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Psychological Responses to Exclusion: Examining Rejection Sensitivity Pattern in Asian and European Patients Population

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- Rejection sensitivity pattern
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Abstract

Background: This article aims to investigate and compare rejection sensitivity patterns in patients from Asian and European cultural backgrounds who have experienced social exclusion. Rejection sensitivity, a psychological construct characterized by heightened responsiveness to perceived rejection, is often associated with negative psychological outcomes. By examining the experiences of exclusion and their impact on rejection sensitivity in patient populations across diverse cultural contexts, this study seeks to shed light on the interplay between socio-cultural influences and psychological and physiological responses to social exclusion.

Methods: The clinical trial included 119 young Asian patients aged 16-24 years who suffered from a history of exclusion and long-term difficulties in relationships, with a diagnosis of mental disorders, and 45 healthy subjects. The results were compared with those for a group of European patients in a similar age group.

The study employed a cross-cultural comparative approach, utilizing quantitative and qualitative exploration to examine rejection sensitivity in patients with experiences of exclusion in Asia and Europe. Through this investigation, the study intends to discern potential cultural variations in the ways individuals from different cultural backgrounds interpret and respond to exclusion, as well as its implications for their psychological well-being.

Results: In both European and Asian populations, respondents were identified as suffering from a syndrome of rejection sensitivity, a large number of depressive symptoms, and low quality of current social relationships. Both groups reported similar mechanisms of defensive and self-sabotage behaviors, including: self-isolation, satisfying the needs of others, anger, addictions, and physiological symptoms characterized by high systolic blood pressure, referred to as CHAT (inflated systolic heart pressure amplitude).

Discussion: The findings of this study showed the potential to confirm culturally sensitive interventions and therapeutic strategies tailored to address rejection sensitivity in patients from diverse cultural backgrounds. Furthermore, this comparative analysis yields valuable insights into the intersections of culture, social experiences, and psychological responses, contributing to a deeper understanding of the impact of exclusion on individuals' mental health across varied cultural contexts.

BACKGROUND

In psychology, social exclusion is defined as the result of depriving a person of one of the most basic human needs - the need to belong [1-4]. A person at risk of exclusion unconsciously anticipates the impending loss of interpersonal relationships and has a premonition of impending loneliness or isolation.

The mechanism of coping with exclusion and restoring a sense of belonging is explained by the individual's desire to repair their relationships and improve their well-being. This phenomenon is presented in terms of a conflict between intimacy and avoidance [5,6]. In a situation of exclusion, the individual attempts to get closer to the group or to their significant other. However, such activities are judged by the individual to be potentially dangerous and often fail [7,8].

When faced with the risk of social exclusion, individuals are observed to show a temporary increase in social response and sensitivity to interpersonal feedback [9,10].Thwarted attempts at belonging and fears of renewed rejection create intense tension [5], that can result in an immediate retaliatory response or a general increase in hostility and aggression towards the current social environment [11-14]. It has been observed that people at risk of exclusion show less prosocial behavior and empathy, and show greater emotional indifference and insensitivity to pain/suffering [5,15,16]. There was also a reduced threshold of subjectively perceived physical pain [17].

Deprivation of belonging may be directly related to worsened mental functioning and to the debilitation of the immune system [18-20].

People, especially young men, are more likely to react automatically and directly by excluding themselves before anybody else manages to exclude them. They become immersed in the world of the Internet – in computer games or Internet pornography [21].

Pain of Exclusion and Coping

American researchers MacDonald and Leary [17], propose the theory *of social pain* as an explanation for the response of individuals to social exclusion. Advanced brain imaging methods show that social and physical pain work through physiological processes that are managed by the same brain regions. People react to situations of exclusion and thus to ostracism and rejection by developing significant somatic symptoms. Exclusion is even sometimes referred to as "social death." Predicted exclusion is the "kiss of death" because it carries with it a very tangible risk of its consummation [22,23]. In the face of death or its harbingers, the body gradually or suddenly ceases to feel pain, and "experiences" coldness and alienation, with no hope of change or return among the living [24,25].

