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Response to Commentaries: Toward a Unifying Framework for Understanding and Improving Sexual and Gender Minority Mental Health

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In my Target Article (Feinstein, 2019), I described how the rejection sensitivity (RS) model (Downey & Feldman, 1996) could be used to complement and extend minority stress theory (Meyer, 2003) and the psychological mediation framework (Hatzenbuehler, 2009). The commentaries on my Target Article expanded on the relevance of the RS model for diverse sexual and gender minority¹ (SGM) populations (e.g., adolescents; see Baams, Kieken, & Fish, 2019; transgender and gender diverse individuals; see Wells, Tucker, & Kraines, 2019), and described additional theories that could also be used to advance our understanding of SGM mental health (e.g., explanatory models of suicidal thoughts and behaviors; see Wells et al., 2019; ecological systems theory; see Downey & Daniels, 2020). Here, I respond by discussing three issues that were raised in multiple commentaries: (1) the extent to which social versus individual factors should be considered in models of SGM mental health; (2) the range of existing theories that could be used to inform our understanding of SGM mental health; and (3) the need to not only intervene on RS, but to prevent it before it develops. Ultimately, by acknowledging the complex ways in which SGM people interact with the social environment, we can move toward developing a unifying framework for understanding and improving SGM mental health.

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¹Although my Target Article specifically focused on sexual minority mental health, here I refer to sexual and gender minority (SGM) mental health because several of the commentaries on my Target Article broadly referenced these populations. My Target Article specifically focused on sexual minorities because of the lack of research on RS among transgender and gender diverse (TGD) individuals. Wells et al. (2019) acknowledged that the RS model may be relevant to TGD individuals' mental health, but they also raised concerns about extending it without considering their unique experiences. As such, while I generally refer to SGM mental health in this article, readers should be cautious about extending findings from research on sexual orientation-related RS to the experiences of TGD individuals.

Individual vs. Social Influences

Meyer (2019) raised important concerns about the RS model including that "...it can divert our attention from the actual rejection that SGM experience daily..." and "...it introduces a perspective to minority stress that highlights the person, rather than social conditions, as the source of adverse health outcomes." I share the perspective that it is critical to attend to the rejection that SGM people experience and the social context in which it occurs. While minority stress theory and the RS model have different emphases (i.e., minority stress theory places greater emphasis on the social environment and the RS model places greater emphasis on the individual), both incorporate social and individual factors. For example, the RS model proposes that anxiously expecting, readily perceiving, and intensely reacting to rejection are all rooted in early experiences of rejection (Downey & Feldman, 1996). As such, rather than ignoring the role of the social environment, the RS model positions it at the beginning of a dynamic process. Similarly, while Meyer (2019) emphasized that minority stress theory is rooted in the objective stress perspective, he also acknowledged that "the objective stress perspective does not deny the importance of the individual as an appraiser..." and that "...there are differences in the actual impact of the [stressful] event on any specific person that depend on characteristics of the person and the event..." This is consistent with how he defines proximal minority stressors as subjective processes that rely on an individual's perceptions and appraisals (Meyer, 2003), recognizing the role that SGM people play in minority stress processes. The psychological mediation framework (Hatzenbuehler, 2009), rooted in transactional definitions of stress (Monroe, 2008), also acknowledges that minority stress processes involve interactions between SGM people and the social environment.

In sum, minority stress theory, the psychological mediation framework, and the RS model all acknowledge that SGM mental health is influenced by social and individual factors. By doing so, they recognize that, even in the context of oppressive social systems, SGM people can have agency over their behavior and, as such, they can have an influence on their well-being. However, concerns about "blaming" SGM people as opposed to their social circumstances have limited the extent to which scholars have considered the full range of ways in which SGM people interact with the social environment to influence their well-being. In fact, Meyer (2003) warned, "As researchers are urged to represent the minority person as a resilient actor rather than a victim of oppression, they are at risk of shifting their view of prejudice, seeing it as a subjective stressor—an adversity to cope with and overcome—rather than as an objective evil to be abolished" (p. 691). This raises important questions about SGM people's agency as it relates to minority stress processes. Can they be resilient actors and victims of oppression? Are there benefits to simultaneously situating minority stress in the context of unjust social structures and acknowledging personal agency in minority stress processes?

