Family and Friendship Networks and Obsessive-Compulsive Disorder Among African Americans and Black Caribbeans

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OCD involves obsessions and/or compulsions. Obsessions involve repetitive thoughts, ideas, or impulses that are excessive and experienced as outside of the individual’s voluntary control (American Psychiatric Association, 2013). Compulsions are defined as repetitive behaviors or mental acts that are performed according to specific rules or standards and are designed to relieve distress and/or reduce the frequency or intensity of obsessional thoughts. Obsessions and compulsions center on a range of issues including but not limited to concerns related to dirt or contamination, symmetry or order, making catastrophic mistakes, harm coming to or harming others, and religious blasphemy (American Psychiatric Association).

OCD typically first occurs in childhood or early adulthood (Kessler, Chiu, Demler, Merikangas, & Walters, 2005) and approximately 2% of the general population in the U.S. meets structured interview-based diagnostic criteria for the disorder in their lifetime (Kessler et al., 2005). International studies indicate that OCD is present at similar rates across culture and that symptom profiles are remarkably similar from country to country (Weissman et al., 1994). Within the U.S., there is some variation in the prevalence rates of OCD across race/ethnic groups. Our previous research indicates that approximately 1.6% of African Americans and Blacks of Caribbean descent meet criteria for OCD at some point in their lives (Himle et al., 2008). This prevalence rate is somewhat less than rates typically found among Whites in the U.S. However, when OCD is present in African American and Caribbean Blacks, it is typically more severe compared to Whites (Himle et al.). Contamination compulsions are particularly common among African Americans (Williams, Abramowitz, & Olatuni, 2012) whereas symptoms related doubt and uncertainty may be more prevalent among Whites (Nota et al., 2014).

OCD is associated with deterrents in several important areas of functioning, including family relationships (Murphy & Plessner, 2015). Two dimensions of family functioning, family accommodation and high levels of expressed emotion within the family, have received substantial attention in the OCD literature. Family accommodation refers to OCD-related behaviors/avoidance performed by family members (e.g., participating in compulsions, providing repetitive reassurance) in order to relieve distress among sufferers (Braga et al., 2014). These behaviors, although they can reduce anxiety in the short run, have been found to be associated with a worsening of symptoms over time and a recent meta-analysis indicates that high levels of family accommodation have a substantial negative impact on treatment outcome (Bloch, Lebowitz, Panza, & Su, 2012). Expressed emotion refers to a range of interpersonal behaviors involving loud talking, belittling, criticism, arguments, and overinvolvement in another person’s affairs (Vaughn & Leff, 1976). Prior research indicates that high levels of expressed emotion in the family are associated with more severe OCD symptoms (De Berardis et al., 2008) and poorer response to treatment (Peris, Yadegar, Asarnow, & Picentini, 2012). The temporal relationships between OCD severity, treatment outcomes, and expressed emotion in the family are largely unknown given the paucity of longitudinal studies related to this issue, but it is likely that high symptom levels and poor treatment response both contribute to and result from increased expressed emotion among OCD families.

The relationship between OCD and family functioning beyond issues of accommodation and expressed emotion is not well known, particularly among adults with OCD. The pediatric OCD literature indicates that parents of children with OCD are less likely to encourage independence (Barrett, Shortt, & Healy, 2002), are overprotective (Wilcox et al., 2008), expect their children to be highly responsible (Farrrell, Hourigan, & Waters, 2013), and are less positive and warm (Barrett et al., 2002) in their interactions compared to parents of children without OCD. Literature related to the impact of adult OCD on family interactions beyond the influence of high expressed emotion and family accommodation is also limited. It is clear that having an adult family member with OCD is often distressing for their relatives (Amir, Freshman, & Foa, 2000). Family members often report feelings of anxiety and depression (Amir et al., 2000; Cooper, 1996) and feel burdened by their relatives with OCD (Cooper, 1996). These burdens include disruption in relatives’ social life and financial well-being as a result of living with a family member who has OCD (Cooper, 1996). Only one study has looked at the connection between family communication and OCD in African Americans. Using a retrospective self-report questionnaire, no connection was found between OCD severity and problematic family functioning in the areas of “communication and emotionality” (Sawyer, Williams, Chasson, Davis, & Chapman, 2015).

