Experiences of Rejection Sensitive Dysphoria in Women with Late Diagnosed ADHD

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Abstract

Aim: There is a dearth of empirical literature examining the role of rejection sensitive dysphoria (RSD). Women are more likely than males to receive a late diagnosis of attention-deficit/hyperactivity disorder (ADHD), leading to significant negative life consequences. Thus, the aim of the study was to contribute to a deeper understanding of the lived experiences of women with ADHD and RSD, who have been diagnosed in adulthood. Method: Six women with a diagnosis of ADHD (in adulthood) completed an online semi-structured interview about their experiences of RSD. The interviews were analysed with Interpretative Phenomenological Analysis. Results: Four GETs were generated: ‘strategies for survival’; ‘the immediate emotionality of RSD’; ‘the reinforcing cycles of rejection’ and ‘the pivotal moment of discovering RSD’. The women discussed the lifelong nature of RSD despite not knowing about the term until adulthood. Participants masked RSD to prevent further RSD episodes and stigmatising beliefs from others, which increased negative self-beliefs. Implications: Clinical recommendations included providing better signposting and support for women with ADHD women, and to combat the stigmatising narratives and behaviours of educators, managers, employing companies, academic institutions, and the physical and mental healthcare workers in the UK. Finally, it is imperative that research advances continue regarding RSD and the nuances of this in women and girls with ADHD to mitigate the harmful gendered narratives that currently dominate not only literature but societal discourse regarding ADHD and RSD.

Keywords: *RSD, female phenotype, masking, ADHD, adult ADHD*

Introduction

This research focuses on the experiences of rejection sensitive dysphoria (RSD) in women, who have been diagnosed in adulthood with attention-deficit/hyperactivity disorder (ADHD). This introductory chapter stipulates the philosophical stance the research adopts, followed by a description of key terms currently defined. The remainder of the chapter provides an overview of the history of ADHD within academic literature, and what is known to date about RSD. Thus, providing the rationale for the empirical project, and systematic literature review (SLR) that follows.

Philosophical Stance

A brief epistemological and ontological underpinning of the project is outlined. These positions are reflected through the research and discusses how this translates to the topic under study.

Ontological and Epistemological Position

A realist ontological position was adopted, supporting the notion whereby a reality exists, independently of individual perceptions (Maxwell, 2012). The major research project (MRP) was conducted under a critical realist (CR) epistemology (Bhaksar, 1975). The CR perspective posits that within the 'reality' that exists, the knowledge that individuals possess is not fully reflective of this real world, but rather a partial reflection, with interpretations of this influenced by contexts pertinent to that individual at that time, including but not limited to culture and society (Stutchbury, 2021). Critical realism depicts that reality exists independently of the existence of time (Lawani, 2021) therefore interpretations that individuals make can change with time, due to these being influenced by our experiences (Brunson et al., 2025).

Critical realism fits with the primary population under study (adults with ADHD) along with individual experiences of RSD. Under a CR epistemology, both phenomena under study (ADHD and RSD) can be described as 'real', and experiences of this shaped by individuals' life experiences. For example, under a CR position, this would acknowledge that the label for RSD, and the diagnostic classification of ADHD are social constructions, including the resulting stigma experienced by this population, based on a predominantly neurotypical view of the world. Experiences are therefore based on individual's interpretations of their life experiences. This study examines the experience of how individuals (with ADHD) make sense of this phenomenon (RSD) based on their life experiences as a woman with late-diagnosed ADHD.

How I Came to Study the Topic at Hand

Under a CR perspective, individuals often describe their experiences without explicitly referencing underlying mechanisms accounting for their interpretations (Brunson et al., 2025). Therefore, have relied on context to inform how participants' experiences may have been shaped, and thus my own biases and assumptions in my interpretation of their narratives (Willig, 2019). Subsequently, it is important to acknowledge where my own interpretations may originate from. Whilst self-reflexivity is detailed in chapter 3, it feels pertinent to start here with 'why this topic?'

My passion for adding to the field of research around late diagnosed neurodivergent females stems from my own personal experiences of being a woman and discovering my own neurodivergent identity in adulthood. This is complemented with an additional interest within this topic stemming from personal relationships. Knowing others who have gone through the process of obtaining ADHD diagnosis in adulthood, and their 'lightbulb moment' stemming from the moment they heard about the term RSD. Upon researching this concept and finding a dearth of empirical literature that has attempted to explore this phenomenon, this started the conceptualisation of the current research.

Introduction to Key Terms and Broad Overview of the Study

Under a CR framework, it is important to acknowledge the current terms within the topic area and how these are commonly conceptualised in the world. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) characterises ADHD as a set of symptoms including inattention, impulsivity, and hyperactivity which result in a reduction of functioning in various settings, such as socially, academically and/or occupationally.

There are increasing references regarding individuals with ADHD who are identifying with the term RSD, which is separate to, but an aspect of emotional dysregulation, triggered through a perception of rejection (Dodson, 2016). Whilst not a term acknowledged within the DSM-5 or International Classification of Diseases (11th ed.; ICD-11; World Health Organisation, 2019), RSD is commonly labelled as a condition that presents with ADHD only. RSD refers to an intense pain occurring from perceived rejection, criticism, or disappointment from others (or self) such as loss of approval, or respect (Dodson, 2016). “It may also be triggered by a sense of falling short - failing to meet their own high standards or others’ expectations” (Dodson, 2025a). This article further discussed that trauma in childhood although (as with other mental health conditions) can exacerbate its effects, does not cause this, as it is an ADHD trait (Dodson, 2025a). Despite the term’s first introduction within research in 2006 (Dodson, 2006), there remains limited research examining ADHD and RSD.

Adults with ADHD – the Research Thus Far

The reconceptualised diagnostic criteria for ADHD, as detailed in the DSM-5 represented the first description of how the condition manifests in older adolescence or persists into adulthood. Consequently, this has resulted in a steady increase of studies researching adults with ADHD (Musullulu, 2025). Since then, the social, healthcare and psychological impacts of ADHD are well documented. Adults with ADHD are more likely to experience reduced quality of life when compared to peers without ADHD (Lensing et al., 2015). This level of decreased quality of life is evidenced throughout the lifespan and decreased further when combined with unemployment (Lensing et al., 2015). Additionally, research has demonstrated that adults with ADHD experience stigma (Webster, 2018), and enhanced levels of criticism from others (Beaton et al., 2022). This can cause social and relational difficulties, leading to decreased self-esteem (Hirsch et al., 2018; Schrevel, Dedding, van Aken & Broerse, 2016) and increased self-judgemental attitudes (Beaton et al., 2020).

Historically, ADHD was viewed from a deficit-based model, underpinned by the medical model of disability (Lauder, 2021). Research primarily sought to investigate the ‘deficits’ of individuals with ADHD, to 'fix' symptomatology, and reduce the impacts of this condition. Over time, and perhaps largely due to the social model of disability, originating from the UK disability rights movement (Oliver, 1983), research regarding neurodivergence has become commonly aligned with this perspective. For example, research into ADHD is increasingly operating from the social model approach, investigating the topic from a strengths-based perspective. Kistler (2022) discussed ADHD through this lens, theorising how society negatively impacts individuals with a diagnosis of this condition, rather than ADHD itself causing 'impairment'. The current MRP is situated under the same lens, framing underlying constructs within society (gender norms, socio-political factors and neuronormativity) as underpinning the disabling socio-psychological difficulties individuals with ADHD within the United Kingdom (UK) face.

Late Diagnosis

With the introduction that ADHD can be experienced in adulthood, this means that there is a subset of the ADHD population who 'missed' a diagnosis in childhood, therefore receiving a 'late' diagnosis in adulthood. Reasons provided within literature for a late diagnosis of ADHD is due to individuals internalising symptoms rather than externalising them (Shipp, 2025). Individuals with higher intellectual ability, and less "emotional and behavioural issues" have been found to be more likely to experience a late diagnosis of ADHD (Barclay et al., 2024).

Research on adults with ADHD discovered that "ADHD is a condition with a whole life impact that has grave consequences when left undiagnosed and untreated" (Webster, 2018 p.2). The impacts of late diagnosis span beyond healthcare into social care (National Health Service; NHS England, 2025). Research has recently started to explore these impacts of receiving an ADHD diagnosis in adulthood and evidenced that this can cause lower academic attainment (Barclay et al., 2024) and emotional suffering (Long & Coats, 2022). For example, studies have found there to be a double bind, whereby the diagnosis increases self-understanding, whilst shifting self-identity which leads to a grieving for the delayed diagnosis and how life may have been alternatively (Hansson Halleröd et al., 2015; Young et al., 2019). Moreover, during the Covid-19 pandemic, increased numbers of women and girls began recognising themselves as having traits of ADHD (Auro et al., 2024). Over the last decade, awareness of ADHD in the UK has increased as demonstrated by ADHD being the second highest condition to be viewed on NHS England (NHS England, 2024). Despite the emerging literature on ADHD in adulthood, further research is required as studies are outnumbered by research in childhood, and current diagnostic classifications remain based on children (Ginapp et al, 2022).

Female Phenotype

There is emerging evidence regarding not only the impact of late-diagnosed ADHD, but the nuance of these impacts for females, who typically present with a different symptom profile than males (Young et al., 2020). For example, females are suggested to be more likely to be diagnosed with inattentive rather than hyperactive (or combined subtype) symptoms of ADHD (Huynh et al., 2024). Women are more likely to receive a late diagnosis of ADHD, than men (Morgan, 2024; National Institute for Health and Care Excellence; NICE, 2018). Reasons for this within the empirical literature are due to masking, a male centred model of symptomatology and gendered societal norms meaning professionals lack awareness of how this may present differently in women and girls (Armijo, 2024; Morgan, 2024; Rapoport & Groenman, 2025). Reasons for women with internalised symptoms being diagnosed with ADHD later in life has been suggested to be due to ‘masking’ symptoms (Young et al., 2020). However, as the DSM-5 ADHD criterion are more sensitive to boys than girls (Gilbert et al., 2025), emerging evidence suggests masking could be partially attributed to societal gendered norms, with a lack of awareness in professionals regarding differences in gender presentation contributing to delayed diagnosis of women and girls (Bradley et al., 2025). Gender related expectations based on societal norms has the propensity to contribute to a misdiagnosis, and delayed diagnosis of women and girls with ADHD (Rapoport & Groenman, 2025). Due to the stigma that women with ADHD experience, this may cause prevention of seeking medical or psychological support (Rapoport & Groenman, 2025). Even following an ADHD diagnosis in adulthood, women describe little support post-diagnosis (Morgan, 2024). Furthermore, once a diagnosis is received, women with ADHD continue to experience worse outcomes compared to males. For example, recent literature reviews have identified that females with ADHD are at an increased risk of emotional dysregulation (Attoe & Clitie, 2023) and suicidality in comparison to males, which is further heightened if there is previous history of depression or childhood maltreatment (Todzia-Kornaś at al., 2024). Internalising symptoms, emotional dysregulation, and high intelligence have been suggested to contribute to delayed diagnosis of ADHD in girls (Shipp, 2025). Women who experience a late diagnosis of ADHD have been found to experience an internalisation of their difficulties, culminating in decreased self-esteem (Armijo, 2024).

Rejection Sensitivity, Emotional Dysregulation and RSD

Research denotes that individuals with ADHD are more likely to experience peer and social rejection (Mueller et al., 2012). It is suggested that underlying reasons for this remain largely unknown (Babinski et al., 2019). Research has evidenced that children with ADHD experiencing relational rejection experience a negatively impacted quality of life, including experiencing mental health difficulties (Mrug et al., 2012). It has been hypothesised that experiencing peer exclusion, and stigma from others in childhood and adolescence can contribute to developing a sensitivity to experience rejection (Babinski et al., 2019), termed *rejection sensitivity*. Whilst this term is not unique to ADHD alone, the literature suggests that individuals with ADHD experience a heightened rejection sensitivity and subsequently, psychological distress (Hussain, 2024). Critically, the majority of empirical ADHD literature explores the role of rejection sensitivity in childhood and adolescence, rather than its impacts in adulthood relationships (i.e. romantic relationships, work relationships, parenting roles). Increasing literature sources are describing a phenomenon arguably unique to ADHD, RSD. Grey literature denotes that many people feel like RSD fully captures their experience, rather than an ADHD diagnosis alone, due to its encapsulation of experiences that the current diagnostic criteria of ADHD does not address (Dodson, 2025b). For many individuals with ADHD, the most distressing aspect of RSD is the *dysphoria* element, which refers to an “extreme, unbearable intensity that usually stops the person from functioning for a highly variable period” (Dodson et al., 2024, p.6). There is always a clear trigger to experiencing this dysphoria, which is a perception of a rejecting scenario (Dodson et al., 2024). Limited empirical literature has examined this construct thus far and there are conflicting accounts for what types of ADHD profile are most likely to experience RSD. Some studies suggest RSD has most relevance for inattentive subtype females (Ginapp et al., 2023) and others have indicated emotional dysregulation is relevant to individuals with ADHD with hyperactivity and working memory deficits (Groves et al., 2020). For unknown reasons, males exhibiting emotional dysregulation are more likely to be diagnosed earlier, in comparison to females with these difficulties (Barclay et al., 2024). Overall, there remains no consensus within empirical literature on this emerging area of RSD thus far.

As RSD is a subset of emotional dysregulation (Bedrossian, 2021), it is imperative to understand the nuances on the impacts of this within the population. Emotional dysregulation refers to a difficulty in regulating emotional responses (Macklem, 2008). Research often refers to the concept of ‘emotional dysregulation’ in the ADHD literature rather than ‘emotional regulation’. This language may be reflective of the deficit-based model of ADHD. SLRs have found that the emotional dysregulation aspect of ADHD has been identified as one of the most common reasons that medical consultation is sought (Shaw et al., 2014). As RSD is not a terminology within current ADHD diagnostic criteria, experiences of this phenomenon fall within the label of emotional dysregulation. Emerging literature is suggestively reframing emotional dysregulation as a core component of the ADHD profile (Beheshti et al., 2020, Hirsch et al., 2018). Despite this, DSM-5 criteria remain unchanged, and diagnosing clinicians are encouraged to record a co-occurring condition of emotional dysregulation (Beheshti et al., 2020). The clinical implication is that current approaches to support individuals with ADHD may not tap into what is commonly cited as a major contributing factor to individuals with ADHD’s distress, emotional dysregulation (Shaw et al., 2014). A more nuanced understanding of this area only has the potential to strengthen how these individuals are supported by professionals to enhance their quality of life.

At the time of writing this MRP, there was no gold standard measure to capture RSD. Some quantitative studies have utilised the adult rejection sensitivity questionnaire (A-RSQ; Berenson et al., 2009) to investigate the role of rejection sensitivity in ADHD (Bondu et al., 2015; Canu & Carlson, 2007; Müller, et al., 2024). This requires rating anticipated anxiety across 18 theoretical scenarios. Unlike RSD, rejection sensitivity is not a concept that is unique to ADHD. Furthermore, the A-RSQ does not examine the resulting dysphoria of a scenario. There remains a significant gap in the empirical literature regarding the experience of RSD. RSD is an emerging topic within the empirical literature, and forms a concept more often brought by participants to qualitative studies, rather than a phenomenon directly being pursued as a topic within itself (Ginapp et al., 2023).

It is important the narratives of women with ADHD are explored, as they often represent an underdiagnosed and under-researched part of the ADHD community (Kooij et al., 2025). Furthermore, despite the dearth of academic research regarding RSD, it is a well described phenomenon outside of empirical literature and remains commonly discussed online within the UK spanning ADHD community organisations, charities, ADHD coaches, ADHD community interest companies (see Appendix A). RSD is starting to make its way into mainstream media outlets and presented as part of neurodivergent informational advice in NHS trusts (see Appendix A). Overall, the ADHD community are overwhelmingly reporting experiencing RSD, yet empirical research remains limited in this field (Webster, 2018). This MRP works under the assumption that RSD is an intrinsic part of the ADHD experience, based on pre-existing narratives of individuals reporting their experiences of RSD (Blaszczak, 2023). Therefore, this MRP is relevant to the community for which the research is related to. There is a gap in the current empirical knowledge base, making it a novel area to investigate. The aim is to contribute to a deeper understanding of the lived experiences of women with ADHD and RSD and the potential nuances between late ADHD diagnosis and experiences of RSD.

Within the UK, it is estimated that the population rates of ADHD are underdiagnosed (NHS England, 2025). This underdiagnosis has clinical impacts because when coupled with research denoting that women are more likely to access mental health services prior to an ADHD diagnosis (Royal College of Psychiatrists; RCP, 2017). Due to ADHD being a highly comorbid condition, there is potential for misdiagnosis due to it presenting similarly to other conditions (Musullulu, 2025). This has a clinical implication that there are individuals experiencing a misdiagnosis, possibly delaying an ADHD diagnosis. Adults with ADHD are likely to already be known to community mental health teams prior to their ADHD diagnosis (RCP, 2017). This could lead to receiving inappropriate care and support for ADHD, prior to receiving a diagnosis. Understanding the RSD phenomenon and how it presents in the ADHD population is paramount to ensuring effective clinical care.

In summary, after critically considering the existing literature within the field, there is progress regarding late-diagnosed ADHD and its impacts, and emerging literature around the impacts on females specifically. Furthermore, female differences in the symptomology of how ADHD manifests is an emergent area within the empirical literature. Despite progress in these areas, there remains a dearth of research investigating the experiences of RSD for individuals diagnosed with ADHD. Consequently, an expansive synthesis of the experiences of RSD in individuals with ADHD would be useful to define the parameters in which an empirical study within this topic area would be beneficial. Hence, a need for an SLR to investigate what empirical literature has captured about the experiences of this phenomenon within this area, thus far.

Systematic Literature Review

This chapter explains the process of how the SLR was conducted, based on the gaps identified in chapter 1. Therefore, the overall aim of the SLR was to identify and synthesise existing literature on the perspectives of children and adults with ADHD regarding RSD, prompting the question: What does the literature tell us about the experience of RSD in individuals with ADHD? This overarching aim was further broken down into four smaller questions, to help structure and provide the framework for the review:

1. How has RSD been defined in relation to ADHD (both in those diagnosed with ADHD and/or those that self-identified as having ADHD)?
2. How has RSD been measured?
3. What are the experiences of RSD in children and adults with ADHD?
4. Do experiences of RSD differ depending on individual characteristics such as age, gender, and co-occurring mental health and/or neuropsychological conditions?