I believe the answers to these questions are yes and that the most comprehensive approach to understanding the causes of mental health problems experienced by SGM people is to consider the roles of society and SGM people themselves. It is important to explicitly acknowledge that SGM people can engage in behaviors that contribute to their well-being in both positive and negative ways. The growth of research on resilience in SGM populations

(Meyer, 2015) suggests that scholars are comfortable considering the positive ways in which SGM people can influence their well-being, but acknowledging personal agency in minority stress processes requires consideration of the negative ways as well. To be clear, I unequivocally agree that minority stress is rooted in unjust social systems. However, by emphasizing the interactions between SGM people and the social environment, rather than focusing exclusively on the social origins of minority stress, SGM people can be empowered to become agents of change even in the absence of broader societal change. There is a clear need for structural interventions to reduce prejudice and stigma at their sources. Still, while we work toward social change, we can simultaneously work toward a better understanding of the complex ways in which SGM people interact with the social environment, and we can translate that information into evidence-based interventions to help SGM people cope with the consequences of oppression.

It is also worth noting that concerns about blaming individuals for their mental health problems as opposed to blaming their social circumstances are not unique to research on minority stress. For example, similar concerns were acknowledged in the development of the stress generation model of depression. The stress generation model was developed to describe the ways in which depressed individuals contribute to stressors caused, at least in part, by their own behaviors or characteristics, which then exacerbate their depression (Hammen, 1991, 2006). Early research on stress generation made it clear that "...the purpose of the stress generation model is not to blame depressed people for their predicaments. However, depressed people are not merely passive recipients of life's troubles. Although faced with often debilitating symptoms, they still play an active role in the construction of their lives, and thus, they can play an active role in the maintenance of depression..." (Davila, Hammen, Burge, Paley, & Daley, 1995, p. 598). Davila et al. went on to propose that, "If we are to develop effective treatment interventions for depression, we must identify how depressed people interact with their environment to affect the course of their depression. Only then can we help them play a more adaptive role in the process of managing their depression and lives" (p. 598). Similarly, I believe that we need to consider the full range of influences on SGM mental health, including the ways in which SGM people interact with the social environment, in order to continue to move the field forward.

Additional Theories That Warrant Consideration

While the goal of my Target Article was to describe how the RS model could be used to complement and extend minority stress theory and the psychological mediation framework, Bailey (2019) called for reconsidering, rather than extending, minority stress theory. In his Commentary, he suggested that support for minority stress theory has been limited to cross-sectional associations (although that is not entirely true; for examples of support for longitudinal associations, see Birkett, Newcomb, & Mustanski, 2015; Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Dyar, Sarno, Newcomb, & Whitton, 2020; Tucker et al., 2016), and he also suggested that rival hypotheses have not been eliminated. In his concluding remarks, he reasserted his position from two decades prior (Bailey, 1999), at which time he expressed that "although the idea that these problems [sexual orientation-related health disparities] arise from 'societal oppression'—what has become known as 'minority stress'—was certainly possible, other explanations were also possible and should

be considered” (p. 3). I agree that other explanations should be considered and that is exactly why I wrote my Target Article describing the RS model as a framework for understanding sexual minority mental health. Still, there are countless other possibilities for integrating existing theoretical models to further advance our understanding of SGM mental health.

Wells et al. (2019), for example, proposed a conceptual framework that integrated components of the RS model with components of existing explanatory models of suicidal thoughts and behaviors. Several features of their proposed conceptual framework are noteworthy, especially their distinction between overt negative social experiences (e.g., discrimination, victimization) and ambiguous social experiences. They proposed that overt negative social experiences are likely to lead to some experience or perception of rejection, whereas the extent to which ambiguous social experiences lead to the experience or perception of rejection is likely to depend on RS. In addition, they proposed that experiences or perceptions of rejection would lead to negative affect, but that the strength of this association would depend on RS. Their proposed conceptual framework is an excellent example of how multiple existing theories can be integrated in an attempt to more fully explain aspects of SGM mental health.