Beyond the association between OCD and family functioning, very little is known about the impact of OCD on other relationships. Much of the research that has been done related to friendships and OCD is limited to pediatric OCD. Kim and colleagues found that children with OCD had reduced social competence, fewer friend-
ships, and had greater difficulty making friends compared to matched controls without psychiatric problems (Kim, Reynolds, & Alfano, 2012). A second recent study confirmed increased difficulties with peer relations among youth with OCD compared to nonpsychiatric controls. Borda and colleagues (Borda, Feinstein, Neziroglu, Veccia, & Perez-Rivera, 2013) found that youth with OCD report having fewer friends, more trouble making friends, experience increased levels of peer victimization, and report greater fears of negative evaluation from peers compared to youth without OCD. In terms of ethnic minority youth, a large study in London found that minorities receiving treatment for OCD had more peer relationship difficulties as reported by parents compared to their White British counterparts with OCD (Fernández de la Cruz et al., 2015). If this pattern of difficult interpersonal functioning also occurs in Black American youth with OCD, it could result in greater alienation when compounded with marginalization due to minority status (Williams & Jahn, in press). As for adults with OCD, information regarding the impact of OCD on relationships outside of the immediate family is limited to studies that report high levels of overall social impairment without reference to impairment in friendships specifically (Piacentini, Bergman, Keller, & McCracken, 2003). Thus, there is a clear paucity of information about the relationship between OCD and friendships.

The limited knowledge base related to the impact of OCD on relationships with family and friends notwithstanding, essentially nothing is known about family functioning and friendships among African American and Caribbean Blacks with OCD. Gathering information about family and other interpersonal relationships among African Americans and Blacks of Caribbean descent with OCD in the U.S. is critical in order to understand the treatment needs of these groups.

The purpose of the present investigation is to gain further understanding on the impact of OCD on family relations and friendships. This is the first investigation on the impact of OCD on the family and social network of African American and Caribbean Blacks with OCD. This study utilizes data from the National Survey of American Life, the largest representative study of the mental health and well-being of African Americans and Caribbean Blacks available in the U.S. to date.

**Methods**

**Participants**

The National Survey of American Life: Coping with Stress in the 21st Century (NSAL) was collected by the Program for Research on Black Americans at the University of Michigan’s Institute for Social Research. The NSAL includes the first major probability sample of Black Caribbeans. For the purposes of this study, Black Caribbeans are defined as persons who trace their ethnic heritage to a Caribbean country, but who now reside in the U.S., are racially classified as Black, and who are English-speaking (but may also speak another language).

**Procedure**

The data collection was conducted from February 2001 to June 2003. A total of 6,082 face-to-face interviews were conducted with persons aged 18 or older, including 3,570 African Americans, 891 non-Hispanic Whites, and 1,621 Blacks of Caribbean descent. Due to time and cost restraints, OCD was assessed in the African American and Black Caribbean subsamples but not among non-Hispanic White participants. Consequently, this analysis is only among African Americans and Black Caribbeans.

The overall response rate was 72.3%. Response rates for individual subgroups for African Americans and Black Caribbeans were 70.7%, and 77.7% respectively. Final response rates for the NSAL two-phase sample designs were computed using the American Association of Public Opinion Research (AAPOR) guidelines (for Response Rate 3 samples; see Jackson, Neighbors, Nesse, Trrieger, & Torres, 2004, for a more detailed discussion of the NSAL sample). The NSAL data collection was approved by the University of Michigan Institutional Review Board.

**Measures**

**DEPENDENT VARIABLE**

*Diagnostic assessment of OCD.* Diagnostic assessment was conducted using the Diagnostic and Statistical Manual (DSM-IV) World Mental Health Composite International Diagnostic Interview [WMH-CIDI] (Kessler & Ustian, 2004). The WMH-CIDI is a structured, lay interviewer-administered diagnostic interview. The CIDI short-form version (CIDI-SF) Obsessive-Compulsive Disorder diagnostic module (Kessler, Andrews, Mroczek, Ustin, & Witchen, 1989) was administered rather than the full WMH-CIDI OCD module. A CIDI-SF OCD diagnosis should be considered a probable DSM-IV OCD diagnosis, since the section does not fully assess DSM-IV criteria. Specifically, persons with a positive CIDI-SF OCD are estimated to have an 84.21% chance of also meeting full CIDI criteria for OCD according to the CIDI-SF OCD scoring guidelines. The CIDI-SF OCD questions assess the presence of obsessions and compulsions, the inability to put such thoughts “out of your mind,” a sense that these obsessions/compulsions were unreasonable and/or unnecessary, and levels of distress and impairment.