Review Protocol

Although not a prerequisite to journal publication, or thesis requirements, the SLR was registered on the International Prospective Register of Systematic Reviews (PROSPERO No CRD420250638010; Cox et al., 2025). PROSPERO is an online platform for registering SLR protocols in healthcare research. It is important to prevent duplication of similar SLRs within research and registering protocols on PROSPERO increases the transparency of prospective reviews within healthcare (Page at al., 2018). There were no further amendments to the protocol following the registration of the review.

Search Strategy

The search terms for the review were generated by extracting key words from the three core concepts underpinning the aim of the review, and by utilising the University of Hertfordshire (UH) search planning tool (for full search terms, see Appendix B). These concepts were: ADHD, RSD and reported experiences of this phenomenon, which were combined with Boolean operators (‘AND’) to ensure that search results yielded articles relevant to the review. For each of the three concepts, alternative search terms were identified and included to incorporate as many differing words as possible that may refer to the same key words (use of the Boolean operators ‘OR’). For example, worldwide terminology for ADHD has evolved throughout the years following the inception of this term in diagnostic classification manuals (Smith, 2017), and there may still be differences in language utilised in literature to describe the same phenomenon. Additionally, search terms were truncated where relevant (through using asterisks as a Boolean operator) to capture spelling variations. The dates of database searches spanned 07/12/2024–20/02/2025.

To the research team’s knowledge, no previous SLRs had been conducted to synthesise the literature on ADHD and RSD. No reviews in this area were registered on PROSPERO, nor were any SLRs on this topic identified in preliminary scoping searches. Whilst RSD is an ADHD-specific terminology that is a recent addition to the empirical literature, the term *rejection sensitivity* is not specific to ADHD and predates the term RSD. Therefore, it was suspected that some literature in the review would predate the introduction of the term RSD and thus use the terminology rejection sensitivity. As the SLR aims to synthesise all relevant evidence within the subject area, and the topic is not exclusive to a specific time, date restrictions were not applied to the review.

Three databases (Scopus, PsycINFO and PubMed) were identified to conduct the searches to allow for adequate variation of literature (Charrois, 2015). Scopus was selected because of its breadth of peer-reviewed research and inclusion of grey literature. PubMed was utilised given its biomedical focus. PsycINFO was chosen due to its psychologically-focussed content and incorporation of grey literature. These database searches were conducted through UH and NHS Open Athens access. Google Scholar was used for forwards citation searching following the final included articles to generate additional research on the topic of RSD (February 2025–June 2025).

Inclusion and Exclusion Criteria

The sample, phenomenon of interest, design, evaluation, research type (SPIDER) framework (Cooke et al., 2012) was selected to aid the formulation of the research question, and to inform the inclusion and exclusion criteria. There are alternative tools available such as the population, intervention, comparison and outcomes measure (PICO; Richardson et al., 1995). However, research has demonstrated that the SPIDER framework has greater specificity for qualitative research in comparison to other tools such as PICO (Methley et al., 2014). Furthermore, the PICO framework’s subsections are less relevant for the present review, as the SLR is not comparing interventions.

Additionally, the current review's incorporation of primarily qualitative and mixed-method research justifies why the SPIDER tool was selected.

Table 1 provides a summary of the inclusion and exclusion criteria, which was established to aid the search strategy. Each inclusion and exclusion criteria were selected, as without these, the research aim and question(s) for the review would not be sufficiently answered. The research aim and question(s) mapped directly to the areas of the SPIDER framework as referenced in Table 1: what does the empirical literature tell us about the experience (3, 4, 5) of RSD (2) in individuals with ADHD (1)? The decision to include grey literature was made due to the emergent area of RSD within ADHD academic texts, meaning there was a dearth of empirical research on the topic. Due to limited sources, excluding grey literature would have narrowed the information available to synthesise for the review. The justification for the decision was furthered by the fact that some studies are more likely to be funded and published in journals than others, thus biasing the retrieval of research from database searches (Petticrew & Roberts, 2008). The inclusion of grey literature can mitigate funding and publication bias (Adams et al., 2016). As the present review is concerned with qualitative and mixed-methods research, these types of studies may involve sample sizes that are deemed too small for publication, whereas quantitative studies are more likely to be funded for research because they use large sample sizes. This only strengthened the need for non-exclusion of grey literature.

Table 1

Inclusion and Exclusion Criteria

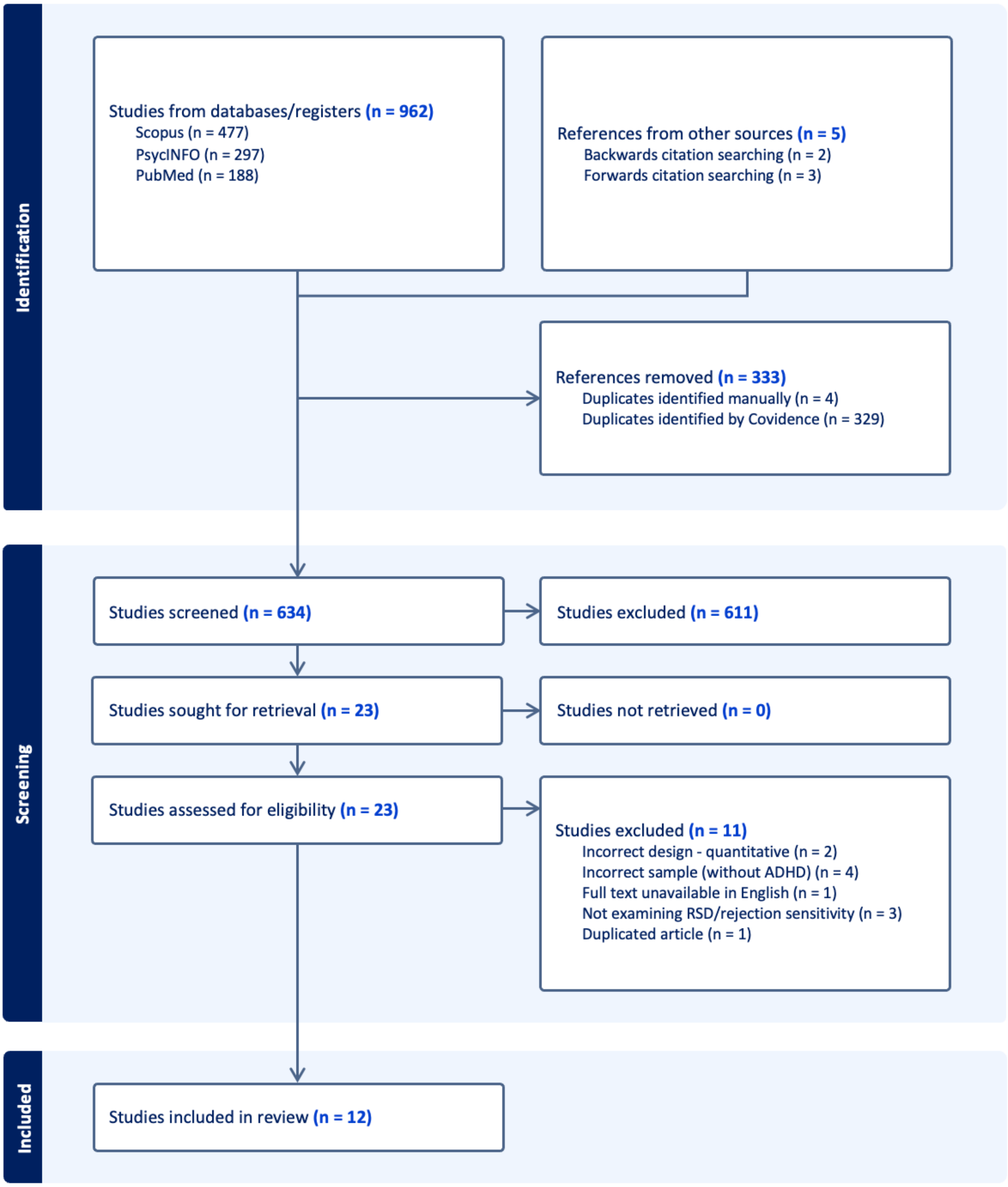
SPIDER category	Inclusion criteria	Exclusion criteria
1) Sample	Children and/or adults with ADHD.	Children and/or adults without ADHD.
2) Phenomenon of interest	Indicators of rejection, rejection sensitivity and RSD within this sample.	Studies that do not report on adults and/or children with rejection, rejection sensitivity or RSD (i.e. examining emotion dysregulation, peer rejection or parental rejection only).
3) Design	Primary research studies (qualitative and mixed methods approaches, including grey literature).	Primary research involving quantitative research methods only. Non-primary research methods such as reviews, commentaries, editorials, books/book chapters, SLRs, conference abstracts.
4) Evaluation	The experience of RSD.	Exclusively exploring treatment of ADHD and/or RSD symptomatology, or the effect of intervention types on these symptoms, rather than the phenomenon of RSD.
5) Research type	Article written in English or translation is available.	Not published in English/transcripts available.

Search Process

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) consort flow diagram (Figure 1) provides a visual representation of the study selection process. This was followed for transparency and to minimise bias that may arise from ambiguity in the search process (MacFarlane et al., 2022). Covidence software was used to manage the search process, as recommended for SLRs in healthcare research due to its ease of collaboration with multiple reviewers (Harrison et al., 2020).

Figure 1

PRISMA Flowchart for the Search Process



All articles acquired from the final database searches were imported into Covidence, which automatically removed duplicate articles. The first reviewer manually excluded a further four duplicate articles. A pilot title and abstract screening against the eligibility criteria was conducted as recommended within research (Polanin et al., 2019), to mitigate possible pitfalls in the inclusion and exclusion criteria and to aid consistency in ratings. Two independent reviewers (working in parallel) screened 20% of studies imported into Covidence (126 studies). Dual independent review from the title and abstract screening stage can increase the number of relevant studies identified for SLRs (Stoll et al., 2019). This dual review approach continued throughout the full-text review stage to minimise the selection bias caused by using a single reviewer (Li et al., 2019). Key information from the papers were assessed against the inclusion and exclusion criteria. Ineligible papers were excluded from the review. Any conflicts that arose were discussed via email between the two reviewers, and when necessary, resolved by the thesis supervisor.

As demonstrated in Figure 1, the searches from the three databases yielded 962 articles. As 333 articles were identified as duplicates and subsequently removed from the screening, 629 titles and abstracts were screened by the review team. Twenty-two full texts were read. Eleven studies were excluded. Seven studies progressed to full analysis (data extraction and quality assessment completion). Following this, a backwards and forwards citation search began with the seven included articles. Backwards citation searching was employed given it is form of supplementary search, recommended to improve rigour of SLRs (Cooper et al., 2018). This was conducted manually and systematically, involving reviewing the bibliographies and/or reference lists of included articles, to help identify any grounding texts within the review. Forwards citation searching was utilised to capture more recent research which can be helpful in areas where terminology has shifted (Gusenbauer & Gauster, 2025). In the present study, this is particularly pertinent given the language evolution around ADHD and RSD. Forwards citation scoping involved systematically searching two citation indexes (Scopus and Google Scholar), as recommended when conducting SLRs (Gusenbauer & Gauster, 2025). Research has purported that both platforms have nuances in the type of articles these two citation indexes contain (Kulkarni et al, 2009). Therefore, this method was an attempt to ensure that possible articles relevant to the SLR were not missed through not meeting specific criteria of each citation index alone. Backwards and forwards citation searching generated a further five studies for full analysis. Two of these were identified through the process of backwards searching and three from forwards citation indexing (Google Scholar). Overall, twelve studies were included in the SLR.

Data Extraction

Once the search process was complete, data was independently extracted and collected on a data extraction table in Covidence by the first reviewer and checked for accuracy by the second reviewer. This provided a template of what data to collect, to minimise errors and ensure a level of consistency in the data extraction process, as recommended in chapter 5 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Li et al., 2019). The essential components comprising a data extraction table include reference information, eligibility criteria, participant characteristics and results (Li et al., 2019). After an initial pilot testing of the data extraction tool with three articles, amendments were made to the participant characteristics section to incorporate explicit headings around what informed the sample characteristics. Extracted data can be observed in Appendix C.

The research team collectively decided to extract data from studies regarding context applicable to the present review, to facilitate sufficient data synthesis (Snyder, 2019). This incorporated age of ADHD diagnosis (including whether participants had a formal diagnosis, was awaiting assessment or were self-diagnosed), and subtype. Information regarding co-occurring conditions, and where applicable, if a control group was used was collected. Any comparisons made between factors such as gender, age of diagnosis and experiences of RSD within the studies was included. Study findings (relevant to the experience of RSD in individuals diagnosed with ADHD, including strengths and limitations reported by the paper) were collected.

Quality Appraisal

An appraisal of the quality of the included studies was essential to ensure methodological rigour. Two tools were selected to appraise the included texts within the review: The Critical Appraisal Skills Programme (CASP, 2018) tool for qualitative research and the Authority, Accuracy, Coverage, Objectivity, Date, Significance appraisal tool for grey Literature (AACODS; Tyndall, 2010).

The CASP was selected over other tools because it is the most utilised appraisal framework within healthcare research, as recommended by the Cochrane Qualitative and Implementation Methods Group (Long et al., 2020) and has been evidenced to be a well-rounded framework to assess transparency of qualitative research (Long et al., 2020). The AACODS was selected as the only framework known to the research team that is specifically created for quality appraisal of grey literature, without requiring adaptation.

Quality appraisal of the included studies was conducted independently by two reviewers, in parallel. Any disparities in the ratings were reviewed and discussed together, to inform consensus in the final ratings, in determining whether each included text met the threshold for the review. Critically, the CASP does not produce an overall quality score. Researchers have proposed and employed their own scoring system to supplement the framework (Boeije et al., 2011). This involves quantifying the CASP's evaluative format of *yes*, *no or cannot tell* with a 3-point scale: 0 (item is absent), 1 (it is either not discussed or not discussed in sufficient detail) and 2 (it is satisfactorily discussed in the report). Whilst the CASP is a 10-item framework, the last question forms an overall narrative judgement on "how valuable is this research?" For the purposes of quantifying this, the question was reframed on Table 2 to "is this research valuable?" Therefore, by applying a numerical format, this provided the CASP with a total evaluative score out of 20, a procedure outlined in Boeije et al. (2011). Total CASP quality scores can be observed in the final row of Table 2.

Table 2

Quality Appraisal Table for Qualitative Research

Study ID	Section A: Are the results valid?						Section B: What are the results?			Section C: Will the results help locally?	Total score (out of 18)
	Aims clearly stated	Is qualitative methodology appropriate?	Does the design address the aims?	Is recruitment appropriate to aims?	Is data collected addressing the research issue?	Was the research participant relationship considered?	Have ethical issues been considered?	Was data analysis rigorous?	Is there a clear statement of findings?	Is this research valuable to the current review?	
Baig, 2024	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Beaton, 2022	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Friio, 1999	✓	✓	?	?	✓	✓	✓	✓	✓	✓	18
Ginapp et al., 2023a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Ginapp et al., 2023b	✓	✓	?	✓	✓	✓	✓	✓	✓	✓	19

Henry & Jones, 2011	✓	✓	?	?	✓	✓	?	?	✓	✓	16
Lunde, 2019	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Maya Beristain & Wiener, 2020	✓	✓	✓	?	?	?	✓	?	✓	✓	16
Power, 2024	✓	✓	✓	?	?	?	✓	?	?	?	14
Rowney-Smith et al., 2024	✓	✓	✓	?	✓	?	✓	?	✓	✓	17
Wallin et al., 2022	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19
Webster, 2018	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19

Note. A tick symbol represents a *yes*, a question mark symbolises a *cannot tell* and although not relevant to these ratings, a cross symbol would have confirmed a *no* rating.

Inter-rater reliability analysis was conducted using Kappa's coefficient (Cohen, 1960). The observed agreement between the two raters was 0.92 (K=0.77). Thus, demonstrating substantial agreement in accordance with Cohen's (1960) model. Disparities between reviewer scores were resolved through discussion. See Appendix D for full scoring from the dual review. Most studies stated their aims clearly and used a qualitative methodology appropriately. These two quality checks form section A of the CASP, thus determining "is it worth continuing" (reviewing the article). Subsequently, all articles were deemed to be worth continuing the quality appraisal with the CASP. However, reporting of the results represented the largest weakness of included articles. Four of the 12 studies did not report an adequate level of information regarding justification for how they designed the research, particularly why the design was selected to address the aims over alternative qualitative methodologies. Most studies (eight) were unclear about participant recruitment, although all seemed appropriate to the aims. Four of the studies did not supply enough information about the researcher-participant relationship. Four studies could have benefitted from further information of how themes were derived from the data. The findings were usually clear and well-reported. CASP (2018) explains that an overall decision as to whether an article is low, moderate or high quality is based on researcher judgement. On balance, all articles were deemed of value to the present review and quality assessment of the included studies demonstrated they all met the threshold for inclusion, with quality ratings deemed by the research team between moderate and high quality on the CASP (Table 2).

The Cochrane Handbook denotes that journal articles may refrain from fully reporting its limitations meaning their outcomes may be omitted from the publication (Li et al., 2019). This led to reduced scores in the CASP quality assessment ratings due to the researchers' inability to assess the clarity of the paper's limitations. However, it was acknowledged by the research team that publications not reporting its research limitations may reflect this information may not have been a prioritised area for journal submission. This does not mean that it was not considered by the research teams conducting the studies and reflects a limitation of the CASP in that strength of researcher reporting can affect CASP ratings (Long et al., 2020).

As all grey literature was deemed to have acceptable methodological rigour, it was deemed by the research team that inclusion would not impact the validity of the findings. It is important that both peer-reviewed and grey literature are assessed for methodological quality with the same tool (Tyndall, 2010). However, these contributed 50% of included articles (unpublished theses or academic texts that had not undergone the rigour of peer-review). Two unpublished theses were retrieved systematically from the database searches, with the remaining texts being yielded through the backwards and forwards citation searching of included texts. An additional layer of quality was conducted to ensure robustness of included articles beyond the methodological rigour of its qualitative methods. The AACODS was selected as a supplementary tool to the CASP for the grey literature, as it was created to evaluate quality in unpublished research. Results are presented below (Table 3).