In addition, Downey and Daniels (2020) discussed the need for a framework that captures how RS is shaped by the dynamic ecology in which people develop. More specifically, they emphasized the importance of considering “the multiple layers of acceptance and rejection that unfold dynamically over the course of our lives and shape expectations and concerns about the social world.” They proposed that Bronfenbrenner and Morris’ (2006) ecological systems theory could be used to accomplish this goal, and they provided a number of examples of research questions that could be addressed by integrating ecological systems theory and the RS model. For example, they described that, in ecological systems theory, microsystems refer to the institutions and groups that most immediately and directly impact the individual (e.g., family, school, work) and mesosystems refers to the interconnections between microsystems. They went on to suggest that researchers could examine how acceptance and rejection are communicated by different people and groups, and how experiencing acceptance in one microsystem and rejection in another would influence the development of RS and subsequent aspects of the RS dynamic (e.g., reactions to rejection, mental health).

Finally, Bailey (2019) put forth the hypothesis that mental health problems may be the cause, rather than the effect, of minority stress. He emphasized the importance of acknowledging temperament (e.g., neuroticism) in order to understand the mental health of sexual minorities and, in doing so, he referenced potentially shared genetic contributions to both nonheterosexuality and mental health problems such as depression (Ganna et al., 2019; Zietsch et al., 2012). That said, emerging research indicates that chronic stress can influence biological processes including gene expression (Slavich & Cole, 2013), and researchers are beginning to document associations between minority stress and these same biological processes (for a review, see Flentje, Heck, Brennan, & Meyer, 2019). These findings point to the complex relations among minority stress, biological processes, and mental health, and the need for additional research to better understand the ways in which individual (including biological) and social influences interact to influence SGM mental health. Still, Bailey’s

(2019) suggestions to examine the roles of temperament and biological processes in sexual minority mental health are consistent with my general recommendation to consider additional theories to further advance our understanding of SGM mental health.

Intervention vs. Prevention

In my Target Article, I noted that a number of interventions have been developed to reduce sexual minority stress and its consequences (see Chaudoir, Wang, & Pachankis, 2017), and I described how one intervention—ESTEEM (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015)²—targets sexual orientation-related RS using an ambiguous picture exercise (Burton, Wang, & Pachankis, 2019). I also noted that the broader literature on RS points to additional strategies for reducing RS, such as identifying and challenging negatively biased interpretations of ambiguous situations (Normansell & Wisco, 2017) and targeting deficits in social problem-solving associated with RS using problem-solving therapy (Kraines & Wells, 2017). In their Commentaries, LeBeau (2019) and Baams et al. (2019) identified a number of additional interventions that potentially could be used to reduce sexual orientation-related RS. LeBeau described how attention bias modification (ABM) could be used to target biased attention to threat cues, how cognitive bias modification for interpretation (CBM-I) could be used to target dysfunctional thought patterns that contribute to perceiving threat in ambiguous situations, and how behavioral activation (BA) could be used to target avoidance of situations where rejection might occur by increasing engagement in a variety of activities. In addition, Baams et al. described how eye movement desensitization and reprocessing therapy could be used to target the memory bias in RS.

LeBeau (2019), however, also pointed out the likely need to adapt existing evidence-based interventions for use with SGM populations. For example, he noted that ABM and CBM-I are both based on the assumption that the individual is mistakenly detecting threat in benign situations. Given that SGM people face real threat in their lives, there may be adverse consequences associated with training them to not attend to threat cues or to reinterpret threatening situations in a neutral manner. Wells et al. (2019) echoed this concern, noting that hypervigilance to rejection/threat and interpreting ambiguous cues as threatening can serve a protective function for transgender and gender diverse individuals. LeBeau suggested that interventions may need to be modified to help SGM people distinguish between accurate and distorted perceptions of threat. Interestingly, London, Macdonald, and Inman (2020) noted that RS not only biases attention toward cues of threat, it also contributes to difficulty perceiving cues of acceptance (Romero-Canyas & Downey, 2005). As such, it may also be possible to adapt ABM to focus on increasing perception of cues of acceptance rather than decreasing perception of cues of rejection. LeBeau also suggested that BA may need to be modified to account for outness (e.g., if a person is not out, then they may face barriers when trying to engage in some types of social activities), and that safety planning may be necessary for those who live in hostile contexts.