**INDEPENDENT VARIABLES**

*Family and friendship variables.* There are five independent variables representing selected measures of involvement in extended family and friendship informal social support networks. Three measures assess involvement in family support networks and two measures assess involvement in friendship support networks. Degree of subjective family closeness is measured by the question: “How close do you feel towards your family members? Would you say very close, fairly close, not too close or not close at all?” This item was also asked of friends (i.e., Subjective Friendship Closeness). Frequency of contact with family members is measured by the question: “How often do you see, write or talk on the telephone with family or relatives who do not live with you? Would you say nearly every day, at least once a week, a few times a month, at least once a month, a few times a year, hardly ever or never?” This question was also asked of friends (i.e., Friend Contact). Lastly, negative interaction with family members is measured by an index of three items. Respondents were asked, “Other than your (spouse/partner) how often do your family members: (1) make too many demands on you? (2) criticize you and the things you do? and (3) try to take advantage of you?” The response categories for these questions were “very often,” “fairly often,” “not too often” and “never.” Higher values on this index indicate higher levels of negative interaction with family members (M = 1.85, SD = 0.59) (Cronbach’s alpha = 0.74).

*Control variables.* Demographic variables used in this analysis included age, gender, marital status (married, unmarried), education, family income, and ethnicity (African American, Black Caribbean). Missing data for family income and education were imputed using an iterative
regression-based multiple imputation approach incorporating information about age, gender, region, race, employment status, marital status, home ownership, and nativity of household residents. The distribution of the study variables is presented in Table 1.

Data Analytic Strategy

The distribution of basic demographic characteristics, Cronbach’s alpha and weighted logistic regression analyses were conducted using SAS (Version 9.1.3). Odds ratio estimates and 95% confidence intervals are presented. Standard error estimates are corrected for unequal probabilities of selection, nonresponse, poststratification, and the sample’s complex design (i.e., clustering and stratification), and results from these analyses are generalizable to the African American adult and Black Caribbean adult populations.

Results

Multivariate Analysis

Table 2 presents the logistic regression of the family and friendship social support variables and lifetime obsessive-compulsive disorder among African Americans and Black Caribbeans. The frequency of negative interaction with family members was the only family or friendship variable that was significantly associated with OCD. Respondents with OCD had more frequent negative interactions with their family members than respondents without OCD. Based upon the findings of previous research (Taylor et al., 2015), we tested whether there were significant interactions between the family and friendships social support variables and lifetime OCD. In particular, we tested interactions between negative interaction and family contact, negative interaction and family closeness, negative interaction and friendship contact, negative interaction and friendship closeness, family contact and family closeness, friendship contact and friendship closeness, as well as family contact and friendship contact. None of these interactions was significant.

Discussion

Negative Interaction

The present paper adds to a growing literature confirming the relationship between negative family interactions and OCD. Similar to previous research (Chambless, Floyd, Rodenbaugh, & Steketee, 2007), the present study found that persons with OCD reported significantly more negative family interactions compared to persons who did not have OCD. This is the first paper to report this relationship among a nationally representative sample of African Americans and Blacks of Caribbean descent living in the U.S. This finding is concordant with prior research; studies on risk factors for psychiatric problems among African Americans have documented a positive relationship between negative interactions and a range of psychiatric problems. Individuals who report more negative interactions with family members are more likely to meet criteria for mood and anxiety disorders as well as a greater number of these disorders (Lincoln et al., 2010). For instance, several national studies of depression in African Americans found that respondents who reported more negative interactions with family members were one and a half times more likely to meet criteria for major depression (Taylor, Chae, Lincoln, & Chatters, 2015) and experienced more depressive symptoms (Chachelle, Taylor, Woodward, & Nicklett, 2015). Negative interactions are also predictive of suicide ideation and attempts (Lincoln, Taylor, Chatters, & Joe, 2012; Nguyen, Taylor, et al., 2016), PTSD (Nguyen, Chatters, Taylor, Levine, & Himle, 2016), and social anxiety disorder (Levine, Taylor, Nguyen, Chatters, & Himle, 2015) among African Americans.