Table 3

Additional Quality Appraisal Table for Grey Literature

AACODS		Rowney Smith et al., 2024	Friio, 1999	Baig, 2024	Power, 2024	Lunde, 2019	Webster, 2018
Authority	Identifying who is responsible for the intellectual content. **Individual author:** • Associated with a reputable organisation? • Professional qualifications or considerable experience? • Produced/published other work (grey/black) in the field? • Recognised expert, identified in other sources? • Cited by others? (use Google Scholar as a quick check) • Higher degree student under "expert" supervision? **Organisation or group:** • Is the organisation reputable? (e.g. W.H.O) • Is the organisation an authority in the field? **In all cases:** • Does the item have a detailed reference list or bibliography?	✓	✓	✓	✓	✓	✓
		Associated with a reputable organisation. Does have reference list. Cited by 1 on Google Scholar but only published less than 1 year ago.	Reputable university. Reference list included.	Reputable university. Reference list included.	Reputable university. Reference list included. Cited by 2 on Google Scholar since last year.	Reference list included. Organisation is university.	Cited by 6 on Google Scholar. Reputable university.
		?	?	?		?	?
		Unclear individual qualifications/other work in field unknown. Part of a junior research associate summer programme	Cited by 1 on Google Scholar, despite being 26 yrs old.	Not yet cited on Google Scholar, but been online less than 1 year		Not on Google Scholar to check citations.	On research gate but never peer-reviewed/published.

Accuracy	Does the item have a clearly stated aim or brief? • Is so, is this met? • Does it have a stated methodology? • If so, is it adhered to? • Has it been peer-reviewed? • Has it been edited by a reputable authority? • Supported by authoritative, documented references or credible sources? • Is it representative of work in the field? • If No, is it a valid counterbalance? • Is any data collection explicit and appropriate for the research? • If item is secondary material (e.g. a policy brief of a technical report) refer to the original. Is it an accurate, unbiased interpretation or analysis?	✓	✓	✓	✓	✓	✓
		Clear aim that is met Methodology stated and adhered to. Not yet peer-reviewed. On medRxiv which usually preludes later peer-review. Supported by credible references. Novel area of work in the field.	Clear aim that is met. Methodology stated and adhered to. Data collection explicit and appropriate to achieve its aims. Supported by credible references. Pre-DSM V criteria but was novel for its time.	Clear aim that is met. Methodology stated and adhered to. Data collection appropriate. Novel research.	Aim clearly stated, unsure if met.	Clear aim and methodology, which are adhered to. Data collection explicit.	Methodology stated and clear, as is data colelction.
		?	?		?	?	?
		Data collection reasons not justified, but clear how conducted.	Not peer-reviewed. Earliest paper retrieved.		Methodology not stated, data collection not fully explicit.	Not peer-reviewed.	Unclear aim(s) – vague. Not peer-reviewed.
Coverage	All items have parameters which define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report could be designed to answer a particular question or be based on statistics from a particular survey. • Are any limits clearly stated?	✓	✓	✓	✓	✓	✓ ?
		Limits of population discussed but could have been detailed in greater depth.	Has a section exploring the limits (and acknowledges it thus affects its claims).	Limits well discussed, with rationale for these decisions.	States some limits around adults having ADHD.	Explores limits. It does justify its exclusions.	Did explore limits (adults with ADHD) but could have explored in greater depth, particularly given vague aims.
					?		
					Limits around method and inclusion/exclusion criteria not stated therefore unclear.		

Objectivity	It is important to identify bias, particularly if it is unstated or unacknowledged. • Opinion, expert or otherwise, is still opinion: is the author's standpoint clear? • Does the work seem to be balanced in presentation?	✓ Opinion and standpoint clear. Balanced in presentation. ? Bias unacknowledged.	✓ Opinion and standpoint clear. ? Bias stated but not explored in depth.	✓ Clear epistemology, views and standpoints. Balanced and justfifies decisions.	✓ Presentation does seem to be balanced . ? Bias isn't really mentioned.	✓ Balanced claims. ? Bias stated but not explored in depth.	✓ Opinions are clear, bias considered.
Date	For the item to inform your research, it needs to have a date that confirms relevance • Does the item have a clearly stated date related to content? No easily discernible date is a strong concern. • If no date is given, but can be closely ascertained, is there a valid reason for its absence? • Check the bibliography: have key contemporary material been included?	✓ Date stated for data collection. Relevant and recent references utilised.	✓ Date stated. ? Date pre-dates DSM-V criteria. Oldest reference, no longer contemporary material.	✓ Date stated and contemporary.	✓ Date of blog post collected from stated.	✓ Date stated. ? Contemporary references but some ADHD and some Tourette Syndrome related.	✓ Date stated. Contemporary references. First to mention RSD, therefore grey literature used to introduce novel concept.

Significance	This is a value judgment of the item, in the context of the relevant research area • Is the item meaningful? (this incorporates feasibility, utility and relevance) • Does it add context? • Does it enrich or add something unique to the research? • Does it strengthen or refute a current position? • Would the research area be lesser without it? • Is it integral, representative, typical? • Does it have impact? (in the sense of influencing the work or behaviour of others)	✓	✓	✓	✓	✓	✓
		Meaningful. Relevant. Rich. Unique. Strengthens and refutes research. Influential due to novel topic.	Novel for its time to discuss experiences and impact of rejection. Although is unique to school environment with studying adolescents.	Meaningful, relevant, novel. Strengthens research therefore impactful.	Valuable context around ADHD and masking, this enriches the research.	Strengthens need for adults with ADHD to be researched, alongside rejection.	Novel. First study to actively mention RSD. Therefore unique.
Overall		✓	✓	✓	✓	✓	✓
		Limitations acknowledged are methodological (see CASP).	Limitations are mostly around date of publication and that its conclusions around findings aren't really emphasising the novel aspects of rejection (see CASP).	Not many methodological limitations (see CASP) and a lot considered. Just not primarily examining RSD.	Significance is a strength. Although, awareness of limitations and bias not stated. Main limitation is methodology (See CASP).	Limitations are cannot be prised from Tourette Syndrome, and does not mention RSD.	First study to mention RSD, even though not specifically targeted as main topic.

Overall, the significance of all studies was deemed to be a strength. They all explored novel areas of relevance to the review, and thus strengthening a more holistic understanding on the topic of RSD and ADHD. Five of the six grey literature sources were more contemporary studies and dated between 2018 and 2024, meaning they were relevant to the review. Whilst one study was conducted in 1999, this was deemed as relevant as it was the first study to consider rejection and experiences of this, from the perspective of adolescents with ADHD. This article discussed peer and social rejection significantly before the remaining articles. However, this source has not since been cited by others on Google Scholar. Similarly, the remaining five grey literature articles had either no or limited citations on this platform (and Scopus). Whilst this brings into question the authority of these papers, they were all affiliated with reputable organisations. Notably, at the time of writing, three articles were produced in 2024, and citations may follow in the future. A further strength the AACODS demonstrated was that most of the studies had clear aims and methodology that were adhered to. Overall, most papers discussed the limits of what the study covered, although two articles would have benefited from deeper discussion of this. The main area that the AACODS identified as an overall weakness was "objectivity". Objectivity was not explored in depth for three of the articles, whereby bias was not explicitly discussed. This pattern was also observed in the CASP with empirical literature not discussing the researcher-participant relationship in depth.

Whilst considering the potential biases of grey literature with the AACODS, each of these studies, except for two (Friio, 1999; Lunde, 2019) outlined rejection sensitivity and RSD within the paper. Therefore, these four articles were noted as inspirational to, and to hold relevance as being up-to-date in their content and significance regarding the phenomenon of interest compared to some of the peer-reviewed articles and therefore were deemed as invaluable to the review.

The Cochrane Handbook denotes that searching for grey literature is highly desirable in SLRs as it represents an extensive search (Lefebvre et al., 2019). Furthermore, their inclusion minimises publication biases that can arise from peer-reviewed research (Adams et al., 2016). With the combined approach of utilising the CASP and AACODS for quality assurance checks for these papers, all articles were deemed of an acceptable quality to be included within the data synthesis. Nevertheless, caution should be considered when interpreting the findings.

Data Synthesis

The findings are presented in a narrative synthesis as the selected methodology due to its ability to detail the narratives of the 'story of RSD' thus far (Popay et al., 2006). Furthermore, this method of synthesis lends itself well to reviews that pose multiple questions (Popay et al., 2006). However, narrative synthesis has been critiqued for its risk of privileging some study contributions without justification (McKenzie & Brennan, 2019). To mitigate this bias, the analysis followed the methodological framework outlined by Popay et al. (2006), which was created in response to the claim about lack of rigour in narrative synthesis. Thus, the steps of Popay et al.'s methodology were followed, with some adaptations for the current review. Given it is not focussed on intervention, or outcomes of this, these steps were removed. Whilst the process was not linear, the steps incorporated conducting a preliminary synthesis, grouping and organising articles to allow exploration of both relationships between papers and consideration of differences, then synthesising across studies, before assessing the robustness of the synthesis through consideration of methodological rigour of the papers (Petticrew & Roberts, 2008). The process of the narrative synthesis is outlined to increase transparency and minimise bias, as omission of this process is a commonly cited critique of SLRs (Dixon-Woods et al., 2005).

Results

The findings are presented with an initial descriptive summary of study characteristics, followed by an analysis of the relationships with and between studies. An overall assessment of their robustness has already been evidenced in the data extraction and quality appraisal sections. Data synthesis was conducted in relation to the review questions.

Study Characteristics

Four of the twelve studies were conducted in the United States of America, four in the UK, two in Canada, one in Sweden and one in the Republic of Ireland. Four studies investigated young adults, four examined working age adults, one focussed on older adults, two considered adolescent experiences, and one study spanned adolescence through to young adulthood (Wallin et al., 2022). Six studies had a research design of semi-structured interviews. Three held focus groups, and one combined both designs; focus group and semi-structured interviews (Wallin et al., 2022). Two studies utilised open text responses, one collected in a pre-existing larger study (Beaton et al., 2022), and one considering textual information on pre-existing online blog posts (Power, 2024).

No studies reported whether experiences of rejection, rejection sensitivity or RSD change depending on individual characteristics. Important to note was that not all the studies were found to have collected consistent information about age, gender, or co-occurring conditions. Therefore, this is how I began to group studies for synthesis. When examining at a study characteristic level, many of the studies (seven) did not state the ethnicity of the participants. Of the five that did (Baig, 2024; Beaton et al., 2022; Ginapp et al., 2023a; Ginapp et al., 2023b; Henry & Jones, 2011) all had a majority of participants that identified as White. Regarding the gender of samples: two studies had approximately 50/50 split of gender, and one paper did not discuss the gender of its participants (Rowney-Smith et al., 2024). One study comprised mainly a male sample, three studies recruited females only, and the remaining five were majority female. One study presented an observation that more females than males reported experiencing RSD (Ginapp et al., 2023b). However, it must be noted that this was a focus group. Not every question was repeated at each group due to its semi-structured nature, and it may have been that the males that did not speak about this and/or did not have this question or topic in their group. One study (Maya Beristain & Wiener, 2020) reported that females were the only participants diagnosed with anxiety, learning disability or mood disorder, and stated that this was higher than expected for this population.

Regarding the age of diagnosis of participants, nine comprised of samples who some participants at least, received a diagnosis as a child. Of the eight studies that recruited at least some participants of a working age, two examined individuals who received an ADHD diagnosis in adulthood (Baig, 2024; Webster, 2018). Five studies comprised of diagnoses both within childhood and adulthood. One of these studies included participants where age of diagnosis was unclear for almost half of the sample (Power, 2024). Comparisons were not made in experiences based on age of diagnosis.

Half of the included studies did not state co-occurring diagnoses of its participants. One of these did collect this information but then actively excluded those with additional diagnoses (Beaton et al., 2022). Of the six papers that did collect and name information on co-occurring conditions, most listed anxiety and depression (five). Other co-occurring conditions included participants who identified as being diagnosed as autistic (three), with bipolar disorder (one), learning disability (one), dyslexia (one), obsessive compulsive disorder (one) eating disorder (one), and Tourette syndrome (one). No studies made comparisons of experiences depending on co-occurring conditions. Studies that did refer to co-occurring conditions typically stated that it could not be clearly understood what experiences were related to ADHD only, rather than influenced by any other condition. One research project actively excluded participants that declared co-occurring conditions, for this reason (Beaton et al., 2022). Nevertheless, this ostracises a large subset of the population as research determines that ADHD is a highly co-occurring condition (Njardvik et al., 2025). Another study explored social experiences of young adults with both with ADHD and Tourette syndrome (Lunde, 2019). However, an inability to elucidate any comparisons in experiences of rejection, rejection sensitivity or RSD in ADHD when other comorbidities (such as Tourette syndrome) are present has the potential to distort the data findings.

Eleven of the twelve studies investigated domains not primarily associated with rejection, rejection sensitivity, or RSD. Rather, the themes of rejection (3), rejection sensitivity (4), or RSD (4) emerged from the dialogues brought by the participants when discussing their lived experiences across many domains such as late diagnosis (Baig, 2024 & Webster, 2018) and adolescent experiences of ADHD (Friio, 1999 & Lunde, 2019), and contexts such as criticism from other people (Beaton et al., 2022), online relationships (Ginapp et al 2023a), friendships (Maya Beristain & Wiener, 2020), academia (Power, 2024) and sexual relationships (Wallin et al., 2022). Contrastingly, only one study from the outset aimed to investigate the phenomenon of rejection sensitivity (Rowney-Smith et al., 2024) Notably, this was a grey literature source. Regarding Review Question 1: How has RSD been defined in relation to ADHD?, all studies that mentioned and provided a definition of RSD, explained this as a condition related to ADHD specific populations only.

Narrative Synthesis

Firstly, findings were grouped based on their participant characteristics to help identify points of convergence and divergence. This enabled patterns to emerge, and comparisons of themes across the final selection of articles. These were evaluated with the mindset of answering Review Question 3: What are the experiences of RSD in children and adults with ADHD? And 4: Do experiences of RSD differ depending on individual characteristics such as age, gender, and co-occurring mental health and/or neuropsychological conditions? Three key themes emerged from the extracted data. Across studies, the narratives participants described regarding their experiences of these phenomena typically spanned three areas, triggers for rejection, rejection sensitivity and RSD, effects of, and strategies that aid coping.

Triggers for Rejection, Rejection Sensitivity and RSD. Strikingly, the commonalities across the literature regarding what were the triggers to experiencing RSD were dominated by social and relational aspects (10 of the 12 studies described triggers). For those studies who were exploring the experiences of children and adolescents, peer and social rejection were mostly described in relation to the school experience. There was a minor overlap in what age rejection at school presented as the most difficult to experience, with this ranging from secondary school in Ireland (Power, 2024), to middle school in America. Rejection at this time was dominated by exclusion of peers, and for some being bullied by friends (Maya Beristain & Wiener, 2020). Other triggering aspects of the school experience included teachers setting “unrealistic expectations” (Friio, 1999) which despite being unintentional, teachers were perceived to underestimate the effects of their actions on the students. However, accounts of peer rejection were reflected not only in the papers investigating child and adolescent experiences of ADHD, but also in studies examining experiences of adults.

Peer rejection was listed as an issue across the lifespan, even in a study that did not specifically refer to RSD, impacts of this rejection were described in participants described with ADHD in older adulthood (Henry & Jones, 2011). This was also evidenced in another study investigating experiences of ADHD in individuals diagnosed in adulthood (Webster, 2018). Within this study, one participant described “it’s the emotional element that has the biggest impact” in relation to RSD which they reported could be triggered by “anything”. Other participants provided examples of triggered through criticism at school, feeling “different” to peers and social rejection. Rejection from others was also evidenced in the literature to be present in romantic relationships. Wallin et al. (2022) described perception of words and facial expressions during sexual encounters served as a trigger for “living with intense emotions.” Similarly, triggers of perceived abandonment from loved ones were described in another study (Ginapp et al., 2023b).

Social exclusion further extended beyond loved ones and peer friendships. One study depicted a theme of “difficulty with online communications” (Ginapp et al., 2023a) which described a hypersensitivity to social exclusion online, with a key trigger including not receiving communication from others in response to content that they had posted online. One study listed an array of triggers including receiving negative feedback from others about work, including academic performance (Ginapp et al 2023b). This was corroborated with other studies evidencing that being criticised by others can exacerbate a narrative of being “sensitive to criticism” (Beaton et al., 2022) and feeling “not good enough” (Baig, 2024). Here, feeling understood by others can mitigate possible perception of being rejected by others (Beaton et al., 2022). Alternatively, other literature concluded that individuals attributed experience of rejection sensitivity to a repeatedly experiencing social and relational rejections throughout life (Ginapp et al., 2023b; Wallin et al., 2022), with other participants hypothesising that this was due to picking up on social cues that others perhaps do not notice, which is therefore perceived as rejection (Ginapp et al., 2023b). Contrastingly, one study stated that three participants reported they did not experience RSD. This was attributed by the participants to be due to having "strong social support" (Ginapp et al., 2023b).

Effects of RSD. Each of the included texts reported the effects culminating from experiencing rejection, rejection sensitivity or RSD. Regarding the studies that described rejection, or rejection sensitivity, these effects seemed to correspond with the definition of RSD. The literature described long term effects of these intense and painful emotional experiences. Many studies encapsulated the experience of pre-emptively worrying about experiencing rejection. This spanned areas of life including school, future romantic partners, employers, family, friends and seeking medical support. A commonality within the literature was the way fear of future rejection manifested. Many studies reported participants taking steps to mitigate re-experiencing previous associated distress of social rejection or criticism from others. Avoidance of experiencing criticism caused unintended consequences by people-pleasing (Beaton et al., 2022). Participants in one study labelled this as masking, partly as a method to prevent being labelled by others as "oversensitive" but this led others to assume that they remained unaffected by criticism (Rowney-Smith et al., 2024).