The partial overlap of physical and social pain is evolutionally functional, as it alerts individuals to the fact that their belonging is at risk. The affective component of pain signals the potential threat, activates a strong stress-response and initiates the mechanisms of flight, fight, freezing or fainting [25,26]. While social pain is a sub-category of emotional pain, the two notions tend to be used interchangeably [27].

People who can find neither their own place among others nor a path to belonging respond to social exclusion with emotional indifference in order to shield themselves against suffering [22,28].

A recent study carried out by UK-based Professor Paul Gilbert and colleagues [29], has revealed that mindful compassion practised towards oneself may help people reassess their situation and their relations with others. By learning compassion, people may better understand their emotions, live in the moment and feel deep bonding with others.

One of the indicators of a sense of social exclusion is a reduced sense of belonging and a related set of other symptoms, such as low self-esteem, increased levels of anger and aggression, depressed mood, and limited empathy [14,30-34]. Such a constellation of traits weakens an individual's ability to cope with stress and solve problems by interacting with others, expressing their feelings, seeking support, and actively looking for solutions [1,35].

Self-Destructive and Aggressive Behaviour

Emotional indifference, atrophy of pro-social feelings, increased anger and aggressive behaviours represent only a handful of possible responses to the threat of social exclusion [1,36-38].More and more young people report loneliness and its consequences such as addictions (to the Internet, dieting, physical effort, psychoactive substances) and other mental health complaints [31,39]. The US Surgeon General's Report on youth violence [34], demonstrated that social exclusion, operationalised as "weak social bonds," was the strongest predictor of violence among teenagers; its causative impact surpassed that of gang membership, poverty and drug addiction. It has been shown that early rejection causes an increase in aggressiveness [13,14,34,37,38]. school achievement, reduction of pro-social behaviours, self-destructive surrender to drugs [34,40], and other signs of relinquishing self-control [8]. Garbarino [25], has found that many perpetrators of serious crimes are young people who feel rejected by family members, peers and society in general. Direct evidence that lack of belonging thwarts social-emotional adaptation has been presented by DeLongis, Folkman and Lazarus [41].

Traumas and fear of loneliness

The sources of conduct disorders in excluded people are associated with the traumas of neglect in early childhood, which can be considered part of a new transgenerational trend [42,43], in the aspect of relational trauma based on the Neuroaffective Relational Model (NARM) of Laurence Heller [44], traumas of the first bond with a parent [45], and their consequences in the form of impaired functioning, including "intelligent survival styles" [44]. Psychological traumas are indicated in contemporary literature as important factors influencing the formation of self-image and the experience of one's participation in social life [46].

The pattern of the child's primary bond with the caregiver – based on an incorrect insecure style – generates uncertainty in further interpersonal relationships and shapes a fearful, avoidant or disorganized attachment pattern. Theories in the field of psychosomatics and their application in clinical practice indicate that a person who is unaware of the frustration of his or her own important emotional needs, internal conflicts and emotional deficits, experiences somatic symptoms – the body reacts with changes in physiological parameters and also suffers from illness [47]. The changes are explained by the complex interactions between genes and memes and the resulting health disorders and body problems [35,48,49]. Research findings on the distinction between the mind and the brain [50,51], are complemented by the research of De Meester [52], which indicates a possible role of lipid acids in the transfer and storage of information, including unconscious information.

The cardiovascular response to mind/body interaction is monitored by rhythmic fluctuations in blood pressure as well as pulse [53][1]. Several previous studies have shown that depressed people experience internal "paralysis," reflected in a decrease in heart rate in isolation (HRV) and an increase in heart rate variability when engaging in social interactions [30,54]. Changes in neuronal response are also evident in fMRI neurobrassing of

[1]Vascular variability (vascular rhythm) is one of the most sensitive detectors of changes in emotions. It fluctuates continuously with varying frequency and amplitude depending on the heart's response to emerging situations.

the brain [17,28]. The contemporary concept of the cascade of defences [26], distinguishes four states of defence in response to stress: the most adaptive is the alert response (*arousal)*; the next most adaptive state is the mobilisation to act through fight or flight (*fight or flight).* Responses involving the opioid defense system, i.e., paralysis of the nervous system in highly stressful situations (*freezing*), or periodic loss of consciousness (tonic immobility and collapsed immobility*)* are so-called "last chance" reactions.

