993), an "objective view defines stressful life events as real and observable phenomena that are experienced as stressors because of the adaptational demands they impose on most individuals under similar circumstances. The subjective view defines stress as an experience that is contingent on the relationship between the individual and his or her environment. This relationship depends on properties of the external event but also, significantly, on appraisal processes applied by the individual" (Meyer, 2003a, p. 263). That is, stress viewed as an objective exposure is assessed not by how it is understood or processed (or appraised) by the person, but by the potential it has to demand adaptation on similarly situated persons. Losing a job is a stressor not because of how a specific person experiences it but because it is a significant stressful event for most people. (Of course, there are differences in the actual impact of the event on any specific person that depend on characteristics of the person and the event, but in this view of stress, and in the minority stress model, these are understood as part of the mediating and moderating effects of other elements of the stress process, like coping and social support).

To be clear, I emphasize these distinctions for heuristic purposes. The objective stress perspective does not deny the importance of the individual as an appraiser, and the subjective perspective does not deny the importance of external events and conditions (after all, without external events and conditions, there would be nothing for the individual to appraise). Still, this seemingly semantic-only difference in the definition of stress raises important issues about our understanding of stress and health. The very notion of *stress* (which appeared in writings explaining health only after World War II) represented a conceptual shift from consideration of internal psychological or biomedical events to a focus on external events and conditions in the etiology of illness. For example, psychoanalytic theory, which dominated psychiatric thinking prior to the emergence of the stress concept, has been more concerned with the development of internal conflicts, their resultant anxiety, and their resolution by individuals, than with the actual stressors that may have given rise to conflict and anxiety.

Stress discourse has shifted this concern, focusing on external events or conditions that are taxing to the individual, and that exceed the individual's capacity to endure, therefore having

potential to induce mental or somatic illness. As Singer and Krantz (1982) noted, “anxiety [the building block of psychoanalytic work] can be conceived of as a failing of the individual. Stress implies something in the environment, or at the very least an individual confronting the environment and interacting with it” (p. 959). Stress as an objective phenomenon has been almost unconcerned with, even if not unaware of, internal processes.

Thus, there are important ethical considerations that are especially important in discussing minority stress. Defining stress as a subjective phenomenon “may imply that prejudice and racism are merely problems related to perception, thus indirectly and unintentionally undermining the notion that racism and other forms of prejudice are social [problems rather than matters of individual sensitivities]” (Meyer, 2003a, p. 264). In contrast with Lazarus and Folkman’s (1984) quote from Shakespeare, the minority stress perspective defines the source of good or bad in the social world, not in the person’s appraisal of that world.

Feinstein (2019) describes the rejection sensitivity model as a cognitive-affective process whereby some LGB persons become overly sensitive to experiencing rejection. The process can “become maladaptive if it is activated indiscriminately, in response to minimal threat, in situations in which strategic behavior would be more functional, or when efforts to prevent rejection undermine other goals...and can create a self-fulfilling prophecy in which individuals behave out of fear, in turn eliciting rejection from others.” In turn, “the consequences of rejection [such as depression] are greater for individuals who are more sensitive to rejection” (Feinstein, 2019).

This formulation focuses the cause of mental health problems at the individual’s sensitivity rather than the rejection itself. In a sense, this is the benefit of looking for rejection sensitivity—that it helps predict who among SGM would be more susceptible to rejection. It is also helpful in developing individual psychological interventions. As Feinstein (2019) says “intervening at the level of cognitive-affective reactions has the potential to prevent behavioral reactions as well as subsequent behavioral consequences.” Of course, this is important: Intervention at all levels is necessary if we are to address disparities in health outcomes between SGM and cisgender heterosexuals. But the challenge of rejection *sensitivity* is that it can divert our attention from the actual rejection that SGM experience daily, and from the stress that is generated by homophobia and transphobia. Rejection sensitivity thus risks blaming the victims of prejudice for being too sensitive to prejudice.

This is a *challenge* for the rejection sensitivity perspective but not a fatal flaw. An approach for intervention that uses the minority stress model *should* consider individual-level interventions, but it must do so in the context of the structural level interventions that must strive to remove, not only reappraise, stressors (Meyer & Frost, 2013). For example, the ESTEEM model situates rejection sensitivity within the overall context of minority stress structural and interpersonal minority stressors (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). The challenge for counselors and therapists is how to address individual psychological processes without diverting the focus of minority stress from broader social and political issues that we know are at the center of the stress–disease association for SGM.

In conclusion, although rejection sensitivity is an important predictor of various mental health outcomes (Feinstein, 2019), it introduces a perspective to minority stress that highlights the person, rather than social conditions, as the source of adverse health outcomes. While potentially an important point of intervention, interventionists need to resist a reductionist focus on the individual and must view rejection sensitivity within the context of societal stressors. The minority stress perspective reminds us that we must always strive to remove the stressor, not make the person more inured to it.

References

- Bayer R (1981). *Homosexuality and American psychiatry*. New York, NY: Basic Books.
- Dohrenwend BP (1998). *Adversity, stress, and psychopathology*. New York, NY: Oxford University Press.
- Feinstein BA (2019). The rejection sensitivity model as a framework for understanding sexual minority mental health. *Archives of Sexual Behavior*.
- Hendricks ML, & Testa RJ (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice*, 43(5), 460–467. doi:10.1037/a0029597
- Meyer IH (2003a). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health*, 93(2), 262–265. [PubMed: 12554580]
- Meyer IH (2003b). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. doi:10.1037/0033-2909.129.5.674 [PubMed: 12956539]
- Meyer IH (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), 209–213. doi:10.1037/sgd0000132
- Meyer IH, & Frost DM (2013). Minority stress and the health of sexual minorities. In Patterson CJ & Augelli AR (Eds.), *Handbook of psychology and sexual orientation* (pp. 252–266). New York: Oxford University Press.
- Meyer IH, Schwartz S, & Frost DM (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine*, 67(3), 368–379. doi:10.1016/j.socscimed.2008.03.012 [PubMed: 18433961]
- Lazarus RS & Folkman S (1984). *Stress, appraisal, and coping*. New York, NY: Springer Publishing Company.
- Pachankis JE, Hatzenbuehler ML, Rendina HJ, Safren SA, & Parsons JT (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. doi:10.1037/ccp0000037 [PubMed: 26147563]
- Pearlin LI (1993). The social contexts of stress. In: Goldberger L & Breznitz S (Eds.), *Handbook of stress: Theoretical and clinical aspects*, (pp. 303–315). New York, NY: Free Press.
- Singer JE, & Krantz DS (1982). Perspective on the interface between psychology and public health. *American Psychologist*, 37, 955–960. [PubMed: 7137707]
- Testa RJ, Habarth J, Peta I, Balsam K, & Bockting W (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity*, 2(1), 65–77. doi:10.1037/sgd0000081

Figure 1:
 Minority stress mediates the relationship between social status and health outcomes
 Note: Adapted from Meyer, Schwartz, and Frost (2008)