Another strategy included "retreating" from the people who had previously induced the rejecting experience (Ginapp et al., 2023b). This further extended to "self-isolation" through "not letting others get close" (Maya Beristain & Wiener, 2020) and avoiding social situations (Ginapp et al., 2023b; Lunde, 2019). This included preventing the self from communicating with other people online (Ginapp et al., 2023a). One study described this self-protective strategy as "withdrawal" culminating in an absence of creating meaningful relationships (Rowney-Smith et al., 2024). This study further described effects in other areas of life such as limiting efforts of work at university (purposefully submitting poor quality or late academic work) and avoidance of completing job applications (Rowney-Smith et al., 2024). Another paper found similar findings, although not directly named as RSD, a subset of older adults described experiences such as switching jobs often, short-term marriages, and rejecting their children (Henry & Jones, 2011). One study described a subset of participants who were aware that their measures to prevent rejection were disproportionate, but that despite this, they remained unable to control their responses (Ginapp et al., 2023b).

At the outset, these experiences appear individuals place themselves in situations that serve to avoid rejection form others. However, these appear to effect participants in other ways. For example, guilt and shame were described in conjunction with “feeling different” to others (Henry & Jones, 2011). This finding was widely corroborated, emotional distress was described across all studies. An array of negative emotional experiences such as self-blame (Wallin et al., 2022) and shame were effects commonly cited across the research (Henry & Jones, 2011, Wallin et al., 2022). Studies described this led to effects such as rumination (Ginapp et al., 2023b) and culminated in beliefs such as feeling unlovable (Rowney-Smith et al., 2024). Furthermore, some studies explained that emotional distress incorporated feelings of hopelessness and despair which led to a loss of self-trust (Maya Beristain & Wiener, 2020) and decreased self-esteem (Power, 2024).

Two studies that explored experiences of adolescents with ADHD found that participants felt unheard at school from those (teachers and counsellors) in authoritative positions (Friio, 1999; Maya Beristain & Wiener, 2020). One of these studies reported that one male adolescent described feeling “powerless” and other participants more widely depicted becoming mistrustful of others (Friio, 1999). Two studies further replicated this finding that participants felt unheard regarding their experiences of RSD, specifically regarding experiencing a misdiagnosis of mental health condition prior to obtaining an ADHD diagnosis (Baig, 2024; Webster, 2018). Although, two studies explained that mood disorders (anxiety and depression) were at times a secondary diagnosis (Power, 2024; Webster, 2018).

One study reported that frequency of self-imposed isolation lessened as the participants advanced with age (Lunde, 2019). However, this was a study on young adulthood. It may be that levels fluctuate throughout life, given the theme of relational avoidance being evidenced across the lifespan. Furthermore, there was contrast within the participants in the study, with two female adolescents still reporting to experience fear of judgement from others as they entered emerging adulthood (Lunde, 2019). Reasons for this were not hypothesised in the study, although it is suggestive that gender could possibly account for this disparity, as out of the four participants that did not continue to experience these phenomena, three were males. Overall, the main divergence across this theme was that there was limited evidence around bodily effects of RSD, with one study briefly describing an effect of somatisation (Ginapp et al, 2023b). This finding was only replicated in the findings of one other article. There was divergence in the physicality that participants described (with the location of effects to the stomach being the only commonality) but a reported consensus was that these bodily effects were felt to be overwhelming (Rowney-Smith et al., 2024).

Strategies to Cope. The third theme is characterised by the techniques utilised either consciously or retrospectively were adopted to help aid coping with RSD (six of the 12 studies detailed coping strategies). It is worth noting that these were not day to day strategies of coping but more so utility of *what helped* at key points of transition in individuals with ADHD’s lives. This resulted from either a late diagnosis of ADHD, and protective factors existent during schooling years and approaching emerging adulthood. Two studies investigating experiences of ADHD in adolescence and emerging adulthood described strategies that mitigated social rejection. One of these included ascending through the years of middle school feeling isolated, until the transition to secondary school involving being placed in a special educational needs class, where they connected with like-minded peers (Maya Beristain & Wiener, 2020). However, in this study, not all participants found this experience the same, with two participants describing the entire school experience being friendless. The remaining study cited extended familial networks as a buffer to fear of rejection through decreased impacts of anxiety, depression and increasing self-esteem (Lunde, 2019).

Retrospective aids were associated with those studies with participants who obtained a late ADHD diagnosis, thus finding out about the concept of this, and RSD in adulthood. Literature evidenced the utility of having a new vocabulary for the set of experiences (Ginapp et al., 2023a, 2023b). This had an impact through one's sense of identity start to shift, with ADHD being viewed as a strength (Henry & Jones, 2011). This enabled a reframing of previous life experiences (Baig, 2024) and alleviated the sense of shame, anxiety and depression previously felt (Henry & Jones, 2011). One study explained that the reframing was due to a shift in a way of viewing oneself changing from being a fundamental "personality flaw" previously reinforcing beliefs of self-judgement and shame, to bolstering self-compassion (Baig, 2024). The way that RSD is conceptualised in papers is as an ADHD specific experience. The aetiology is unknown within this literature, but regardless, the implications of this is that it seems for those with late ADHD diagnosis, this was a tool post-diagnosis providing extra knowledge and new terminology to reconceptualise self and externalise some of the internalised stigma. A transformative experience in that this is not central to having a "personality flaw" but it being an experience commonly experienced within the ADHD community.

Critical Evaluation of Evidence

Overall, the literature examining the experiences of RSD for individuals with ADHD is sparse. Within this, encouragingly, there was consistency of the parameters in which RSD was defined. The review found that across the literature, RSD been defined as an ADHD specific experience. These experiences of RSD have been measured with interviews and focus groups primarily, and to a lesser extent through sourcing access to previously written open-text information about ADHD. No mixed-methods research was found investigating this topic. The SLR concludes that there is a dearth of qualitative and moreover, mixed-methods research exploring experiences of RSD in individuals with ADHD. Despite the dearth of literature discussing RSD, there are even less studies aiming to investigate this as a topic in its entirety. Rather, this is typically brought by the participants, (11 of the 12 studies). The resulting effect was that some papers were limited in the information contained to directly answer the review questions. This may have been affected by the quality of reporting findings within the studies. Furthermore, of the 11 articles that did not aim to explore RSD, it was notable that if the term (RSD) was not brought by the participant, the topic of rejection (and participant's experiences of this) would not be framed by the paper as rejection sensitivity or RSD, despite its descriptions of these experiences appearing to overlap with these concepts. Arguably, this may have been impacted by the year some of the research was conducted. It is evident this topic forms a rapidly emerging area of research as ten of the twelve studies were produced from 2018 onwards, which marked the first time a paper in the review mentioned the term RSD. Despite the language variations, there appear to be striking consistencies and similarities in the themes described by participants. Studies describe negative impacts on wellbeing and affecting multiple domains of life, throughout the lifespan.

The evidence that RSD is experienced across the lifespan, and described worldwide, is a finding that bolsters the value of the review. Furthermore, the articles explored participants' experiences at different time points across the lifecycle, and on an array of topics regarding the experiences of individuals with ADHD. This makes it difficult to assess the robustness the strength of conclusions and generalising the SLR findings across groups and contexts, as comparative experiences of RSD based on individual characteristics such as age, gender, and co-occurring mental health and/or neuropsychological conditions have not been conducted. Some studies could be gleaned that there are tentative differences between the experiences of rejection experienced in males and females in terms of frequency rejection is experienced, and length of time impacts interfere with life for, however this was not explored in depth. Critically, there is a lack of representation of marginalised groups within the ADHD population (such as late-diagnosed experiences and female perspectives). Despite this, the studies in this SLR provide a level of insightful representation of females with ADHD and RSD. However, as studies were not homogenous in aspects such as age of diagnosis, co-occurring conditions, or the gender of participants, this has the potential to limit the quality of knowledge produced in this area.

An additional area of marginalisation that was noted within the review, was that all the articles in the SLR were conducted in (and primarily recruited form) Western countries (Europe and North America). The resulting effect is that participants were, therefore, disproportionately western, educated, industrialised, rich and democratic (WEIRD) populations (Henrich et al., 2010). WEIRD populations are often overrepresented in psychological research (Muthukrishna et al., 2020). Furthermore, it is worth noting is that 50% of articles were grey literature sources, with five studies being unpublished doctoral theses (another unpublished text is awaiting peer-review). Other than an article that recruited children from schools, the remainder of the research conducted recruitment from either charitable organisations, ADHD support groups, or universities. Recruitment from universities represents an additional area of WEIRD population (educated) which forms the seminal article primarily investigating RSD. Future research could benefit from broadening recruitment beyond the university domain.

An additional methodological aspect of the inclusion of grey literature is that this does pose questions regarding why this forms such a large subset of the research base for experiences of ADHD and RSD. This bears the question of whether there are structural barriers to research in this field such as limited funding for this topic which ultimately may be contributing to the knowledge gap in empirical evidence. Over time this could undermine research and subsequent policy. Although combining grey literature with the empirical evidence is deemed a strength of the review, rigour must be acknowledged. Despite being scholarly works, these have not undergone the peer-review rigour of published articles. Although inclusion of grey literature is beneficial in terms of minimising publication bias, there could be a presence of institutional or confirmation bias. However, this is not relevant to grey literature alone, it was a notable blind spot within empirical research too, that there was a lack of discussion regarding the researcher-participant relationship.

Summary of Evidence

In summary, the review was intended to synthesise the current research within the field of ADHD and RSD, to highlight convergences and disparities of the experience of the RSD phenomenon within the ADHD population. This SLR appears to be the first review to capture and synthesise the pre-existing literature denoting the experiences of rejection, rejection sensitivity and RSD for individuals with ADHD. A key strength of the review was its attempt for exploration of all available evidence within this area. The SLR demonstrated that the term RSD entered academic research contained within this SLR since 2018. Prior to this, rejection sensitivity was more commonly used in its place, but used interchangeably with variations such as rejection, criticism (and a *sensitivity* to each of these terms). Encouragingly, the review evidenced that this term is relevant to the population and a facet associated with ADHD being brought to research by participants.

Importantly, information derived from the review gleaned that there are indeed commonalities experienced in the trajectory of this phenomenon, causes, defining features, the impacts on self and to a lesser extent, how individuals manage RSD. Thus, culminating in the review concluding with three themes, triggers of RSD, the effects of RSD and coping strategies. Furthermore, the SLR evidenced that there are fundamental characteristics of RSD described across the literature. These include the emotional load of RSD experiences, right from the point of experiencing a trigger to RSD, and this seems to remain consistent throughout life, through childhood and adulthood but perhaps triggered by different scenarios. What can be concluded from the studies is that there is strong evidence for the relational aspects of RSD. Triggers are well-defined in relation to school, but less reported in terms of what triggers these experiences within later life, even in the studies investigating this phenomenon in adulthood. Conversely, there were gaps noted within the evidence base, thus highlighting that further empirical research in this area is warranted. For example, there remain gaps in the aetiology, and variation in immediate and long-term impacts across settings and populations, particularly in reference to the bodily sensations and somatisation described in two of the articles. These findings were not replicated in the remainder of articles in the review.

Regarding the theme “strategies to cope”, making sense of ADHD and thus RSD later in life through a late diagnosis was described as transformative to the experience of RSD and sense of self. This may have the implication of individuals being able to attribute this to an aspect of ADHD during adolescence having the opportunity to navigate ‘what helps’ at a sooner age, could have the potential for lesser social and relational repercussions. That said, control and power still reported to play a part even in adolescent samples, with one participant at school age, describing feeling “powerless” in education (Friio 1999). Adolescence is a pivotal time of identity formation, particularly in adolescents with ADHD (Frick et al., 2025). Knowing about RSD sooner may transform this experience for adolescents with ADHD, in addition to being transformative for late-diagnosed adults.

Clinical Implications. One of the implications from the SLR conclusions is that RSD is a lifelong experience for individuals with ADHD, that is little understood by others. Participants reported that working professionals (in education and healthcare) are unaware of this phenomenon, meaning they are ill-equipped to support individuals with ADHD experiencing RSD. The SLR concludes that some individuals experienced a misdiagnosis prior to their ADHD diagnosis. Thus, resulting in invalidation and subsequently, there is a subset of individuals with ADHD masking their experiences of RSD and their identity. The review additionally demonstrates that language regarding RSD can alter self-perceptions. This has the potential to empower and reframe negative self-image. However, finding out about RSD only happens post ADHD diagnosis. This has further implications for late-diagnosed individuals. Even for those diagnosed with ADHD in childhood, it is pertinent that RSD is still a relatively new term. Therefore, even if ADHD was conceptualised, the struggles regarding relational experiences and resulting emotional distress may have been framed very differently.

Research Implications. Overall, the SLR highlights that further research is warranted to primarily investigate the experiences of RSD in individuals with ADHD. More diverse populations and increased reflexivity in qualitative research would aid the growing evidence base. Furthermore, the implications of the effects described in this review are wide reaching, yet despite this, a variation beyond educational experiences was not fully explored or described by participants in the literature. Therefore, more nuanced research into how RSD presents in adulthood would aid the body of literature. The SLR evidenced that RSD has wide reaching impacts such as quality of life, work, education, relationships (friends, family and romantic) access to timely and appropriate support and interventions for both physical and mental health. Whilst there was a consistency in the literature in terms of triggers and effects, arguably RSD was viewed from a deficit-based model, and only half of studies discussed coping strategies. Further research from a strengths-based model may be imperative to combat stigma in this population and mitigate the impact of these clinical implications.

Limitations of the Review. Limitations of the SLR include delays in the review due to difficulties obtaining access to some of the grey literature sources and requiring inter-library loans. However, despite this delay, all the articles were sourced. Additionally, the backwards and forward citation indexing was completed by a single reviewer, due to time complexities in completing this manually. This may have introduced a level of selection bias into this portion of the review. However, the included studies identified from this were then reviewed by the second reviewer, to mitigate reviewer bias (Li et al., 2019).

Conclusion. The literature was sourced worldwide, and the one study investigating primarily RSD was conducted in the UK. The study inferred that the age of ADHD diagnosis was within childhood. As RSD was widely evidenced in this paper, it makes sense to elaborate on this research. However, the paper was limited to undergraduate students in one university. To broaden the scope of the research, a wider age range is recommended, incorporating those diagnosed with ADHD in adulthood, and being inclusive to all areas of the UK as a logical next step for an empirical project. Female late diagnosis is already under-researched in ADHD literature (Kooij et al., 2025).

There is a lack of empirical research in this field, where RSD is the primary source to be investigated, rather than a topic brought by the individual as pivotal in their lived experiences of life with ADHD. This, combined with the fact that to date research has not examined how the role of RSD impacts females who are diagnosed with ADHD in adulthood means that the empirical part of this thesis should be a foundational piece. The findings from the SLR helped to inform the research aims and questions.

Research Aims and Questions

Following an in-depth SLR, an overarching aim was created: to contribute to a deeper understanding of the lived experiences women with ADHD and RSD, who have been diagnosed in adulthood. The underlying research questions underpinning the primary research aim are as follows:

1. What are the key features of RSD as it is understood by females who have been diagnosed with ADHD in adulthood?
2. What are the impacts of experiencing RSD on this population?
3. What is it like to experience RSD as a female diagnosed with ADHD in adulthood and what are the impacts of this on daily life?
4. How has conceptualisation of self in relation to RSD changed over time?

Methodology

This chapter addresses the rationale for the research methods that were selected for the research question(s). This includes why a qualitative approach was selected, together with a justification for the design of the empirical study, and the process of how the research was conducted at each stage.

Design

A qualitative methodology was selected because this approach is concordant with the aim of the empirical study: to contribute to a deeper understanding of the lived experiences of women with

ADHD and RSD, who were diagnosed in adulthood. Furthermore, the epistemological position (CR) the research adopted aligns with qualitative methodologies as both are concerned with the nuance of individual accounts. Conversely, quantitative research would not uncover underlying insights into mechanisms of how this phenomenon manifest in the form of individual's experiences. Thus, justifying why a qualitative research design was selected over a quantitative methodology, to explore a rich and full account of the target population's experiences of RSD.

Whilst focus groups would have been a sound research design to achieve these aims, its main weakness includes the possibility of conformity amongst members or lack of dissenting opinions, possibly culminating in participants feeling unable to express discomfort (Sim & Waterfield, 2019). Given the exploratory nature of the topic, and its potential to invoke emotional responses or recollections, semi-structured interviews were selected as the qualitative method of choice. This allowed participants to provide in-depth accounts of their experience in their own words (Lim, 2025). The strength of semi-structured interviews is they provide scaffolding to help participants curate a narrative and incorporate prompts to explore the content they discuss to help elicit underlying meaning (Ruslin et al., 2022).

Online interviews were selected as an optimum tool for the study as it allowed for data collection within multiple geographical areas of the UK, which would not have been feasible with face-to-face interviews given the time and financial constraints of the empirical project. Using online platforms for research purposes are a "greener" alternative to what in-person interviews involve (Ridge et al., 2023). However, there are limitations to online interviews, as some individuals may prefer face-to-face interviews based on the nature of their neurodivergent presentation. Whilst common limitations of a qualitative research design include concerns around replicability, and reproducibility due to the interpretative nature of analysis (Lim, 2025), transparency of analysis can somewhat mitigate this, as elucidated in the data analysis section.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) was selected as the method of data analysis because it has been evidenced as a useful technique when investigating areas of psychological or healthcare research that are understudied (Cassidy et al., 2011; Peat et al., 2019). The SLR highlighted there is a dearth of qualitative research primarily focussed on exploring individuals with ADHD's experiences of RSD. Moreover, the experiences of RSD in females with late-diagnosed ADHD are even less well documented. Overall, this subset of the ADHD population is marginalised and form an under-researched area. Furthermore, late-diagnosed ADHD has been demonstrated to be perceived as a major life experience, leading to reconceptualisation of identity (Bradley et al., 2025; Hansson Halleröd et al., 2015). As the topic of investigation in IPA should be meaningful to participants and given the SLR demonstrated that RSD is typically discovered after an ADHD diagnosis is provided, this marks a significant transition period. Furthermore, the sample is homogenous, which IPA is well-suited to (Noon, 2018).

The study aimed to capture a phenomenon possibly unique to individuals with a diagnosis of ADHD. Whilst in IPA, there is no one set ontological position in which it draws from, the process of data collection is constructivist, which complements a critical realist epistemology (Willig, 2016). The theory behind IPA is predominantly rooted in phenomenology, idiography and hermeneutics (Noon, 2018). This fits with a CR epistemology, and its premise of hermeneutics aligns with my positioning as an insider-outsider researcher. Researchers should attempt to understand the experiences of the individual through trying to make sense of the narrative each participant provides, to understand their personal lived experiences. Meaning therefore, is co-produced (Smith et al., 2009). Both IPA and CR aim to infer beyond description, to form an understanding. CR infers that to explain why something happens you first need to explore how it is experienced (Lawani, 2021). IPA provides the means for in-depth data through multiple layers of analysis, which in the present study, is to understand underlying meanings and possible mechanisms of RSD. Moreover, two outcomes of IPA are to 'give voice' to participants and to 'make sense' through interpreting participant's accounts

(Larkin & Thompson, 2011). Under a CR position, participant's accounts are what they have interpreted of reality, thus they cannot be objective. By extension, neither are researcher interpretations.