When people are faced with possible exclusion, they are incapable of initiating any constructive coping strategies. Fear of rejection triggers a primitive response of attack (e.g., aggression), flight (e.g., alcohol and substance abuse), or freezing (emptiness strategy) [35].

Sense of belonging and need to belong

In human development, childhood and early adolescence are key stages in light of the formation of a pattern of increased sensitivity to rejection. As research has shown, relational factors such as adverse childhood experiences, especially trauma of neglect and current relationship problems, show a common pattern in European and Asian cultures.

The need to belong is a precursor or antecedent of the sense of belonging [30,35,55]. It is defined as a person's potential, energy, and drive for meaningful commitment and as a resource that can be shared or can complement other resources [58]. The need for belonging refers to an individual's desire to engage in relationships in a meaningful way, to be valued, and to fit in with others [56].

Individuals feel threatened with exclusion when their need to belong is not met and when, despite their desire to be involved, they fail to achieve a sense of belonging (Newman, 2004). The need to belong in people at risk of social exclusion is usually less visible than in people who are not at risk of social exclusion [1,7,8,30]. Young people withdraw from relationships and minimize their expectations of others if they fear that they will be rejected again [25]. The need to belong serves as a mental motivation to seek the attention of others and communicate one's need to be an integral part of a group [31].

A sense of belonging means both the experience of being valued, needed, respected, and important to others, and the experience of fitting in or feeling compatible with other people, groups, organizations, or environments. Belonging is the opposite of exclusion and is a unique concept that differs from other constructs such as loneliness, alienation, or seeking social support that are discussed in the literature [1,30,57].

A sense of belonging is a prerequisite for a person to establish his place in the group, in the sense of his own distinctiveness and uniqueness. If this condition is not fulfilled to the requisite extent, the person begins to feel insignificant, unnecessary, unwanted and, as such, has no chance of a happy life, and especially no chance of a successful relationship with another person. People who feel they belong are less depressed and have better social performance [35,58].

The unsatisfied need for belonging is related to experiences of exclusion in the past [30,31]. The aim of this study was to isolate, define and describe the mechanism of the pattern of rejection sensitivity in people with a history of exclusion in the European and Asian groups.

Rejection Sensitivity Pattern in European Patients

The results of research conducted over the last two decades allow us to describe the pattern of sensitivity to exclusion and the activation mechanisms of defensive and self-sabotage behaviors for Europeans, especially Poles. The results of the studies described below suggest that exclusion is the main cause of behavioural and emotional disorders in people under 18 years of age and may lead to the development of future mental disorders.

Study one – types of exclusion and coping: The aim of the study was to identify and describe the types of coping with exclusion – self-perception and dominant behaviours, depending on the type of exclusion. The main statistical tool was structural equation modeling (SEM), in particular its variant referred to as path analysis (PA), which takes into account indicator variables [30,31]. The study randomly enrolled 318 young people (average age 16 years) from various schools in Poland. Personality constructs were measured using standardised research tools: sense of belonging and need for belonging, anger, mood, empathy, ways of coping. A self-questionnaire was also constructed to examine types of social exclusion risk – *the Social Exclusion Risk Scale.* The need to belong and the sense of belonging were measured using the SOBI tool, an adapted version of the Sense of Belonging (SOBI) instrument developed by Bonnie Hagerty and colleagues [57,58]. who made it available for the purposes of the Polish study [31]. Mood was measured using the *UWIST Mood Adjective Check List* developed by Gerald Matthews, A. Graham Chamberlain, and Dylan M. Jones and empathy was also measured. Coping with stress was measured using the "How are you coping?" (JSR) scale developed by Z. Juczyński and N. Ogińska-Bulik [59]. who relied on the transactional theory of coping with stress developed by Lazarus and Folkman [31].