Elevated levels of negative family interaction among African American and Caribbean Blacks with OCD is likely a bidirectional phenomenon. It is likely that African Americans and Caribbean Blacks with OCD exhibit behaviors that are frustrating and worrisome to their family members. It is not difficult to imagine that family members express these concerns with a range of interpersonal behaviors ranging from words of sympathy and support to excessive criticism and angry outbursts (Alonso et al., 2015). This broad range of responses is understandable given that clinical impression suggest that many individuals without OCD view OCD symptoms as senseless, excessive, and at times manipulative. Conversely, it is also

| Table 1. Demographic Characteristics of the Sample and Distribution of Study Variables |
|------------------------------------------|-----------|-----------------|
| **% (SE)** | **Mean (SD)** | **N** |
| Lifetime OCD | 0.02 (0.10) | 4995 |
| Negative Interaction | 1.85 (0.59) | 5145 |
| Family Closeness | 3.64 (0.49) | 5145 |
| Family Contact | 6.06 (1.00) | 5147 |
| Friend Closeness | 3.29 (0.59) | 5070 |
| Friend Contact | 6.60 (1.00) | 5175 |
| Age | 42.18 (12.45) | 5191 |
| Gender | | |
| Male | 44.50 (0.81) | 1914 |
| Female | 55.50 (0.81) | 3277 |
| Education | 12.46 (1.94) | 5191 |
| Income | $37,545 (28,775) | 5191 |
| Marital Status | | |
| Unmarried | 57.75 (1.00) | 3268 |
| Married | 42.25 (1.00) | 1915 |
| Ethnicity | | |
| African American | 93.02 (0.52) | 3570 |
| Black Caribbean | 6.98 (0.52) | 1621 |

*Note. Frequencies are unweighted; Percents and means are weighted to be nationally representative of the given population and subpopulations in the U.S.*
likely that increased stress associated with negative family interactions can increase risk for the development of OCD. The onset of OCD is often associated with stressful life events among individuals at risk for OCD (Albert, Asinari, Bogetto, Maina, & Rosso, 2011). It is possible that persons with subclinical OCD experience increased vulnerability to development of clinical OCD when family interactions are overly negative. Overall, the increased rate of OCD among respondents reporting higher-than-average negative family interactions is consistent with the literature documenting the relationship between high EE and OCD (Chambless et al., 2007).

In terms of clinical implications, when working with African Americans with OCD, it would be important for clinicians to ascertain the nature of the family communication styles to determine if high EE is present. If so, clinicians should consider including these family members in the certain aspects of the treatment process to provide education as to how they can best support their loved one while in treatment, for example, by emphasizing the importance of reducing conflict and increasing compassionate communications surrounding mental illness. Family members who have been involved in the client’s rituals may be suffering and stressed as a result; therefore, therapists should provide coping resources for these individuals and also work with the client to underscore the importance of not involving family members in OCD rituals.

### Family and Friendships Social Support and OCD

Somewhat surprisingly, no other relationship variables were predictive of OCD risk. This finding stands in contrast to other research documenting the protective qualities of family support against meeting criteria for a range of disorders among Black Americans, including posttraumatic stress disorder (Nguyen et al., 2016), social anxiety disorder (Levine et al., 2015), and major depression (Lincoln & Chae, 2012; Taylor et al., 2015). However, our finding that neither positive family relations nor supportive friendships reduced the likelihood of developing OCD is consistent with research indicating that biological factors such as genetic abnormalities (Taylor, 2015) and altered functional activation in brain regions involving affective and cognitive cortico-striatal-thalamic circuits (Brem et al., 2012) are central to the etiology of OCD. Perhaps family support and close friendships are not powerful enough to protect vulnerable individuals from developing OCD whereas negative family interactions may be toxic enough to increase the risk of OCD among those with a predisposition to OCD. In fact, research on negative interactions has indicated that the harmful effects of negative interactions can offset the protective effects of social support (Gray & Keith, 2003; Lincoln, Chatters, & Taylor, 2003, 2005). Negative interactions are particularly pernicious to mental health because they can erode one’s positive self-appraisals and perceptions of competence and efficacy (Lincoln, 2000, 2007) and interfere with effective coping (Glanz & Schwartz, 2008). The use of adaptive stress coping strategies is often dependent on perceptions of self-efficacy and competence (Glanz & Schwartz). Thus, along with a decreased sense of self-efficacy and competence, negative interactions can also lead to compromised stress coping responses. The results of this study may be particularly relevant here given that the particularly close kinship ties in Black communities were still not associated with reduced risk of OCD. The relationship between high levels of expressed emotion within the family and increased risk for the development for a range of psychiatric disorders (Barrowclough & Hooley, 2003) clearly suggests that negative interactions are either a marker of elevated psychiatric symptomatology, a particularly strong contributor to psychiatric distress or a combination of both. These results suggest that assessing and remediating negative family interactions could be of substantial benefit to both identifying and reducing OCD risk in the African American and Caribbean Black population in the U.S.