Thematic analysis was considered to generate commonalities across themes. However, IPA was selected over this approach as it acknowledges diverse perspectives of lived experience (Eatough & Smith, 2017). IPA endeavours to unravel nuanced narratives which in this current study, related to the experiences of women with ADHD and RSD. Another aspect that IPA centralises that many methods of analysis do not is its use of double hermeneutics. As described by Smith (2011, p. 10), double hermeneutics is "access to that experience comes from a participant who is him/herself also engaged in making sense of what is happening to them". Under this foundation there is a crucial role researchers play as objectivity cannot be assumed. There are links between researcher's subjective experiences and the interpretations that are inferred (Tuffour, 2017). Therefore, engaging in reflexivity of possible biases and assumptions aids quality of the analysis (Dodgson, 2019). A further limitation of IPA is the time-consuming nature of the analysis (Lee et al., 2025). Furthermore, whilst CR aims to uncover the mechanisms underlying experiences (of RSD in women with late-diagnosed ADHD), what participants discuss may not be reflective of this deeper meaning (Lawani, 2021).

Ethical Approval and Considerations

Ethical Approval was obtained from the UH ethics board (protocol number: 0347 2025 Apr HSET; Appendix E). Three further amendments were made to the ethics protocol (Appendix E). Whilst each ethical amendment was submitted and awaited approval, (as per ethics board stipulations), participant recruitment was paused. The first amendment was required to update the interview schedule and debrief sheet following collaboration with an expert by experience (EbE; as stated in original ethics application). The second amendment was to extend the data collection period and widen the inclusion criteria to allow any participant with a diagnosis in the UK, which included minor amendments to relevant forms. Amendment three included altering forms to stipulate how long participants had to withdraw from the study, and to extend the data collection period. The main ethical issues that required specific management during the study are outlined below.

Consent

Prior to the interview, participants were provided with a participation information sheet and consent form (Appendix F) to ensure that they were aware of the purpose and potential impact(s) of the research. Whilst access was provided to both documents online, these were able to be downloaded by the participants. Furthermore, it was important that individuals did not feel pressured to take part once they registered their interest, completed their consent form, or if they changed their mind post-interview. Thus, prior to the interview commencing, verbal consent was reiterated, and each participant was reminded about the process of opting out.

Confidentiality and Data Protection

Matters concerning confidentiality, data storage and anonymity were explained within the participant information sheet. To protect the (electronically stored) data, passwords were added to all transcripts whilst they were being transcribed and analysed. The participant information sheet explained that where quotes were used in the thesis (or for possible future publication) anonymity could not be guaranteed as the participants may recognise their own narrative. However, this was mitigated by efforts to maintain confidentiality. The use of pseudonyms and minimisations (or removal) of personal and/or identifiable information aided anonymity and confidentiality.

Further information denoted in the participant information sheet included how data would be stored on a password-protected personal laptop and stored in the principal investigator’s UH OneDrive account, in line with UH ethical guidelines. The research team were the only individuals with access to the transcripts, data, and codes. In accordance with UH data protection guidance, pre-screenings, interview questions and study information (including the participant information sheet) were distributed online through the UH licensed Qualtrics account.

For those individuals who registered their interest in research participation, they contacted the principal investigator via email. This contact information was retained until they participated in the interview, unless participation was withdrawn. Unless they stated they wished to receive a summary of the research at the end of this study, then contact records were kept until the dissemination of the findings. Once these processes were completed, and in accordance with UH ethical guidelines, their data was destroyed.

Participant Wellbeing

I was mindful of the language used in the creation of the project due to the accounts of stigmatisation of ADHD detailed in the research (Mueller et al., 2012), and attempts were made to ensure avoidance of stigmatising or pathologising terms (Robling et al., 2023). Throughout the process, I aimed to use respectful and inclusive language that accurately represented participants' experiences. When probing about a specific concept brought by a participant during the interviews, I tried to reflect the same language, words and phrasing as used by the interviewees themselves for further detail or exploration.

Due to the nature of discussing RSD and their experiences of this phenomenon, there was potential for this to invoke difficult emotions. This was highlighted prior to the interviews commencing; thus, participants were encouraged to only talk about what was within their remit of what they felt comfortable disclosing and discussing and were reassured that breaks could be taken if needed during the interview, and that they could let me know if they did not want to discuss a particular topic.

The potential impact of the study on the participants' wellbeing following the interview were considered during the creation of the debrief form (Appendix F) which included signposting individuals to relevant mental health support where appropriate. Additionally, following each interview, the principal investigator verbally debriefed each participant, to check in with them. All participants indicated they were otherwise okay, and glad to have taken part, acknowledging feeling tired or drained, or that emotions were invoked but this felt releasing to them. Some explained they found the interview illuminating, making sense of their experiences for the first time. All participants were invited to ask additional questions should they wish.

Researcher Wellbeing

It is important for researchers to disclose their positionality to the subject, particularly in qualitative research. An outsider researcher has been defined as conducting research with a group or population, of which they do not belong (Dwyer & Buckle, 2009). Whilst I do not have an ADHD diagnosis, I must acknowledge the personal relevance of this topic's location within wider neurodiversity, in which I identify as an insider research position to the broader field of being a late-diagnosed neurodivergent female. Additionally, I bear witness to partial insider knowledge due to the personal relationships I hold with individuals with late-diagnosed ADHD. Therefore, this affects aspects such as my approach to research, interest in the topic, hope for the project's impact as a contribution to knowledge, how I relate to participants, and what is disclosed. However, researchers are increasingly stipulating that these positions are not binary or static (Htong Kham, 2024). Thus, I claim an insider-outsider positionality within this MRP. A reflexive journal was conducted from the inception of the research idea (discussed in greater detail in the 'quality, validity and self-reflexivity' section) to serve a dual purpose of protecting my own wellbeing due to the emotionality of the topic, and to illuminate my own interpretations of data (Tufford & Newman, 2012).

Web-Based Research

The nuances of conducting web-based research were considered in line with the British Psychological Society's ethical guidelines for internet-mediated research (BPS, 2021). For example, ensuring that participants had access to a device in a comfortable and private location for the duration of the interviews was essential. Advice was given regarding a stable internet connectivity where possible, and to self-familiarise with the software (Microsoft Teams). For the online Qualtrics form, mobile phone compatibility was ensured. In line with UH ethical guidelines, financial reimbursement for project participation was not offered until the interview was completed.

Consultation with Experts by Experience

From the project's outset, I intended to collaborate on the project with EbE consultation. It was important this was an individual who could contribute both from a perspective of lived experience, but who was able to reflect on their professional practice supporting others with these experiences. An individual was recruited as a research consultant who worked clinically alongside the population intended to be investigated: females diagnosed with ADHD in adulthood who experience RSD. They also identified with these experiences themselves (experiences RSD and received a diagnosis of ADHD in adulthood). Consultation was managed ethically through recognising their value and contributions and providing support for their participation. This included the option of financial reimbursement being offered post participation to ensure adequate repayment for their time. The EbE contributed to the development of the interview protocol and provided feedback on the project proposal and recruitment process, including access to participants.

As part of the EbE consultative meeting, their feedback impacted the study through implementing suggestions regarding the flow of the interview schedule, and the meaning of the questions, to allow for enhanced clarity and language. Some of the additional prompts to questions used were typically 'how does it feel' or 'can you anticipate or predict it'. By adding a question about how participants found they coped with their experiences, and how they made sense of RSD since discovering the term, this supported the ability to gather rich and detailed data.

Recruitment

A non-probability sampling frame was utilised, comprising of a purposive sampling frame. This allowed the investigator to contact organisations affiliated with the target population. In addition, participants were nationally recruited. This was initially planned to be through multiple ADHD charity advertisements regarding the study's poster (Appendix G), supplemented with associated social media groups, and word of mouth (opportunistic sampling). However, during the EbE research consultancy meeting, they explained they provided national support for women with ADHD through their charitable company. Consequently, their offer to support with the recruitment process preceded contacting other charities first, and thus they acted as a gatekeeper to participants. An overwhelming number of individuals registered their interest following this method of poster advertisement, thus eliminating the need to contact further charities, therefore opportunistic sampling was not required. This was an ethical decision to make, as the principal investigator had to turn down individuals keen to participate in the research. Each individual was thanked for their interest and although they were not included in the study, they could have an opportunity to be directed to future studies and could receive a final report on the present study. Participant inclusion and exclusion criteria can be observed in Table 4.

Table 4

Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Identifying as female.	Not identifying as female.
Received an ADHD diagnosis within the UK.	Self-diagnosed or awaiting ADHD assessment or received an ADHD diagnosis outside the UK.
18+.	Younger than 18.
Living in the UK at the time of research participation.*	Living outside of the UK at the time of research participation.*
ADHD diagnosis received in adulthood.	Diagnosed with ADHD in childhood.

**Note*. See below paragraph for criterions that preceded the above final inclusion and exclusion criterions.

The original inclusion and exclusion criterions were “diagnosed in the NHS and living in the UK at time of research participation” (inclusion criteria) and “diagnosed outside of the UK/outside the NHS or living outside of the UK at time of research participation” (exclusion criteria). Interested individuals were directed to contact the principal investigator via email if they wished to take part in the research, which enabled participants to self-select for study participation. Upon registering their initial interest, some individuals shared details about themselves and their experiences of RSD. Information was gleaned from these instances. It became apparent that these specific criteria, had the potential to be exclusionary to those who had sought diagnosis privately, or through the Right to Choose pathway. This pathway denotes a choice of healthcare provider. This is important contextual information given the current state of adult ADHD assessment in the UK being in a crisis, with unprecedented waiting times for diagnostic services being cited as four years (Smith et al., 2024) and within a one year period identified by a recent NHS taskforce to have risen to eight years (NHS England, 2025). Individuals are increasingly choosing private providers for diagnostic assessment, due to shorter waiting times (NHS England, 2025). As the nature of diagnostic routes within the UK is not related to our direct aims in this research, recruitment was paused whilst an ethics amendment was submitted and approved to make the inclusion criteria relevant and inclusive to the population, as referenced in Table 4.

Recruitment Challenges

Whilst registering interest for study participation was not an issue for the MRP's recruitment process, individual response rates and times from this point, to interview participation was an ongoing challenge. Following prospective participants emailing the principal investigator to register their interest, individuals invited for study participation were directed to complete a link to Qualtrics. This permitted them to read additional information about the project to consider the decision as to whether they would indeed wish to participate in the study. However, three participants who initially completed the pre-interview requirements, ceased responding when it came to organising a suitable date and time to complete the interview. One additional participant withdrew prior to the interview taking place due to personal reasons. No participants withdrew from the study from the point of interviews onwards. However, additional respondents who participated in the study, still experienced delayed response times in either completing pre-interview requisites, arranging interview dates, or both. The research team ensured that reminders were sent to these individuals, to confirm they had every opportunity to participate should they still wish. During the recruitment process, time allocation was provided to this population to allow for a longer response time and deadlines for interviews, so that they could be afforded more opportunities to participate. However, this ultimately led to delays with the data collection process which led to later ethical amendments to extend the data collection period.

Participants

Six participants took part in the study in line with recommendations for IPA research to be comprised of samples between four and ten (Smith et al., 2022). Demographic information was collected as supplementary information to the interviews. Ethnicity categories were selected according to the UK Office for National Statistics data collection guidelines (ONS, 2024). Five participants identified as White British, and one White and Asian, with ages of these participants ranging from 29–48 years. Participants resided in the East Midlands, South East, South West, London, and North West of England. The types of ADHD diagnoses included: Inattentive (one), Hyperactive-Impulsive (two) and Combined type (two). One participant was unsure of their ADHD subtype.

Additional demographic characteristics (Table 5) included: whether this was the first time accessing ADHD referral (all reported it was their first attempt), and what age each participant was when they received their diagnosis (29-45 years). For example, information on comorbid conditions was collected as research demonstrates that individuals with ADHD commonly experience additional, separate conditions (Katzman et al., 2017). Terminology is increasingly using the term *co-occurring conditions* to highlight when conditions do not only exist together but may influence each other. Whilst limited evidence remains to mark them as either existing independently of each other, or to be regarded as the same (Tyrer, 2018). Given the population studied, there may also be a chance they received a misdiagnosis pre the ADHD diagnosis. Co-occurring neurodivergent and/or mental health conditions can be observed, alongside additional demographics information below (Table 5).

Table 5

Participant Characteristics

Pseudonym provided	Geographical location	Co-occurring conditions	Age of diagnosis	Ethnicity
Jenna	North West	Yes	25-34	White British
Toni	East Midlands	Yes	35-44	White British
Claudia	Greater London	Yes	35-44	White British
Lucy	South East	Yes	35-44	White British
Nicole	South West	Yes	45-54	White British
Mabel	Greater London	Yes	35-34	White and Asian

Data Collection

The first part of data collection involved the development and piloting of an interview schedule, to guide the semi-structured interviews. This included a series of prompts. The topic areas were created based on pre-existing literature, the SLR findings, current definitions of RSD symptoms, and with a view to answer the overall aim and research questions. This included but was not limited to whether knowing about RSD changed the experience of this phenomenon, and what are the associated impacts of RSD. Once the interview schedule was developed, this was reviewed in collaboration with an EbE. Following this, the interview schedule was reviewed again with the principal thesis supervisor. Some tweaks were made to the schedule including additional and clarifying prompts. This included how participants coped with their experiences, and how they made sense of RSD since finding out about the term, in comparison to experiencing this phenomenon before. A formal question to check whether there was anything else they wanted to add before closing the interview was also made. Following this, an amendment to the UH ethics protocol was made.

A pilot interview was completed to test the language, flow of questions, whether they lasted for the approximate interview length, and whether the questions, complete with probes answered the research questions. It was determined that this was successful. Following a reflection, a definition of RSD was added into the interview script. The same script was provided to participants at the start of each interview, to frame each in the same way, meaning that any similarities and differences within the interviews could reflect the variation of the participant’s experiences alongside their own and my own interpretations of these, rather than any undue influence from myself. As part of this I conveyed that I was conducting research and acknowledged that this therefore may feel less of a back and forth conversation. The interview script and beginning of the interview schedule included reading a current working definition of RSD. This served a dual purpose: 1) to ensure consistency that each participant is working to the same working understanding of the phenomenon, and 2) checking with the participants that RSD was a term they identified with/thought to be useful, or whether they used another word or phrase. Each of the women stated that they used the term RSD.

As stated in the key text, the questions comprised for the interview schedule were IPA informed with efforts made for these to remain open-ended and exploratory (Smith et al., 2022). The selected prompts were structured to avoid leading questions and allow for flexibility of participant discourse, whilst adhering to the principles of IPA questioning by exploring the processes and meaning of the participants’ narratives. An example question from the interview schedule is: “can you tell me what it is like to experience RSD?” An example prompt is: “how did you feel in the moment” (Appendix F). Based on the responses participants provided, there was some deviation to the order in which questions were asked, which is where additional prompts were helpful to provide opportunities for further elaboration.

Interviews were completed between March-May 2025. Regarding the timing of interviews and deciding when to terminate the interview with a participant, I decided to allow each participant to offer full explanations of anything they wanted to bring to the interview. However, I remained mindful of when it was appropriate to end the interview, for example picking up on verbal or physical cues from the participants that may have indicated they were tired and ready for the interview to end.

Given the rich, interpretive narratives of IPA, data saturation is not possible as in theory every participant could and would have a different lived experience. Therefore, the number of interviews arranged were terminated once the data had reached a point of richness and detail that inferred theoretical sufficiency, whilst remaining within the advised 4-10 participant bracket (Smith et al., 2022). This was completed in consultation with the primary research supervisor. Once six interviews had been completed it was agreed that there was no need to recruit or interview further participants.

Data Analysis

Interview transcripts were automatically generated on Microsoft Teams. However, these were not wholly accurate. Furthermore, Microsoft Teams does not pick up on pauses, laughs, tone or volume of speech, which would have been helpful in supporting interpretation and context of the interview to aid interpretation (Smith et al., 2022). Therefore, each participant account was manually checked against the audio recordings for correction and accuracy. This aided the coding process.

In accordance with the most recent IPA key textbook (Smith et al., 2022) the analytic process was followed as described. Firstly, each transcript was re-read several times, the first of which, the audio recording was listened to in tandem. Each reading and re-reading of the transcript increased familiarity and consisted of making notes for avenues of interest that the text sparked (exploratory noting). These annotations of the transcript were on paper, highlighting sections of text, and exploratory notes written next to these. In accordance with the process outlined in Smith et al. (2022) I compiled these notes into a table (Appendix I). This table contained three columns to demonstrate the transcript, with exploratory notes immediately to the right. Exploratory notes comprised of three themes which I colour coded for visual ease. These included: descriptive, linguistic and conceptual themes. These exploratory notes were categorised through colour coding, in accordance with whether they were descriptive (colour coded as red), linguistic (colour coded as yellow) or conceptual (colour coded as blue). As my attention was drawn to excerpts of interest, this aided the thoughts and reflection as documented in my reflective log.

Once the coding stage was complete, I moved on to the production of experiential statements. These consisted of consolidating the notes into a series of statements. I added another column to the table to left of the transcript section, to organise the experiential statements (Appendix I). These then led to the development of personal experiential themes (PETs) through organising how the experiential statements fit together to form clusters that reflected their narrative (Appendix I). Finally, I repeated this process (of coding, through to PET creation) for each participant's transcript before developing group experiential themes (GETs). For the following stage of examining the PETs across the group to generate GETs, I completed this manually (printing out the PETs) to allow me to visually notice divergences and convergences in the experiences given by participants. The themes generated, alongside their accompanying participant quotes, were reviewed with the research team. GETs comprised of integrating links between participants and organising these associations in a hierarchical nature. This process allowed for the emergence of subthemes in a way that summarised the narratives brought by the participants.