In the group of respondents, only 35% of people reported that they felt they belonged (the so-called *Socially Included* group). As many as 65% of young people reported that they had experienced exclusion in various forms – in the family, at school, or around peers, or reported that they were outside the system. Excluded people were classified into 3 groups, of which the first were *the Invisible Kids*, who experience exclusion in the family, identify their high need for belonging and describe it as not being met; they doubt their emotional intelligence, have a depressed mood, and manifest high anger.*The Rejected, Frozen and Needy* feel excluded in their peer environment and also identify their need to belong as unsatisfied. They see no possible way of coping and don't take remedial action (they self-sabotage); they are numb, and don't trust their emotional intelligence - they are emotionally frozen. *The Non-needy Loiterers* – they feel rejected by the system

(systemically non-belonging), use stimulants, and transgress or violate social norms. The need to belong is not identified. They have angry (aggressive) and self-sabotaging behaviors. They exhibit low self-esteem and use stimulants as a way to cope with their emotions [30,31].

The study showed that most adolescents have experienced exclusion and activate different coping mechanisms depending on the type and severity of the feeling of exclusion. The most adaptive response is anger in people who experience exclusion within the family. People who experience exclusion from their peers signal that they cannot count on either their family or non-family members – they are emotionally numb and do not show any emotions, even though they would like to feel included. People outside the system are cut off from their emotions, unable to identify their need to belong, and do not take any remedial action.

Study two – imaginary friends and anger: Another study conducted in a group of Polish adolescents aged 11 to 17 (n=70) showed significant differences in the experience of anger and empathy among girls and boys, who perceived themselves in different ways as at risk of exclusion [60]. The study used a tool designed by Agnieszka Wilczyńska called the Social Exclusion Risk Scale (SZWS) [31]. In the group at risk of exclusion, statistically significant differences were noted in terms of two subscales of empathy – "personal unpleasantness" (sympathy with others in feeling unpleasantness and understanding of the suffering of others) and "fantasy" (empathy with *imaginary friends* or fairy tale characters) compared to the group with a low risk of exclusion[2]. The results showed that young people who experience exclusion are sympathetic to the suffering of others because of their personal distress. They compensate for their lack of friends through defensive mechanisms and behaviors: imaginary friendships and empathy with fantasy characters.

Study three – blunting, depression and addictions: The study of the sense of belonging and coping strategies included 178 Polish young people of both sexes (54.3% women) with an average age of 33 years. The need to belong and the sense of belonging were measured using the adapted SOBI tool [31]. Mood was measured using the UWIST Mood Adjective Check List, while empathy and coping methods were measured using the COPE questionnaire [35].

The exploratory analysis used in the study showed that the need for belonging and the sense of belonging independently and directly affect the choice of different strategies of coping with the stress of exclusion. The sense of belonging had a significant impact on the regulation of life satisfaction and depression and influenced the choice of particular coping strategies. People with an unmet need to belong suffered from depressive moods and took defensive and self-destructive coping strategies. In addition, they were more likely to be addicted to psychoactive drugs and the Internet [35]. The greater the unmet need to belong, the lower the sense of belonging and the higher the use of blunting as coping. A satisfied sense of belonging was linked to active engagement, planning solutions, and trying to monitor situations. A sense of belonging was positively correlated with life satisfaction (0.32**) and hedonistic tone, and negatively with depression (-0.41**). People with a high sense of belonging took an active approach and used effective coping strategies; they had negative attitudes towards alcohol and drug use (-0.27**). Studies have shown that long-term or acute exclusion manifests itself in a decrease in the sense of belonging and leads to temporary mood impairment and even depression [35].

People who have experienced rejection in their lives need the support of others more than others, but they are also more cautious in their relationships. A kind of emotional indifference acts as a defense mechanism and allows one to distance oneself from suffering [35]. The use of stimulants – especially alcohol and drugs – is a self-destructive strategy for coping with a lack of a sense of belonging.