²In my Target Article, the citations provided for the description and randomized controlled trial of ESTEEM (Pachankis, Hatzenbuehler, & Starks, 2014; Pachankis et al., 2015) were incorrect. The correct citations are Pachankis (2014) and Pachankis, Hatzenbuehler, Rendina, Safren, and Parsons (2015).

While these intervention adaptations will need to be tested among SGM people, they point to a number of potentially promising avenues for reducing sexual orientation-related RS. However, Baams et al. (2019) called our attention to the importance of preventing the development of sexual orientation-related RS as opposed to simply intervening once it has already developed. They noted that adolescents with high levels of RS may struggle to find their way to mental health providers and that there may be unique challenges for sexual minority youth who may not be out to their parents or who may not feel comfortable disclosing their sexual orientation to their provider. These and other barriers point to the importance of identifying and implementing prevention strategies rather than simply intervening once RS has developed.

In my Target Article, I briefly noted that interventions that seek to reduce stigma and improve attitudes toward sexual minorities may prevent or disrupt the development of sexual orientation-related RS. Baams et al. (2019) went further and described a number of additional strategies that have the potential to prevent the development of sexual orientation-related RS. They suggested that schools could implement inclusive policies and programs to reduce bullying and improve acceptance, that LGBTQ community centers could deliver programs to help sexual minority youth develop coping strategies for RS and its associated mental health consequences, that psychoeducation and advocacy could be used to improve support and acceptance in the family context, and that education and training could be used to improve cultural competence in the medical system. In addition to these strategies, previous research has demonstrated that the presence of a Gender and Sexuality Alliance (GSA; also referred to as a Gay-Straight Alliance) at one's school is associated with a number of benefits including less victimization, less substance use, and better mental health (Heck, Flentje, & Cochran, 2013; Heck et al., 2014; Marx & Kettrey, 2016). Baams et al. also suggested that if rejection occurs in one context (e.g., school) but another context is supportive (e.g., home), then the development of RS might be slowed down or prevented. This suggests that, even if rejection occurs in one context, it may be possible to disrupt the development of RS by intervening in another context.

Ultimately, it is likely that both prevention and intervention strategies will be necessary to address sexual orientation-related RS. Specifically, prevention strategies can help those who have not yet developed RS, while intervention strategies are necessary for those who have. The benefits of inclusive school policies and programs (Black, Fedewa, & Gonzalez, 2012; Day, Fish, Grossman, & Russell, 2020; Day, Ioverno, & Russell, 2019), GSAs (Heck et al., 2013, 2014; Marx & Kettrey, 2016), and LGBTQ community organizations (Fish, Moody, Grossman, & Russell, 2019) are well-documented. However, to the best of my knowledge, these strategies have not been tested in relation to sexual orientation-related RS. In fact, few studies have examined sexual orientation-related RS among youth or used longitudinal designs to examine changes in sexual orientation-related RS over time. As such, there is a critical need for research on the development of sexual orientation-related RS, which will require increased attention to the experiences of children and adolescents.

Conclusion

While minority stress theory and the psychological mediation framework have led to substantial advances in the field, reliance on these models has limited the extent to which other theories have been considered as frameworks for understanding SGM mental health. By describing how the RS model could be used to complement and extend these models, my goal was to encourage researchers to consider additional theories that could broaden our understanding of range of influences on the mental health of SGM people. Ultimately, by acknowledging the complex ways in which SGM people interact with the social environment, we can move toward developing a unifying framework for understanding SGM mental health and, in turn, identifying novel targets for clinical intervention.

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