Quality, Validity and Self-Reflexivity

In addition to contemplating my insider-outsider position in relation to researcher wellbeing, it was considered that my stance and subsequent beliefs, attitudes and assumptions may affect the quality and validity of the study. A reflective diary was kept from project inception, and this was particularly pertinent in aiding reflections on my assumptions during the analysis. Diary entries and reflections supported the quality, validity and the self-reflexivity of the analytic process. This was achieved as any assumptions that presented through the course of the reading and re-reading of the transcripts whilst coding was written in the reflective diary. Writing diary entries enabled a detachment from the thoughts to return to the transcript, without this affecting subsequent coding interpretation. Hence, this process was useful in supporting the authenticity and reliability of data interpretation. Whilst there remains criticism around researcher reflexivity regarding amplifying the narrative of the researcher rather than the participants for the present study, it was sought to be utilised to reflect on personal biases and assumptions within the analysis as a method of ensuring rigour, quality and transparency within the analysis (Olmos-Vega et al., 2023). Examples of excerpts from the reflective diary can be observed in Appendix H.

An additional form of reflexive activity that was completed prior to the analysis of the data, involved conceptualising myself compared to participants (Appendix H). This process involved me visually mapping characteristics of myself and the roles I held, in addition to those of the participants, to prise out similarities and divergences of identity. Three areas overlapped: being a female, late diagnosed with a neurodivergent condition and being British. It was striking to highlight these, and various points of difference: motherhood, marriage, geographical location and co-occurring conditions . This task ensured I was aware of how aspects of identity may intersect for each participant. This was helpful during the analysis to simultaneously hold awareness of these in mind whilst I made interpretations of the data, and grounding interpretations in the participant’s narratives.

Whilst methodological coherence has been explicitly stated throughout this chapter, ensuring quality and validity of the grey literature was additionally ensured through study appraisal, with the measure identified for evaluation of grey literature during the SLR: the AACODS. For each of the six criterions, outlined is how these were accommodated within the study (Table 6).

Table 6

Quality Appraisal for the Empirical Study (MRP)

AACODS	Self-assessment of the empirical project against the AACODS criteria
Authority	This empirical research is undertaken as part of the UH, a reputable organisation. This is undertaken as a doctoral level empirical research project, under expert supervision by two supervisors within the area of neurodivergence. There is a current and up to date reference list.
Accuracy	There is a clear aim that is met which was then organised into a small cluster of research questions, as suggested in the key text of the IPA methodology selected (Smith et al., 2022). The methodology is stated and adhered to. Data collection is explicit, and justified, appropriate to these aims. Not yet peer-reviewed but will be submitted to journal publication for peer-review, in line with course requirements. Supported by credible references. Novel area of work in the field, representing pre-existing literature but also adding a counterbalance.
Coverage	A specific homogenous population is studied, with inclusion and exclusion criteria explicitly stated.
Objectivity	Opinion and standpoint clear. Possible biases and assumptions are reflected upon, in accordance with position as insider-outsider researcher. Behind claims of research finding and discussion of these, attempt has been made for these to be balanced.
Date	Date stated for data collection. Relevant and recent references utilised.
Significance	The research is meaningful, relevant across many contexts. Implications are explored within the discussion section. The study itself is novel, strengthens and refutes research. Integral to this area of research as is a novel topic, integral to future research on RSD.

Results

This chapter addresses the findings from the IPA. Four GETs are presented alongside accompanying subthemes (Table 7) and presented alongside the pseudonyms as recommended in IPA research to enable readers to feel closer to the accounts (Smith et al., 2022). Minor alterations were made to some quotes for results presentation only, to enhance readability (removal of some filler words and immediate repetition, where these were not for emphasis, and self-corrections providing this did not alter participant meaning). The occurrence of each GET across participants is demonstrated in Appendix J.

Table 7

Summary of GETs and Subthemes

GETs	Subthemes
1) "A 360" in valuing self: The pivotal moment of discovering RSD	a) Re-authoring my narrative b) Invalidation through RSD being unknown c) Alleviating the intensity of RSD
2) "RSD ruined my life": Strategies for survival	a) Moulding self since childhood b) Avoiding rejection at all costs c) Escaping the pain of RSD
3) "Riding the wave": The immediate emotionality of RSD	a) Acute bodily changes b) Rapid emotional shifts
4) The reinforcing cycles of rejection	a) Accumulating rejection b) Work based burnout c) The self-critical nature of RSD

GET 1: "A 360" in Valuing Self: The Pivotal Moment of Discovering RSD

Each of the participants attested to the importance of discovering the term RSD. Most cited this as the springboard for re-authoring their self-narrative, and all noted invalidation through RSD being largely unknown to others. Each of the women explored the factors that alleviated the intensity of RSD.

Re-Authoring my Narrative

There was a sense from most of the women that the term RSD was stumbled across, following an ADHD diagnosis. Mabel stated: "it was a fellow neurodivergent who, through hook, or crook had learned about RSD and told me about it. And I looked it up and I just realised how much it hit the nail on the head." The phrase "by hook or by crook" implies a sense of RSD being an elusive terminology that is relatively unknown. Despite this, there seemed to be an immediate affinity with identifying with this term. For these women, a new language provided an alternative lens to view themselves through. Discovering RSD was the catalyst to re-framing lifelong experiences, as noted by

Toni: “the RSD part of it has been like a huge thing in my life, and I'm just finally sort of understanding what it is and why I felt the way I did.” It provided the women the opportunity to reframe their narrative of “being oversensitive”. Mabel explained: “I always thought that I was just really sensitive, to you know, the slightest thing. But then I was introduced to this term, I went, ‘oh, there's a term for it’ (*chuckles*) this is part of neurodiversity.” Jenna explained how it “does validate … years where I thought I was maybe overly sensitive erm, or too reactive, you know, actually there's a chemical reason for that.” Not only was validation widely described from discovering the term RSD, it shaped a recent journey to self-discovery. Many participants reported an “oh my gosh” moment in which they uncovered the term RSD. Lucy exclaimed:

> This is me! Every single word. This is how I behave, this is how I feel. So, I think it was like a ‘wow, there's actually a name for it.’ … feeling so different my whole life and feeling like, ‘why do things upset me so much? Why do I care so much? Why do I behave this way?’ … it was an eye opener.

For each of the women, there was a shared resonance with others who experienced this phenomenon, enabling a revolution of identity. For many of the women, this provided “comfort.” Here is sense that isolation can be mitigated by collective identity. Lucy’s excerpt demonstrates self-directed questions being answered. Many of the women turned to online platforms for answers. Jenna explained how “clinical based stuff is really just related to males” spurred her to turn to social media platforms “to hear more female experiences”. Here, RSD being discovered led to the realisation “someone else has reacted to the extent that I did! … Ruined their life because of rejection.” There is a sense that this was a shock for Jenna, and that this alleviated some of the internalisation of her RSD experiences previously. However, a secondary emotion resulting from discovering RSD was described by two participants. Jenna described “mourning” that RSD was only discovered in adulthood, and she thought that finding out sooner “[I] could have found things a little bit better”. Nicole described how for her, RSD felt “virtually unexplored” and after several years there was “so much to understand and to start to try and make peace with.” However, arguably one of the most helpful aspects of discovering RSD was it enabled a shared dialogue with others, particularly in romantic relationships.

Another aspect that transformed participants’ sense of selves was becoming immersed in neurodivergent spaces and communities. Mabel noted: “at no point did I feel critiqued or unwelcome, or judged or any of those things about what I was sharing and what my needs were.” Unwavering support and lack of judgement from others may have been a newfound experience for Mabel. Unlike many of the stigmatising experiences the women described, this may provide validation for RSD experiences for the first time. Perhaps this underpinned the self-acceptance described across participants. Claudia echoed how self-acceptance was synonymous with: “it’s almost like the control came back to me ... like I became important enough to be like my body’s trying to tell me something. And if other people can’t accommodate that, then I will do it for myself.” For Jenna, she described how she positively affirms herself when experiencing rejection:

> It is a rejection. It's gonna hurt, but you're not gonna make yourself suffer anymore. So, in the longer term, now rejection 9 out of 10 times (*pauses*) there's nothing. It ends at the short term. It doesn't follow me until long term anymore.

Enhanced self-compassion was commonly narrated by other participants. Lucy further described a strategy of reminding herself “I'll be okay and I'll, I will get over it” for RSD to hold “less power over you in your emotions”. A reconceptualisation of identity was typically described across the women as increasing self-worth and diminishing RSD effects. Toni explained:

> Having an understanding … it stops you feeling quite so much like, there's something wrong with you. (*pause*) It helped me notice more when it happens, as opposed to just, like ignoring it or brushing it off or just (*pauses*) accepting that I’m crap.

Here, it appears that self-awareness cultivated decreased self-blame, to relate and respond to RSD in a different way than previously. For Toni, there was a shift to “I was alright on my own. I'm a nice enough person and people do like me just for being me.” RSD stopped affecting friendships and relationships once she valued herself, as it enabled her to view her own qualities. An excerpt from Claudia demonstrates how powerful this reversal of self-worth was: “it’s about putting yourself at the top of the list where we always put ourselves at the bottom.” Participants further diminished the “power” RSD had over them through reframing that RSD is part of them, not their entirety. Toni explained: “it doesn't have to rule your life. Erm it is you, it's part of you, you can't change it. You’ve just got to accept it, live with it and don't allow it to be the defining thing about you.”

Invalidation Through RSD Being Unknown

Each of the women discussed the balance of sharing RSD with others and the invalidation felt when others misunderstood. This included friends, family, medical and mental health professionals. Often, this led to feelings of hopelessness, and a lack of trust. Some participants noted a lack of awareness meant support from others was limited, meaning they were mostly reliant on self-support prior to receiving an ADHD diagnosis. Mabel stated this was sometimes self-imposed isolation but also: “because they don't get how badly you can feel.” Even as participants attempted to try and make sense of RSD before having the language for this, some women explained how general practitioners (GPs) fostered a culture of feeling pushed to quickly “fix” themselves with medication. Two participants described being “misunderstood and misdiagnosed” with depression. Lucy stated:

> My doctors were just very keen to get me to have, you know, antidepressants. And I found it really hard because I was facing … real life problems. So, I think that a tablet wasn't going to necessarily fix those problems.

What Lucy may be alluding to is that medication for her would not “fix" aspects such as stigma from others, or the intensity of which she responded to rejection. Claudia elucidated how her experiences of feeling pushed towards medication to solve difficulties with RSD felt inappropriate because it intertwined with a core part of her experience: “you're adding to this ‘I need to be fixed’, whereas underneath it it's not a problem to be fixed, it's a part of a person.” Jenna further expanded how at the point of ADHD diagnosis, RSD had decreased in intensity, meanwhile, the NHS post-diagnostic support available was limited:

> There isn't anything apart from medication … I'm at a level now where it's [RSD] not leading me to crisis or it's not making me lose my job or make precarious decisions that maybe aren't most helpful in a situation.

Here, there is an implication that the time medication would previously have been most useful, had passed. Another experience regarding how RSD was misunderstood by medical professionals was explained by Claudia:

> It sounds extreme … that it couldn't possibly be true or that they, that you couldn't feel that way often because ‘how can that make you feel a physical pain? But how can that make you feel so bad that you want to end your life over that?’ It feels like you're being very dramatic and almost like, like catastrophising.

For Claudia, there is an underlying tone of invalidation, possibly rooted in a sense of not feeling believed. This perhaps adds to the narrative of disbelief from others and feeling labelled as an “dramatic”. Many women explained how communicating how impactful and distressing RSD is, can be met with their concerns not being viewed as legitimate or debilitating. The meaning participants made from this was that GPs and other medical professionals do not understand the nuances of ADHD and RSD and the interplay with mental health. For Claudia, this would prevent her from confiding about her mental health: “I wouldn't speak to a GP because I just don't think they get it. They don't understand … that makes it feel worse.” There is a sense here that her previous experiences intensified her distress and implied that enhanced understanding and compassion is most required from professionals.

Participants also described a felt sense of being let down by work and therapy through professionals not being familiar with RSD. Mabel discussed her application to Access to Work where she received ADHD coaching which she perceived as “a bit underwhelming … it's been surprising how few people seem aware of how it presents and how, how much it can feed into all the issues one tends to go to a therapist for.” This was echoed by many participants, describing accessing support from a therapist “quite hard”. There was a generalised sense that they “didn't understand ADHD or neurodivergence” (Claudia). Some women felt therapy tried to alter them rather than support to enhance oneself. Furthermore, participants described a lack of emotional support from romantic relationships. Nicole noted: “It's going to sound quite negative … my husband's a really is a good guy, but I don't think understands the, the ups and downs of my emotions and finds them generally probably annoying.” This was also experienced by Lucy, who felt that “actually often what I seek is just comfort. I don't need a solution.” For her, this was most likely to be offered by family than by friends and romantic partners: “It's very, extremely hard in a relationship, for example and friendships, whereas from a family perspective … I think it's definitely understood.” Perhaps acceptance from others is synonymous with an absence of judgement, and the freedom to be authentic.

Overall, discovering RSD enabled a level of reflection from the women on their life experiences, particularly around educational and work settings. Many participants described RSD not being well understood by those who have never experienced this phenomenon, including nuances of navigating understanding in romantic relationships. The women described looking back post-diagnosis, that a lack of understanding and support for RSD at school and work systems could be due to them being “not equipped” to support individuals with experiences of RSD. Mabel stated: “everything feels sort of out of reach or inaccessible … you are trying to function in a neurotypical world.”

Alleviating the Intensity of RSD

Discovering the term RSD enabled the women increased self-understanding to generate new methods of coping. This involved an externalisation of the rejection that had previously been internalised. Participants described embracing aspects of their identity regarding neurodivergence that was previously well hidden, and reframing this as a strength of character. Overall, a core narrative described across participants was increased confidence to share their experiences with others, and enhanced coping. Jenna described the benefits of increased self-awareness:

> I notice what it's like to start feeling rejected or starting to feel guilty or whatever feeling might put me in a vulnerable position to rejection. So, I know when to anticipate it. To an extent, it still doesn't mean I don't feel it anymore. I just feel it less intently.

Jenna’s description infers that sensing RSD enables her to regain control over RSD. Anticipating rejection is suggestive of expecting a negative emotional reaction, yet there is a newfound predictability which brings a slight comfort, rather than the experience being unexpected. Knowing what RSD is means increased recognition of triggers. In response to difficulties in receiving feedback, many women noted new methods to tolerate this. Mabel noted: “Feedback needs to be done very constructively, … language to empower the person … coaching and empowering a person are hugely important, er rather than pointing out what they've done wrong.”

Feedback should be considered to empower and positively reinforce instead of only criticise. “Coaching” may infer that scaffolding these conversations that commonly happen in the workplace, would be useful as a tactic of leadership and management. One interpretation could be that feeling respected and valued rather than attacked, are most helpful techniques. Nicole further reflected on re-examining her experiences at work:

> If I had to have received that feedback in writing in a room by myself without it being quite an intense person to person meeting … maybe if I'd have controlled my environment much

> more… I might still have felt really cross and upset about the thing, but I don't know if the RSD would have been triggered to quite the same extent.

Nicole noted how receiving feedback in advance and preparation can minimise the effects of RSD. Similarly to this excerpt, many participants exhibited a shift in tone from perceiving their responses to RSD as “childlike” and feeling associated shame, to externalising this. Here, Nicole’s response is practically rooted, moving from the perception of feeling totally responsible, to a recognition that RSD requires reasonable adjustments at work. This was echoed by Toni who suggested that RSD should be “acknowledged that this is a thing to start with … it's not just somebody being over-sensitive or touchy or whatever, you know this is this is an actual (*pauses*) condition.” The pause before stating that RSD is a condition signifies a reframing of the old internal narrative. Here, accepting the condition appears to externalise this.

Across the women’s narratives, external validation was valued. This transformative shift in viewing work was echoed across the women. Claudia described self-employment as “life changing”. She felt unable to be authentic regarding her experiences of RSD in employed work, describing feel “forced into an office” and being unable to “take time when I need self-care”. For the women remaining in employed work, effects of RSD were discovered to be mitigated by validation and fostered by empowerment. For Nicole, ensuring “emotional safety” minimised feelings of persecution that colleagues “were not out to get me, before they gave me a bit of negative feedback.” There is an underlying vulnerability here in seeking “emotional safety” from employers. For Nicole, this reassurance prevented feeling attacked. Following experiencing RSD, drawing on the support of friendships was noted across the women to “help you recover” from RSD. There was a sense that those who know you best, can bring positivity, through recognising what you have gone through and remind you of who you are. In addition to the reassurance from others, some women spoke to their experiences of seeking neuro-affirmative therapy to help to “regain their voice” and renegotiate boundaries with others. Some women sought private ADHD coaching, which was only described in these interviews with positivity. Nicole for example explained: “I had a little bit of ADHD coaching, and we talked about creating the scenarios in which you can do better.” Across the women’s narratives, they discussed a plethora of self-help strategies. Lucy commented that reframing her perspective alleviated the intensity of RSD:

> It feels like a life-long sentence of that feeling, but actually by being able ... to just kind of almost step back helicopter view and acknowledge what's happening. It you kind of understand that it's going to pass and you're going to be okay.

Using terminology of “life-long sentence” infers RSD felt like a prison sentence, punishment or something that is deserved, However, Lucy describes escaping this narrative through a “helicopter view”. This incorporates detaching from the instant emotion and allowing self-compassion. Other commonly noted self-help techniques were skills such as breathing exercises. “Physical practice” such as yoga and Pilates, being one with nature, including being outdoors and with animals, was well endorsed by the participants. Lucy described these as enabling her to “feel more grounded, more connected, more at peace.” The mind-body link was well cited across participant’s narratives. For Lucy, this enabled her to recognise her boundaries to prevent burnout:

> I’ve started to implement some boundaries ... I've been really proud of myself, actually not putting myself in a situation to please someone else. To then later feel exhausted, or it's actually really empowering to sort of say no and put a boundary in place.

It seems Lucy is surprised with how effective implementing boundaries is. Previously this would typically have induced a fear of rejection. There is a sense that this is still a fine balance to navigate, but that this has only positive effects.