Study four – activating the Rejection Sensitivity Pattern: A longitudinal study showed the dynamics of changes in self-perception during psychological interventions aimed at including excluded people. The study enrolled 60 patients (age 14-16 years) with experience of social exclusion who were included in a psychological intervention program due to ICD-10 diagnoses of F91 and F92. Adolescents were randomly assigned to 2 types of interrelational experimental interventions, hedonistic and eudaimonistic, and to a group in which participants were not engaged in relationships, but psychological lectures were given (control group) [61]. The longitudinal clinical study was conducted at a medical psychological center.

Testing before and after the intervention included verification of all variables, i.e. mood, anger, emotional intelligence, sense of belonging and coping strategies, and perceived time perspective. Throughout a series of meetings, the participants' specific cardiovascular variability and cardiac parameters, as well as satisfaction with classes, were measured. A non-invasive Ambulatory Blood Pressure Monitoring (ABPM) device was used to study cardiovascular variability. The latest compact and light (215 g) TM-2430 model was used [61]. The basic statistical analysis consisted of the assessment of direct, deferred and long-term effects in all study groups.

The results of the study turned out to be surprising, because despite the reported satisfaction of the participants, after the end of the intervention there was a decrease in the sense of belonging, as well as an increase in parameters characteristic of social exclusion. Direct effects were mainly obtained in the eudaimonistic group, which showed higher scores on anger and fatalistic views of the present, and lower scores on self-esteem and sense of belonging (*r*–Cohen 0.49), compared to the control group at the end of the intervention. At this stage, the hedonistic group showed a significantly lower score in terms of sense of belonging. The most surprising results were the last stage (long-term effects

[2]IRI (Interpersonal Reactivity Index); Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. JSAS Catalog of Selected Documents In Psychology, 10 , 85–103.

after 6 months), in which a large number of significant results were obtained, especially in the eudaimonistic group, which showed significantly lower values in the following variables compared to the control group: energy arousal, hedonistic tone, emotional intelligence, self-esteem, the need to belong, and the sense of belonging ($r \in < 0.29; 0.45>$). The hedonistic group, like the eudaimonistic group, showed significantly lower scores in energy arousal and hedonistic tone in this phase. At the same time, it showed higher scores compared to the control group in two variables: external anger and systolic blood pressure. The effect sizes were lower in group "H" compared to group "E" (0.28 to 0.34). Analysis of heart rate showed several periods of reduced systolic blood pressure, but also high amplitudes of systolic blood pressure in situations of social exposure, in the majority of subjects.

The results obtained indicated symptoms similar to *Vascular Variability Disorder* (VVD) for people in the experimental groups between sessions. *Circadian Hyper Amplitude Tension* (CHAT) occurred in the majority of the subjects just before the start of classes and during meetings in situations of social exposure. CHAT is a rare disorder in young people. Its occurrence indicates the possibility of developing heart disease in the future, given specific genetic and environmental predispositions [53,54]. In psychological studies previously conducted in healthy adults, CHAT appeared in cardiac recordings in situations when the pattern of sensitivity to rejection was activated, in situations of stress related to anticipated exclusion and during negative thinking about oneself, rumination about the risk of refusal, and, especially, fear of being in the center of attention or being judged [54].

The study showed that attempts to integrate into relationships are associated with high tension of excluded people manifested by symptoms of vascular variability disorder, high systolic blood pressure (CHAT, stress) or periods of markedly reduced HRV. In contrast to the stress they experience, individuals exhibit numbness and an apparent reaction of indifference, which seems a better option than exposing themselves to suffering again.

Rejection Sensitivity Pattern in Asian Patients

The cultures of Asia, and especially the Middle East, shape parental roles, the way the family functions, and relationships, and educate children differently than in Europe – however, as the results of the study described below have shown, exclusion is characterized by the same mechanisms. The study aimed to investigate and describe the mechanism of activation of the rejection sensitivity pattern in the Asian population in patients with experience of exclusion.