A second, somewhat surprising finding in this study was that OCD did not significantly impact friendships in a negative way. Clinical experience indicates that persons with OCD can display observable symptoms (e.g., washing hands, repeating) in the presence of friends, arrive late or not at all to scheduled activities because of time-consuming rituals, and appear distracted or distressed because of obsessive thoughts and accompanying anxiety. The maintenance of friendships despite these behaviors likely relates to how much these behaviors interfere with interactions and activities and degree to which these behaviors are seen by the nonaffected friend as disruptive or disturbing.

It is important to remember that unlike family members, friendships are relationships of choice. Whereas family ties are permanent, friendship ties are voluntary, based on a history of reciprocity and trust. Thus, individuals with OCD are more likely to lose friends who have difficulty with their symptoms and are able to maintain friendships with people who are more accepting of the disorder. In this analysis we found that the degree of subjective closeness to friends and the frequency of

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<table>
<thead>
<tr>
<th>Family and Friendship Social Support Network Variables</th>
<th>Odds Ratio (95% CI)</th>
</tr>
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<tbody>
<tr>
<td>Negative Interaction with Family</td>
<td>2.12 (1.56, 2.88) ***</td>
</tr>
<tr>
<td>Family Closeness</td>
<td>1.01 (0.66, 1.54)</td>
</tr>
<tr>
<td>Family Contact</td>
<td>1.04 (0.86, 1.26)</td>
</tr>
<tr>
<td>Friend Closeness</td>
<td>0.84 (0.56, 1.24)</td>
</tr>
<tr>
<td>Friend Contact</td>
<td>0.89 (0.73, 1.07)</td>
</tr>
<tr>
<td>Age</td>
<td>0.99 (0.97, 1.01)</td>
</tr>
<tr>
<td>Gender: Women vs. Men</td>
<td>0.80 (0.44, 1.47)</td>
</tr>
<tr>
<td>Marital Status: Unmarried vs. Married</td>
<td>1.28 (0.63, 2.59)</td>
</tr>
<tr>
<td>Education in Years</td>
<td>0.84 (0.76, 0.92)**</td>
</tr>
<tr>
<td>Income</td>
<td>0.99 (0.93, 1.06)</td>
</tr>
<tr>
<td>Ethnicity: African American vs. Black Caribbean</td>
<td>0.71 (0.30, 1.68)</td>
</tr>
</tbody>
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*Note. p < 0.05 ** p < 0.01 *** p < 0.001; CI = Confidence Interval*
contact with friends was not associated with OCD. However, those with OCD may have a smaller network of friends. Some of these individuals may also be socially isolated from friends as research has found that adults with depression and anxiety are more likely be socially isolated from their friends (Taylor, Taylor, Nguyen, & Chaters, in press).

The lack of an association between friendship quality and OCD diagnosis relates to the fact that many OCD symptoms are private (e.g., intrusive thoughts, mental rituals). Further research is needed to determine the impact of OCD on adult friendships across cultures to determine if our findings are specific to African Americans and Caribbean Blacks or whether the limited impact of OCD on friendships is found among most samples of adults with OCD.

**Summary and Limitations**

The findings from the current investigation are consistent with previous findings related to negative family interaction and OCD risk. It is clear, like with other psychiatric disorders, that negative interactions are more prevalent among respondents with OCD compared to those without OCD. The nonsignificant relationship between friendship quality and the diagnosis of OCD is interesting in that individuals appear to neither be protected by their friendships from developing OCD nor does the presence of OCD substantially impact their friendships in a negative direction. Overall, the findings are consistent with previous work which finds that social support is an inconsistent protective factor of psychiatric disorders, but negative interactions with support network members is more consistently associated with mental health problems (Lincoln et al., 2010).