GET 2: “RSD Ruined my Life”: Strategies for Survival

The second GET denoted the day-to-day life experiences the participants chronicled regarding living in fear of experiencing RSD. Specifically, how this chronicity of RSD permeating life since childhood manifested in a series of self-preservation strategies. These served the purpose of moulding oneself as a tactic to prevent the future self from experiencing further rejection, and the resulting psychological distress accompanying this. All participants described the lifelong trajectory of RSD and is best surmised by Toni: “obviously it’s something that I’ve experienced my whole life.”

Moulding Self Since Childhood

Several participants described how they navigated RSD throughout their lives, starting in childhood. Masking RSD was described by many participants to enable “fitting in” and avoid negative connotations that sharing their experiences of RSD with others, may have caused. Toni described how she hid her RSD from others since childhood and narrated an experience that involved anticipating rejection at school:

> I didn't realise what it was, but yeah, that that week leading up to parents evening … I'd be petrified. Absolutely petrified knowing full well I've not done anything wrong. I was a well masked *(laughs)* child … I wasn't naughty. I never got into trouble … it would be horrible because I'd just be so worried that something would be said about something that I hadn't actually done. But again I masked it. Mum and dad didn't know that that stressed me out. I kept that very well, very well hidden.

Toni highlights how living alone with the stress and weight of anticipating the rejection was experienced as “horrible” and “petrifying”. In the absence of a language for RSD, sharing these anticipatory stresses could form a negative narrative from others. Hence, she felt the need to hide these feelings from her parents where possible to control how others perceived her. The early years was a “foundational template” described by participants that marked feeling different in comparison to others. For Lucy, this was framed “from quite a young age”. For Nicole, she described how ex-partners would “call me overdramatic, oversensitive” and “a cry-baby”. This demonstrates that whilst these labels often began during childhood, these narratives followed throughout life. Over time, judgements from others became internalised for Lucy: “having that you know label, ‘you're just sensitive, you're just sensitive, you're just sensitive' ... which is to repeat my brain every time I would, you know, something would happen."

For Toni and Lucy, one technique utilised to prevent a label of "sensitivity" was comedy. Toni reported she "always used humour to like cover up difficult or uncomfortable situations … to cover up how I'm actually feeling about things". This poses the question as to whether masking RSD with humour when around others culminates in privately experiencing RSD effects, alone. For Toni, humour served a dual purpose, stating: "I think my RSD caused me to be, or at least try to be a really likeable person because I didn't want people to reject me. I was really afraid of not having any friends." Stating "or at least try to be" may infer that RSD has the potential to impact social relationships and therefore could incur the possibility of being less liked. Masking was commonly described and may form a preventative strategy, appearing more likable to others to minimise the possibility of social rejection as there was a sense that even in participants who did not describe humour, they strived to be accepted in other ways, namely through people-pleasing. Mabel noted "doing everything in my power to get an explanation, or to make it up to the person … to be good enough again to be in their good books or accepted." Thus, inferring that she is unsure why she has been rejected, culminating in assuming responsibility and resulting in a decreased self-worth. Whilst this strategy is an attempt to ensure acceptance to keep her safe from the possibility of being rejected, this may cause unintended consequences, such as sacrificing her own desires and needs. For Lucy, masking culminated in realising: "I don't think I've really learnt to like myself or love myself ... I was so aware of trying to regulate other people's emotions and make them happy. That I don't think I've really learnt how to regulate myself." Over time, masking difficulties through people-pleasing culminated in undeveloped skills to value herself. The resulting impact of a lifetime of masking this response culminated in chronic exhaustion for Mabel:

> You realise how much you have to mask everywhere else erm, and how exhausting that can be. And if you don't, how you feel like you might be critiqued or rejected ... I can feel quite a

> strong juxtaposition being rejected for a need that you feel quite strongly about but have to mask.

Mabel describes masking as a survival technique culminating in exhaustion from “strong” feelings through an inability to be her authentic self as it is synonymous with experiencing criticism or rejection from others. Lucy explained that keeping RSD hidden and dealing with it alone has the propensity to increase the length of the experience: “If you're only stuck in your own mind, I find those episodes … can go on a lot longer.” Mabel echoed this sentiment, that masking for so long means feeling “so much more strongly” that it becomes difficult to “not let it blow up”. The intensity of internalising these thoughts and feelings may reinforce a sense of not coping with rejection well, and unfavourable comparisons with others regarding how they manage experiences of rejection.

Two participants did not describe masking. Jenna discussed how being rejected as a child had become a “normalised” part of her life. Jenna explained how it was easier to externalise childhood rejection due to lack of perceived responsibility:

> I had quite, quite a substantive childhood of rejection … I just accepted that that was reality. So it always was normal to me … but then when I got to university, I realised I have control over situations more than I've had before and because I had more control, I felt more responsibility to the rejection.

Jenna implied that physical control over her life led to increased agency. This is perhaps synonymous with a perceived increased emotional responsibility tied to rejecting experiences, which other participants may have felt earlier in life.

The Unintended Consequence of Avoiding Rejection

Accompanying living with the fear of rejection, is a self-preservation strategy of avoidance, often characterised by self-exclusion or withdrawing from society. Mabel offered that anticipating RSD induces avoidance: “it makes me not want to do the thing that you know, is eliciting that kind of feeling. Wanting to give up and do something else.” Starting to associate situations as likely to induce rejection led to avoidance and was widely described across the women. Uncontrollability was commonly echoed across the participants and an ultimate fear of social rejection underpinned avoidance. This affected all areas of the women’s lives. Jenna described: “I was so fearful of rejection, I'd avoid situations where rejection could be a potential.” For Jenna, this fear was so strong, avoidance would be experienced regardless of the level of risk involved:

> I'm like, ‘I'm just useless’, so I'd avoid things day-to-day. I wouldn't approach people romantically. I wouldn't approach friendships. I won't approach jobs. Erm I maybe wouldn't take safe risks if that makes sense. ... So I lived in quite a shell for a few years.

Anticipated rejection extended from oneself being rejected to friends and acquaintances triggering RSD. Jenna further described this in relation to her job: “the rejection hurt me because it was an extension of this person's rejection.” This was echoed across the participants whereby others are viewed as “an extension of self.” Nicole expressed a similar notion in her role of parenting: “you feel it on behalf of your kids.” Toni described this in relation to her business being rejected stating “I take very personally because the company is us.” For Toni, work-based avoidance materialised due to the fear of experiencing negative feedback: “I did training … I still haven't looked at the feedback of because the thought of it makes me feel sick.” The fear of judgement manifested for some participants as preventing them from seeking support from others due to feeling “undeserving” of this. Claudia explained how this affected her as a parent, increasing her struggles as a mother. She described asking for help as “virtually impossible” and putting herself “to the extremes”, thus suggestive that the idea of asking for support was tied into self-worth. This demonstrates the chronicity participants described resulting from fear of rejection, culminating in overthinking relational interactions and suggestive that this depletes self-confidence over time. Whilst avoidance was meant to minimise the effects of RSD, it affected not only themselves, but others in unintended ways. This was commonly described, and best explained by Toni:

> All-consuming I think is probably the way that I would describe it, it's something that affects every part of me as a person. So mentally and physically, but also then that ripples out into like wider connections, so like family and work.

The inference is that the gravity of being affected in every facet of mind and body, the resulting impact on oneself is exhausting. The impact of avoidance across multiple areas of life was further described by Lucy through culminating in a preference to be alone:

> I just find it a lot easier just to be on my own and to be self-employed through all of those struggles and the battles of doing that ... I don't want to be on my own, I do want to find … a healthy, happy relationship … sometimes it's just nice to just be and just to feel what you want to feel without having to explain it, or analyse it or be apologetic for it.

Solitude was preferable to being triggered by others. The resulting impact of having to explain her responses perhaps fuelled avoidance, in addition to anticipation of social interaction possibly leading to RSD itself. This is suggestive of an exhaustion from feeling a need to defend her position, and experience of RSD. Ultimately, the unintended consequences of avoidance, whilst a strategy intended to prevent experiencing RSD perpetuates other reasons to be rejected. Nicole noted how it hindered her career: “it's a double bind because people don't like people who lack confidence either. So, then that becomes the thing that you're criticised for.” Over time, this appears to culminate in an ultimate consequence of avoidance, isolation. Claudia offered:

> I've spent my whole life running away, just running and running and running … as soon as I felt like somebody kind of got a bit too close to me or started to understand who I was or what was happening like, I would just run.

Claudia describes what appears to be an endless pursuit of avoidance, as a method to place distance between herself and others. Overall, experiences of avoidance were described across the participants to cause isolation, leading to feelings of loneliness, and ultimately, self-blame. Lucy denoted: “it’s a really lonely place … the pain is not fitting in, it’s not belonging”.

Escaping the Pain of RSD

The previous subtheme explained avoidance as a pre-emptive technique to mitigate RSD. Despite the strategies enlisted to minimise possible rejection, ultimately this did not prevent participants from experiencing RSD. Most women reported a plethora of strategies to escape the immediate pain of RSD. Whilst this varied across the participants, this often included disengagement, leaving jobs, changing careers and suicidal thoughts. It also incorporated strategies such as drinking alcohol, drug use, and spending significant amounts of money, incurring debt. All serve the function of short-term relief from the emotional pain that RSD caused. This was well described by Jenna to “fill the void that the rejection had created.”

Nicole discussed her experience of RSD following disagreement in a group setting: “at the time I probably just disengaged ... I just couldn't participate any further.” Thus, shutdown functioned to minimise further rejection. Others described becoming self-employed to limit the RSD caused by interacting with colleagues and managers. The participants described a multitude of quick responses to minimise the negative effects of RSD. Jenna stated: “that was how bad in rejection was for me. It was debt, quitting my job, making incredibly rash decisions, irrational decisions ... it was a horrible three years in response to that.” Here, the short-term relief induced detrimental long term consequences.

Many participants described enhanced alcohol consumption “so that I didn't feel anything” (Claudia). Coping privately with this pain numbed the associated emotions that RSD invoked. Toni further reported previously coping in this way: “I’m really hoping as time moves forward that I find some really useful coping strategies. Erm but certainly not the drinking and drug taking that I did when I was younger.” The emphasis of not having a multitude of skills at her disposal at the time to manage RSD. It could infer that the passage of time enabled a development of responses to cope with RSD, but navigating these forms an ongoing balance. Being on the journey towards developing alternative methods of coping was often discussed optimistically and framed many participant’s narratives. Having a plethora of coping techniques for RSD, was typically developed post-ADHD diagnosis. In earlier life, many of the women described being unable to envision an alternative path or resolution of the trigger for RSD. Many participants described permanently leaving jobs. For example, Mabel offered “I just couldn’t face it anymore”. Perceived ability to cope with the resulting rejection, was described as affecting whether a situation is “reflected” on, and subsequently faced, or whether the only felt option is to escape. This was further elaborated by Claudia, who stated:

> I would be so convinced as well at the time that what I was thinking was 100% right. So, I would be like ‘I can see that the way that you're looking at me’ or I can feel it or sense it … I felt like I had this intuition around what was going on. … I was like, ‘that is the absolute truth’.

In this example, RSD may have been triggered by a hypersensitivity to the expressions or body language of others. This may have been perceived rather than an intended rejection from another, but regardless, the outcome is that she experienced a “100%” conviction in her belief that she was being rejected in that moment. Many of the women described that this often resulted in a desire to escape these feelings that was so strong it manifested as suicidal thoughts. For example, Nicole explained: “It's such a mixture of like confusion and *(sighs)* and like such like, dread. I was just like, well, I can't go on.” A subset of participants described the time in their life that these emotions were strongest was at transitional points such as motherhood and their 20s, a time of emerging adulthood. A lack of coping skills at these women’s disposal to cope with RSD induced an immediate desire to escape. Jenna stated: “you're like, well, that's the only way that I can deal with the rejection is to remove myself completely”. Despite this being described as happening “when I was a bit younger”, ruminating on criticism from others for many participants, became internalised in the long term culminating from the self-critical thoughts. As described by Jenna:

> A large proportion of those thoughts were very negative. Very criticising, lots of heavy voices. ... I don't mean it from like a psychosis perspective, but a lot of the voices were criticisms repeating themselves that those staff had said to me. The betrayal that they've been saying everything was going well and then he put me in a meeting where it wasn't. Because those thoughts kept going again and again, they became fact.

Jenna narrated that criticism from others started a spiral of self-criticism, amplifying the negative inferences regarding her core sense of self. Furthermore, the language of a "betrayal" may highlight a deep-rooted pain, from the unexpectedness of receiving a criticism. Similar language around betrayal was used by Mabel who offered a unique perspective around the situations and triggers that were inescapable. For her, this was a health condition:

> There's a sense of betrayal by one's body … I almost feel like a sense of rejection sensitive dysphoria within my body, by my body … It's not something I can move away from or do better or whatever. It's just something I have to manage.

Mabel describes feeling a self-betrayal. There is no method to escape when the rejection is coming from within. Therefore, there is no option but to "manage" the associated painful emotions in another way.

GET 3: "Riding the Wave": The Immediate Emotionality of RSD

Each of the women described a distinct, acute phase of RSD, ranging from "minutes and probably not more than a day or so" (Lucy). Consistent characteristics were that there is a physicality to RSD, accompanied by rapid emotional shifts. There was a felt sense across the participants that whilst experiencing this acute stage, RSD cannot be prevented, with Nicole succinctly describing "there's precious little you can do to prevent it happening."

Acute Bodily Changes

Whilst bodily changes were consistently described as a fundamental aspect of RSD by most participants, there was divergence in how they experienced this. Toni reflected how her physical manifestations of RSD began in childhood:

> I would get really physically sick if I hadn't slept enough. Which only tended to happen around times when I could have or probably did experience RSD … later on in primary school, and then moving into secondary school, I would be physically sick, and I'd suffer from migraines as well … potentially I wasn't sleeping because I was in an RSD episode.

The acute bodily symptoms may have been misattributed to poor sleep, acute vomiting and migraines, without the association that this was a manifestation of RSD. This may imply that school was a source of stress or may represent anxiety. Toni continued to experience an evolution of these physiological responses to RSD throughout her life. Alternatively, Claudia experienced physical symptoms differently, stating "it's like almost like in the chest, like in the heart area ... it's like this severe pain." Claudia may have been attempting to communicate the intensity of this mind-body link with emotive language. For example, the emotional turmoil was akin to "heartbreak", attending to the link between the bodily sensations as a physical manifestation of emotional distress from RSD. Nicole further described how RSD manifested most notably in the upper body: "My chest … in my upper body … coming up my neck and my ears." This was further nuanced by perceived rejections hurting as much as outright rejections. Claudia described:

> A sharp kind of pain. It's like being stabbed in the heart. It seems extreme because it's basically if someone just like looks at you the wrong way and they may not even be thinking what you're thinking … it's like perceived.

This language of being "stabbed in the heart" may represent a similar sentiment to the "betrayal" denoted by Jenna and Mabel in earlier passages. This may be suggestive of momentary vulnerability. The instantaneous nature of feeling "stabbed" suggests being taken by surprise and a resulting immediate emotional and physical pain. Claudia references that whilst this may appear "extreme" to others, particularly if the rejection is "perceived", regardless, this level of pain is experienced. Nicole further described how RSD is a strong but unstoppable physical emotional experience: "Really visceral … you're feeling your emotions physically, in a really strong way, and whether it's proportionate to what's actually happened to you or not, you can't really stop it." Here, she infers that responses may seem disproportionate to the triggering event, given they are immediately and strongly experienced. Contrasting this immediate experience of bodily manifestations, Mabel described a gradual onset, related to insurmountable pressure from anticipating RSD:

> Tension feels exhausting … holding everything together, or trying to. Tension feels like, erm (*pauses*) holding yourself, anticipating what might go wrong, waiting for that thing to be over. Erm, it's, you know, in your muscles holding together. It's in your head, it's in your thoughts, it's in your feet.

Mabel describes a tension building. Perhaps "waiting for that thing to be over" is a sense of dread. It may in tandem, communicate that RSD and its physical manifestations gradually builds until she is overwhelmed by the rejection. This may manifest as feeling inescapable, given the physicality encompasses the whole body. Again, this is another narrative weaving together the link between the body and the mind.

One possibility for the variation described in how the physicality of RSD is experienced is that its psychosomatic nature is "depending on the situation severity" (Mabel). Nicole's narrative further highlighted how RSD is a "very physical experience, depends on the severity of the situation", characterised by:

> Rising heat and a sense of being able to like, hear my own heartbeat. And that's so I feel very, erm almost like in-inward facing. And like the, I suppose how you might imagine when people talk about your body being flooded.

The language regarding Nicole’s “body being flooded” could be interpreted as a wave of emotions rushing over her. Mabel further described:

> It'll affect my stomach, my appetite … I get sort of psychosomatic, it'll come out in my body, depending on how bad it is. It'll affect my sleep again, you know, across the spectrum. It'll affect my confidence as well. It can make me anxious to the point of feeling, I feel depressed.

Overall, commonalities were described across the participants. However, these appear to fluctuate and experienced on a “spectrum” according to the “severity” of RSD. When experienced, RSD was commonly described as “all-consuming”. Narratives across the women often linked these acute bodily changes with an emotional response. In the excerpt from Mabel, it could be suggestive that depression was linked to difficulties with sleeping. These effects described are caused by RSD, triggered by social environments, and provoke an insular physical response.

Rapid Emotional Shifts

The fundamental component of RSD being comprised of intense emotions was widely corroborated by all women. Claudia described RSD as “the worst part of having ADHD.” Nicole explained: “RSD is like a like a little explosion, right? And then it's like the ash comes down.” This language highlights how strong, sudden and impactful RSD is. Nicole further shared: “I don't think I ever know that I'm going to feel as strongly as I do.” This highlights the shock, despite this being a reoccurring experience throughout life. Jenna further attested to the strength of emotions evoked by RSD:

> It leads you to do things that are maybe out of your control. … It's all-encompassing … because it doesn't just kind of provide you with the thoughts it affects the body, it affects the behaviour it takes. I always think about Jekyll and Hyde with it as well. It almost you become somebody who is rejection. It's not you anymore. You are separate. It's somebody different.

Jenna described here feeling consumed by, and therefore synonymous with rejection. RSD was further described as an “emotionally intensive” response, underpinned by a loss of control. A similar narrative was provided by Nicole: “For me, the underlying thing to most of it is the fear of rejection, and a bit of an absence of an ability to rationalise that.” This inability to rationalise was commonly described by the women in the acute stage of RSD, which often perpetuated negative self-perception. Nicole best described the instantaneous jump to self-deprecation:

> I feel the weight of it. It feels heavy, like it feels again like I'm the one to blame, whereas I know when I step back from it all that this is, it's a part a symptom and it's not, it's not my fault. Like it wasn't, you know, like it wasn't my parents’ fault. But when you're like in it, it feels like it is.