The study was conducted during my residency in the UAE from 2020 to 2022 as a part of clinical trials, individual consultations, and psychotherapy.

Study one – development of Rejection Sensitivity Pattern: A clinical trial of young Asian patients aged 16-24 years suffering from a history of rejection used a semi-structured research interview. In addition, the sense of belonging questionnaire was used to measure sense of belonging versus social exclusion. The study included 119 patients reported to outpatient psychiatric care for borderline disorder, depression and anxiety and 45 controls. The research was qualitative in nature, consisting of case studies.

The study was conducted in 2020-2022 using a semi-structured interview questionnaire in patients (n=119) who complained of loneliness and difficulties in establishing relationships. The symptoms reported by patients at the first session were diagnosed as manifesting borderline personality disorders, general anxiety disorders and depression. The control group consisted of international university students (Asian residents).

The first study involved 45 students who were assessed for their sense of belonging, their need for belonging, and their risk of social exclusion and mood, and a semi-structured interview questionnaire was used. The second study included 119 people (Indian and Pakistani nationals and Arab nationals living in the United Arab Emirates, including Jordanians, Lebanese and Emiratis) who came to a psychological clinic for help due to symptoms of loneliness and difficulties in interpersonal communication at work or at home. Subjects from the patient group took part in the study (before the start of therapy) and were given the same questionnaires as the control group.

RESULTS

Eighty-nine percent of the subjects in the patient group were diagnosed with a rejection sensitivity pattern and defensive or self-sabotage behaviors. Feelings of loneliness and rejection have been reactivated in people experiencing exclusion at several stages of development: in childhood, during (the equivalent of) K-12 education, during the early stages of marriage, and in later adult life. Local marriages were mostly arranged, so many patients did not have the opportunity to get to know each other before getting married. Experiences such as life disappointments, family conflicts, lack of support, and, in many cases, traumas of violence were identified there. The family tradition of most respondents was to have many children (average number of siblings 5-8, from 1-3 parent/usually father-related relationships). The most common experience was dealing with the demanding role of the eldest child in the family or being obliged to meet the expectations of parents related to taking care of younger siblings (the need to take over the role and responsibility of a parent, without the support of others). Physical care (cooking and cleaning) was provided by a caregiver from another country who lived permanently with each family Personal contact with one's mother and her attention were absent from patients' experience; the attachment style in childhood was avoidant-anxious or disorganized. The father held an important position through the authority of the male role, but he was often despotic and physically punitive, and in most cases physically and emotionally absent. Traumas were experienced due to conflicts in families and in the form of bullying at home, and then at school and in

the workplace. Subjects from the group of patients experienced a sense of inadequacy or lack of a sense of belonging in their current relationships. Characteristic behaviours of people with the experience of exclusion were: limited self-care (poor quality of meals, overeating, dysregulated day – addiction to video games), experiencing destructive emotions (permanent feelings of guilt, sadness, shame, anger, fear in many life situations) and negative thoughts about oneself and one's place in society (experiencing oneself as an unnecessary, disliked person), revealing a conviction of one's own worthlessness. In addition, people reported not having had their own safe place in the past (several children in one room or in one bed, a mother excluded from taking care of the children, focused on subsequent births), lack of conversations about feelings at home, physical punishment, also for crying or showing weakness. Many of them had imaginary friends.

The context of the upbringing and idiographic experiences of the Asian population was therefore different from that of the European population, but the trait of the sense of exclusion and the pattern of sensitivity to rejection turned out to be the same. All the symptoms of the rejection sensitivity pattern were reported in most subjects (before their therapeutic sessions began): low sense of belonging, low hedonistic tone, negative thoughts, and destructive emotions. Subjects manifested defensive and self-sabotaging coping behaviors. The exclusion consisted mainly of family and social/peer group problems. Individuals identified difficulties in communicating with others, in the workplace or school, and at home, preferring to isolate themselves from others and meeting the needs of other people – similarly to how they had met their parents' expectations at an earlier stage of development. Ten percent of the respondents classified themselves as being outside the system; at work, they showed difficulties in communicating with others, even though they usually worked more than others; on the other hand, their main activity at home was scrolling through their mobile phone, playing video games, or binge watching, gorging on expensive, unhealthy takeaway food. The therapy, focused on belonging, brought an improvement in well-being in the majority of patients after the fifth session (an increase in mood and an increase in the sense of belonging).