This study has limitations. First, although the NSAL is the largest study of psychiatric disorders among Caribbean Blacks and African Americans conducted to date, the relatively small number of African Americans and Caribbean Blacks with OCD limits statistical power when examining the relationship between family relationships, friendships, and OCD. Thus, we caution against overinterpretation of the null findings (e.g., no association between friendships and OCD), which could have been due to insufficient power to detect a small effect, and suggest that future replication efforts are needed. Second, the cross-sectional nature of this study does not allow for assessment of temporal relationships between OCD and interpersonal relationship impacts. Third, the NSAL did not assess OCD among Whites, which obviously does not allow for comparison of the association between OCD and interpersonal relationships among Whites and Blacks in the U.S. Finally, the CIDI-SF may not yield identical rates of OCD compared to rates obtained using the full CIDI OCD diagnostic criteria.

In conclusion, this study is particularly notable given that it is among the first to investigate the relationship between friendship quality and adult OCD. This study is unique in its examination of family relationships and friendships and OCD risk among African Americans and Caribbean Blacks. Also, unlike the vast majority of research on relationships factors and OCD, which is derived from clinical samples of OCD patients, the present study involves a representative, national sample. Finally, further cross-cultural research is needed to expand our knowledge of the bidirectional nature of the relationship between OCD risk and notable interpersonal relationships to better inform research and clinical practice.

**References**


Rejection Sensitivity in Members of Marginalized Groups: Implications for Understanding Mental Health Disparities

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The existence of disproportionately high rates of mental health concerns among members of marginalized groups has gained increasing attention in recent years. A great deal of research has been conducted exploring the psychological and sociopolitical correlates of the development and maintenance of these disparities, as well as intervention and prevention efforts designed to reduce (and eventually eliminate) these disparities. As a result of this research, several theoretical frameworks have emerged for understanding this phenomenon. Paramount among the theoretical frameworks is minority stress theory (Meyer, 2003). The theory, which was originally conceptualized with regard to lesbian, gay, and bisexual (LGB) individuals but has since been extended to other marginalized populations, posits that marginalized individuals experience unique stressors associated with their minority identities (referred to as minority stress) and that such stress accounts for their increased risk for psychological disorders.

Although there is a great deal of evidence in support of the relationship between minority stress and elevated rates of mental health problems, much remains unknown about the mechanisms through which minority stress exerts its deleterious impact on mental health. To address this gap in the research, Hatzenbuehler (2009) proposed the psychological mediation framework, which extended minority stress theory and (like the theory from which it emerged) focused on LGBs. The theory suggests that a combination of general psychological processes (e.g., emotional regulation deficits) and group-specific processes (e.g., internalized homonegativity) mediate the relationship between minority stress and psychopathology.

Despite this being a relatively new line of research, studies have already identified several potential mediators that hold promise for explaining the relationship between minority stress and elevated mental health concerns. One such process is Rejection Sensitivity (RS), a cognitive-affective process that reflects an individual’s tendency to anxiously expect, readily perceive, and intensely react to social rejection experiences (Downey & Feldman, 1996). Significant research has been conducted on RS over the last two decades, mostly focused on two areas. The first explores the relationship between RS and mental health problems, particularly borderline personality disorder and depression. The second involves the interplay between minority stress and RS. In the present article, we aim to provide a brief overview of the extant research on (a) the relationship between RS and psychopathology, (b) RS in members of marginalized groups, and (c) using empirically supported psychological interventions to target elevated RS. Finally, we provide detailed recommendations for future research in this area.

The Relationship Between Rejection Sensitivity and Psychopathology

Extensive research has established a relationship between RS and various mental health problems, irrespective of identification with a marginalized group. The majority of this work has been conducted in individuals with borderline personality disorder (BPD; Bungert et al., 2015; De Panfilis, Meehan, Cain, & Clarkin, 2016; Staebler, Helbing, Rosenbach, & Renneberg, 2011) and unipolar depression (Flett, Besser, & Hewitt, 2014; Fountoulakis, Iacovides, Kaprinis, & Kaprinis, 2006; Kudo et al., 2016; Norona, Roberson, & Welsh, 2016; Zimmer-Gembeck, Nesdale, Webb, Khatibi, & Downey, 2016). Research has shown that high rates of RS are found in individuals with BPD compared to clinical (Chesin, Fertuck,