Constructs describing feelings of exclusion/rejection, especially the pattern of sensitivity to rejection and self-sabotaging coping behaviors, were activated in Asian patients mainly in connection with childhood trauma of neglect and internalized beliefs about oneself as an unimportant or unwanted individual, and a focus on destructive emotions in most life situations.

Eighty-nine percent of the Asian patients were diagnosed with a pattern of sensitivity to rejection and defensive or self-sabotaging behaviors. Ninety-two percent of patients reported experiencing some type of parental abuse or neglect before the age of 18; 86% reported a history of repeated exclusion, abandonment or neglect by both parents in childhood. 67% reported experiencing physical abuse by at least one parent as a child; These experiences were also reported by a certain percentage of people in the control group (exclusion and neglect by both parents [38%], violence by one of the parents [12%).

Subjects in the patient group were significantly more likely than those in the control group to report that caregivers of both sexes reported a lack of recognition and acceptance of the legitimacy of their needs, thoughts, and feelings, did not provide needed protection, neglected physical care, withdraw emotionally from them, and punished them for not meeting their expectations. In 63% of the patients, there was an occasional increase in systolic blood pressure, which indicates the possibility of the psychophysiological syndrome CHAT.

Taken together, the results of this study indicate that neglect, as well as verbal and physical abuse by parents, may be a significant factor in the etiology of social exclusion and rejection sensitivity patterns in individuals diagnosed with depression, anxiety, and borderline personality disorder. They also suggest that biparental failure triggers a pattern of rejection sensitivity and can significantly increase the risk of re-exclusion in relationships in adulthood,

In Asian families, as in European ones, the most common sources of rejection were excessively demanding or absent parents and the lack of a security-based attachment style in childhood, the trauma of neglect. Individuals complained of experiencing severe stress, guilt, shame, anger, and fear: fear of the future and fear as a component of interpersonal relationships. The pattern of rejection sensitivity was manifested by a tendency to accumulate negative information about oneself and experience destructive emotions, as well as a low sense of belonging. The subjects engaged in defensive and self-sabotaging behaviors (emotional numbness, limiting social contacts, isolating themselves, satisfying the needs of others while not noticing their own). Individuals also exhibited low self-esteem, angry reactions, limited self-care, and abandonment of self-control (alcohol addictions, video binge watching, binge eating).

CONCLUSIONS

The results of European and Asian studies with adolescents and young adults have led to the formulation of several important conclusions regarding the formation and manifestation of the Rejection Sensitivity Pattern (RSP):

1) People who have been excluded in the past are particularly sensitive to situations of social exposure in later stages of life.

2) The psychophysiological response to potential social rejection is reflected in the heart rhythm in the form of VVD CHAT. It is one of the most promising psychophysiological indicators of early detection and treatment of exclusion-related disorders. A decrease in heart rate occurs in periods between instances of social exposure, usually as a signal of hopelessness, loneliness, and depression.

3) People with a history of exclusion use defensive coping strategies (including blunting/isolation and empathy with imaginary friends) or undertake self-destructive strategies such

as relinquishing control or indulging in anger, addictions, and drugs.

4) The end of a good relationship is associated with the activation of RSP and intensification of the symptoms of social rejection/exclusion. People with a history of exclusion are characterized by a low sense of belonging, depressed mood, negative assumptions about themselves, and low satisfaction with life.

5) The experience of exclusion is the most painful experience in a person's life and affects future relationships with others and personal development, contributing to the development of mental disorders.

DISCUSSION: BELONGING FOCUSED THERAPY

This therapeutic formula, used in the Asian group and in the European/Polish group [30], takes into account the reconsolidation of the memory of past experiences and the acquisition and consolidation of new ways of experiencing oneself. Referring to material from literature and the results of the author's own research, the therapeutic intervention was applied to patients as a way of integrating several complementary approaches: the psychodynamic approach, constructivist therapy, and coherence therapy [62], as well as elements of contemporary models of therapy focused on compassion and mindfulness.

As indicated by the results of studies conducted in the European group and in Asian culture, an individual is able to cognitively understand that he or she has experienced exclusion, but is unable to cope with the transformation of past negative emotional experiences on his own. Therefore, in addition to the cognitive component, the emotional component in the experience of change is also important. The first stage of the proposed *Belonging Focused Therapy* included an element of memory reconsolidation and the reconstruction of traumatic or difficult emotional experiences from the past as sources of destructive or maladaptive beliefs and behaviors in the present. Memory reconsolidation is considered to be the only known mechanism of neuroplasticity of the brain that allows for the permanent removal or modification of a selected trace of emotional unconscious memory [62]. The proposed second phase is a conscious reorganization of the patterns of thinking and feeling. Emotion regulation (including the inclusion of soothing emotions) and a positive experience of oneself in the present tense from the perspective of the mature self are introduced. Phase three is conscious self-development and building a sense of belonging to oneself and the outside world as a process and as a resource for the future. This is the phase in which the basis of treatment and prevention is the assumption of access to many resources previously overlooked by the individual, which are recognized or discovered – and reinforced in contrast to the previous feeling of lack, sense of being limited/rejected, fixation on negative thinking about oneself, and destructive emotions [30].

Patients, although they understand the process, struggle with pattern changes. If they are successful, the changes that occur in the three phases overlap and support each other, triggering new sequences in the process of perceiving oneself as an important individual who belongs. For this purpose, the assumption of a spiral model of rebuilding resources is used on the basis of previous experiences registered in the mind and body. According to the thought of De Meester [52,63,64], the consolidation of beneficial changes is mainly supported by the conscious work of the human brain – while the storage and encoding of information imprinted at the level of the body can potentially be considered as resonating with psychological changes at the level of the mind. The author points out that the role of the heart, red blood cells, and the proportions and functions of fatty acids of cytoplasmic membranes are important in these processes[3]. A highly emotional past experience is potentially encoded in specific biochemical structures able to transmit information. Internalized rules and assumptions constitute selection sieves that the individual usually uses unconsciously to undertake various decision-making processes at later stages of development. It should be emphasized here that applying the above concept to the interpretation of psychological phenomena is a new idea and requires empirical research. Its new proposals for a biochemical and psychophysical explanation of the functioning of the mind do not contradict the results of contemporary research (psychophysiology, biochemistry, psychophysics) – therefore, bearing in mind this still unrecognized area of psychology, the introduction of this concept into psychological research and the verification of its assumptions in the empirical process seems as necessary as it is promising. *Belonging Focused Therapy,* like other interventions with the potential for change, can neutralize early experiences and replace existing patterns of behavior (including rejection sensitivity) with new strategies. Change is possible to the extent that the patient is aware and ready, and to the extent that the biochemical structures mentioned above are susceptible or resistant to change.

SUMMARY

The current symptoms of the disease in the patients studied were associated with unfavorable exclusionary childhood experiences and a large number of symptoms related to low quality of current social relationships. The current quality of social relationships with parents has not shown a mitigating effect on the relationship between adverse childhood experiences and current symptoms. Most current relationships with parents are imbued with anger or excessive dependency. The rejection sensitivity pattern affects the quality of current relationships with family, co-workers and friends.

These results highlight exclusionary childhood experiences as risk factors for disorders, while rejection sensitivity syndrome tends to reduce the quality of current relationships. Therapy focused on a sense of belonging increased the feeling of satisfaction from personal contacts, regulated psychophysiological parameters, and caused an increase in mood.

[3]Fatty acids in cell membranes are to memes what nucleic acids in cell nuclei are to genes, i.e. biological sets of information that determine a person's phenotype [52].

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