Here, there is a sense that in the moment, RSD makes you view yourself negatively despite later possibly being able to reframe this and knowing you are not “to blame.” This was similarly noted by Toni: “Short term is erm (*pauses*) quite an intense emotional reaction, erm (*pauses*) like instantly upset. Erm gutted, defensive, disappointed all at the same time, so it's like a whole host of things going on.” This account provides a multi-layered experience in the acute phase of RSD, which may be interpreted as chaotic. Claudia further highlighted how in the immediacy, RSD is an inward-facing experience: “It's almost like the short term, it's like it's really impacting me. It's like very self-centred like my world is crushing, it's ending like. Erm it's quite like a dangerous space.” Here there is an inability to see a way out of feeling like this which may result from the all-consuming nature the women described.

For one participant who did not greatly detail a rapid surge between emotions (Mabel) she did describe: “It hurts, it's confusing, it's emotionally jarring. It's er, very annoying and frustrating.” This endorses an intense emotion of feeling emotionally drained. Mabel, however, did describe how the state of rest in the body affects the emotional impact of RSD:

> There’s times when the RSD will hit harder than others, depending on you know your menstrual cycle or your food, how hungry you're feeling, how slept you are, how rested … I think your, your body and how it's doing can really … flavour how, how hard the RSD hits.

Over time, Lucy described being able to track her menstrual cycle helped to make sense of RSD: “sometimes when I'm feeling extra sensitive or emotional, I've only got to look at my diary and realise exactly what's happening.” This perhaps has the propensity to minimise the heightened responsibility previously outlined in this acute stage of RSD. Through this technique, Lucy noticed: “I think the world gets a bit heightened. Whereas I'm perhaps a little bit less sensitive during sort of a week or so after my period.” Overall, the chronicity of the acute stage of RSD whilst limited to affecting the individual, it is felt immediately, and is extremely distressing, accumulating in both physical and mental distress. There is a sense that once this passes, RSD can be reframed by the individual.

GET 4: The Reinforcing Cycles of Rejection

There were striking commonalities across the participants’ narratives regarding what experiences they attributed to exacerbating the frequency and severity of RSD. These were, accumulating rejection, workplace burnout and self-critical cycles. Together, these were described to perpetuate RSD.

Accumulating Rejection

There was a sense across the women that RSD was experienced most intensely in adulthood. Claudia stated: “It became very fast and very quick, and so I think that kind of like gradually grew through life.” Lucy explained how by the time adulthood is reached there’s has been “a whole lifetimes of being rejected. It’s like you get so used to this like feeling of, like not fitting in or disappointment or, or failing at something that it’s not a new feeling.” Across the narratives, rejection becoming a “normalised” part of life was commonly described. Contributing factors were RSD starting in childhood and responses to rejection being modelled by their parents. Many women suspected that their mother also had ADHD. Whilst it may be helpful in later life to identify with the experiences of others, only the negative emotional effects were noted. Intergenerational trauma regarding RSD was described by half of the women. Claudia explained:

> It's basically like intergenerational trauma, it like passes down to your children. It, like, has a ripple effect like through life. … Looking back at my own mum, it came down from her like she was exactly the same, right. So, it's almost like the impact of it like floats through.

Modelling responses to rejection were not only passed on to the participants during childhood but Claudia suspected this was experienced by her own children. She described this similarly to a trait, that "passes down", affecting her closest relationships. There is a sense in the tone of the extract that there is a worry and responsibility regarding maintaining the cycle of passing painful experiences on. A lack of control and feeling of helplessness may be inferred. Therefore, the experience of RSD does not immediately resolve, it has a longer-term impact. The language of "trauma" was further described by Nicole:

> Your body remembers those, maybe that's like a little trauma, I guess, that's what it feels like. And I think that does get a little bit absorbed into your body like some part of you is, you know, downloaded a little bit of data from that.

These experiences accumulated and shaped Nicole. This may be suggestive that over time "little traumas" became part of a larger trauma response. The phrase "absorbed into your body" may infer perceiving she was internalising rejection. Claudia's experience of herself mirrored this. She described: "I thought it was my personality. I thought it was everything." One possible reason for the "little traumas" accumulating could be due to them being left without resolution, as further described by Claudia: "It got bigger for me because I'm not reflecting … I can't really remember how it happened or why it happened or what triggered it. I'm then not able to help myself or support myself." Whilst in the short-term forgetting may be beneficial as ends the acute phase of RSD, in the long-term, this is suggestive of not being able to learn or reflect on previous RSD experiences. The women described becoming drained as RSD experiences build up over time. Lucy described a daily battle with herself: “ going back at it each day … really chips away at your energy … your confidence and your self-belief and thinking am I just not able to do this? … or again, feeling really alone in it. Accumulating RSD decreased her self-worth whilst increasing negative self-talk.

Furthermore, accumulating life stresses (often characterised by loss) was described as contributing to overwhelm, inclusive of grief, redundancy, breakdown of romantic relationships, introduction of caring responsibilities, moving and purchasing houses. Experiencing rejection at a tumultuous time resulted in Lucy feeling “completely overwhelmed” and culminated in feeling “I just couldn't pick myself up.” Jenna’s narrative may explain this. She described that moments of acute life stressors lead to increased “vulnerability” to experience RSD shortly again, that usually she would have a “high window of tolerance” to deal with. She explained this was due to having less resources to draw from. A similar sentiment manifested for other participants. Nicole found: “it felt so awful to be persistently told that I was wrong and a bad parent.” Perhaps here, the closer the rejection feels to what you value most, the more painful this is to bear. For Nicole, this was motherhood. For Mabel, when learning a new career she reported how repeated rejection through feeling “told off” eventually became internalised, describing: “I feel like an imposter.” With repetition over time, there was a sense from the participants that this leaves you vulnerable. As one’s immediate response in the acute phase of RSD is self-blame, it outweighs an ability to foster self-compassion. Jenna stated that gradually:

> It went from rejection to … self-pity … very much self, self-depreciating behaviour, self-harming behaviour … putting yourself in unsafe positions … the level of self-compassion went down. No self-esteem. I felt like a piece of shit on the bottom of someone's shoe. … Every time I tried to step out of it because I was still so vulnerable to rejection, any type of rejection … that would destabilise me.

Despite her best efforts, her self-worth had eroded so much that RSD became difficult to “step out of”. Jenna further described “another rejection on top of that rejection”, exacerbated by having: “nobody around me, nobody to kind of give me that validation or reassurance ... I had rejection, rejection, rejection but nothing to bring me up.” This is suggestive that a lack of social resources to draw from leads to a detrimental impact from accumulated rejections without social support to buffer the impact of RSD. The repetition of isolation could be interpreted as feeling weighed down by this, leaving her with an emptiness through the emotional distance from others. This is suggestive that connection may have buffered the effects of the “vulnerability” due to “another rejection on top of that rejection.”

Work Based Burnout

The majority of women described how workplace treatment created a negative cycle of emotions. Narrations commonly noted: “RSD can cause burnout because you're just stuck in a cycle”. Burnout was typically re-experienced by women throughout life, reportedly starting in early adulthood, synonymous with starting work. Burnout periodically resulted in requiring time off work. Some participants reported the process of recovery as taking up to two or three years. For some women, burnout occurred shortly before their ADHD diagnosis. Mabel explained: “I got diagnosed … I had burnt-out, falling apart at work and I think a lot of rejection sensitivity because I had a toxic boss … I just kind of crashed.” ADHD and RSD diagnosis were preceded by becoming burnt-out due to a negative work environment. Strikingly, most participants cited work as triggering their most severe or “longest periods” of RSD. One contributing factor to this was suppressing reactions to triggers of RSD at work. As noted by Toni:

> It can be as small as I've not had a reply to an e-mail that I needed a reply to. And then the spiral of overthinking ‘oh have I said something wrong to them? … ‘oh no! Have we tried to, have we charged too much?’ … I've gone immediately worst case scenario.

Toni provided an insight into the numerous self-directed questions resulting from “small” triggers at work. Here, rejection is inferred, and when looking for a reason as to why, this becomes pointed inwards. Toni denoted a “spiral of overthinking”, seemingly questioning everything she thought she knew. Whilst Toni’s extract offered an insight into one trigger at work, the most common precipitating factor for RSD culminating in workplace burnout was receiving feedback. Receiving feedback was described by participants as a lifelong trigger of RSD, often starting in school. There was a sense that the women often felt blindsided due to the incongruence between how they viewed their performance and the feedback received from others. This often led to participants feeling “confused”, persecuted, and “overwhelmed”. In the workplace, evaluation of performance is commonplace. Participants described experiencing RSD quite often resulting from probations, annual reviews or other formal feedback.

Nicole explained that during training: I got some negative feedback and … you can hear your own heartbeat and like your body is so hot and it's like you're just hearing those words over and over and over again.” Nicole described receiving criticism from others and internally replaying them. Nicole may be inferring she is acutely aware that her body is signalling feeling threatened in that moment. To mitigate experiencing RSD, participants attempted to prevent possible comments around decreased work performance. Quitting jobs and changing career was commonly described across the women. Some participants decided to become self-employed. However, for Lucy this resulted in “realising that I’m no good at (or I feel like) and trying to do too many things”. Here, the feeling of spreading herself too thinly triggered RSD, as she felt unable to fulfil all areas well. For those remaining in employed work, there was a sense of a conscious effort to be an “overachiever.” Toni stated that since childhood: “if I'm doing lots and lots and lots of things, then something's got to go right.” It could be inferred that “doing lots” or imposing high self-expectations at work stems from feeling a need to maintain an illusion of balancing work demands well, to minimise possible criticism. Toni explained when she felt “overwhelmed with … that level or perceived level of demands”, self-imposed standards are unable to be sustained. Accumulated rejections at work induced RSD and led to decreased self-worth, including suicidal ideation. Claudia explained how she reached the point of burnout due to her workplace not accommodating reasonable adjustments. This culminated in feeling:

> I was broken, not good enough, that it was all my fault. I was a failure, and I couldn't do anything, like I didn't deserve to be alive. That I was wasting oxygen for people that could be alive … people who are good people.

Here, Claudia described feeling like she was "wasting oxygen" from others. It could be concluded that this stemmed from not only failing to meet self-standards but perceiving she had not met her workplace expectations. Here, this is taken beyond a professional context and interpreted as having personal meaning. Rejection at work, therefore, can cause self-critical thoughts, that extend beyond work tasks, as the subsequent meaning made of this is that others are indicating flaws of character. For many participants, RSD was experienced most strongly at the point of burnout. Mabel described:

> Either a car or a phone where you know the battery or the fuel is running out and you're beginning to like try to drive more efficiently or putting all the settings on low power mode. And eventually, … it just shuts down and you need to … give it fuel, or you need to give it battery, time to recharge.

For Mabel, her main indicator for burnout at work was inescapable exhaustion. Burnout depleted her for a sustained period. She further explained that her "priorities" had to change. Participants who experienced workplace burnout following discovering the term RSD, described ongoing management. Jenna stated how she continues to experience negative emotional cycles at work:

> I already know I'm gonna be rejected by them in one way, shape or form but I still have to communicate with them. So, when they reject me, I then feel embarrassed because I'll often people-please. And I'm not about people-pleasing any more.

Whilst there is an awareness about RSD and tendency to people-please, Jenna infers fighting this instinct to be authentic. This seems to manifest as an internal conflict as she further described she could “stumble” over her words and lose confidence. There is a sense of being resigned to her fate and the outcome remaining the same, experiencing rejection and thus, RSD.

The Self-Critical Nature of RSD

Endorsed by each of the women was the development of self-critical thoughts over time. Participants described feeling relationally unsafe, always on the lookout for social rejection. Upon experiencing rejection, participants frequently attributed resulting blame to themselves. This was perceived by the participants to stem from an early age, thus setting the precedence for adulthood, as described by Mabel:

> There's numerous examples of, you know, where it was undiagnosed ADHD that I was critiqued for and that, you know, has given me plenty of adult anxiety. … Those things partly come from a misunderstood child. … There was such misdiagnosis and so you've got these patterns as guardedness this scared of speaking up, scared of making mistake. Not feeling confident enough to get it wrong.

Mabel experienced criticism and alluded to stigma in childhood and rejection for being herself. This possibly led her to feel not good enough and decreasing her self-esteem, which appeared to exacerbate self-criticism. Some participants described a lifelong awareness of the moods, emotions and non-verbal behaviours of others. Some described this as “empathy” or being “attuned” to others. Other participants indicated that this was a form of hypervigilance which maintained the threat of rejection. As described by Claudia:

> It's constantly like looking for safety and if we're wired to kind of like, think that people aren't safe, we're constantly scanning the room and only seeing those things that keep … reinforcing the beliefs that we have about ourselves, that we’re broken and that nobody cares.

Claudia described almost being primed to notice rejection from others. There is a sense of being blinded by self-critical beliefs, thereby reinforcing a cycle of “constantly looking for safety”. This could be interpreted as never quite feeling safe. Jenna further experienced a cycle of reinforcing negative self-beliefs:

> I felt like scum ... I always felt like ‘I've got potential … I could do it. I can do it because I dream big’. Then my actions weren't mirroring the thought, so therefore it's just adding to it. I just felt worthless. I felt like horrible. I felt like a waste of space.

In her darkest times, Jenna described how thoughts of hope persisted but an inability to reach her “dreams” reinforced negative self-beliefs. Jenna described navigating a balance between knowing her self-worth and feeling optimistic about her future, and the raw feeling of not achieving her self-expectations. Toni further explained how RSD is projected inwards, not outwards: “it's very much a self-centred response. It will very much be to do with me, what I’ve done my impact.” Toni indicated that regardless of the trigger, blame is always self-attributed, rather than externalised. Some participants noted perception of responsibility can shift. Nicole further explored how: “the down part that I described as well is, is also difficult because it's a sense that you're letting yourself or other people down.” The felt responsibility for others becomes a heavy weight to bear. With time, this cycle “erodes” confidence and self-trust. Nicole explained how the self-criticism perpetuated by stigma and criticism from others was due to responses to her experiencing RSD:

> Other people's responses are like, ‘Oh my God, Nicole. Like, you've just completely overreacted, that was unreasonable how you behaved in that situation’. And then you're like, ‘oh, but they’re right’. And so, you it's like erodes your trust in your own thoughts and feeling … it takes away your confidence.

Here, there is a sense of feeling attacked by others, and attributing the reason to self, rather than externalising this. Many participants described how this was enhanced when the responsibility of the scenario increased, whereby as the gravity of the situation becomes heightened, the rejection appears more crushing. Self-criticism intensifies, perhaps underpinned by feeling destined to “fail” (Toni). For some participants, the weight of responsibilities was enhanced by comparing their responses to rejection to others and not feeling “normal”. Participants described negative self-talk that such as “kicking” self. For Mabel, this was exacerbated by times of feeling unimportant and disempowered by others:

> I've always had an issue with being heard or … struggling to justify my thoughts or my case or whatever. I'm feeling really frustrated that you know I can see logically what needs to happen ‘why can’t I convince people around me of that’ and ‘OK, maybe my thoughts aren’t good enough’ or ‘maybe my ideas aren't good enough’ or you know that sense of overwhelm.

Feeling unheard triggers overwhelming self-criticism and questioning why others do not hear her worth. Over time, the women discussed how a lack of self-worth affected confidence in intimate relationships. Claudia explained how she felt she would be in “quite vulnerable places” in romantic relationships due to feeling unable to voice her true opinions through “not wanting to disappoint and not wanting to be rejected.” The women discussed how remaining in intimate relationships provided self-worth when they did not value themselves. Toni further reported that: “I accepted behaviours that I wouldn't accept now, as a result of me not feeling good enough to be on my own.”

Discussion

This chapter summaries the findings, relating these to the research questions. The findings are contextualised further in wider literature and psychological theory, with clinical and research implications discussed. Finally, the chapter outlines the strengths and limitations of the study.

Overview of Results

The empirical project aimed to answer the following four research questions:

1. What are the key features of RSD as it is understood by females who have been diagnosed with ADHD in adulthood?

2. What are the impacts of experiencing RSD on this population?
3. What is it like to experience RSD as a female diagnosed with ADHD in adulthood and what are the impacts of this on daily life?
4. How has conceptualisation of self in relation to RSD changed over time?

Six women diagnosed with ADHD in adulthood, who experience RSD were interviewed. Four GETs were generated, each comprised of two or three subthemes (Table 7). The findings are presented in relation to the four research questions under the following headings, key features of RSD, factors that exacerbate RSD, daily impacts on life as a woman with RSD and ADHD and conceptualisation of RSD over time. Within each heading, the key findings are discussed in reference to the literature outlined in the introduction and SLR findings, and in relation to psychological theory and/or empirical evidence.

Key Features of RSD

The findings demonstrated that the key features of RSD incorporate bodily sensations and an acute emotionality, largely characterised by rapid and intense emotions. These experiences were perceived as “all-encompassing”, appearing suddenly without an ability to anticipate this, and marked with a sense of uncontrollability. For the women, “irrational” yet powerful self-critical thoughts were immediately experienced, invoking self-directed feelings of guilt and shame. The SLR findings conveyed that the emotionality of RSD was the “element that has the biggest impact” (Webster, 2018), and the resulting distress was described in each article. This finding was supported in the narratives of the women in the empirical study who commented “RSD ruined my life” and “it’s where most of like the negative stuff comes from”. “Episodes” of RSD were typically experienced by the women for up to a 24-hour period which contrasts pre-existing literature denoting that “episodes rarely last more than a couple of hours” (Dodson, 2025b). It could be suggestive that some women obtaining a late diagnosis of ADHD experience increased lengths of RSD episodes. Furthermore, the findings around the emotional intensity of RSD being affected by the menstrual cycle, supports previous research that depicts that the mid-luteal phase can affect emotional dysregulation in women with ADHD (Bürger et al., 2024). Further research is warranted to explore the effects of times of hormonal change for women, regarding RSD. These may involve researching puberty, the perimenopause, the menopause and perinatal mental health for example, to provide valuable research insights within this topic area.

The findings highlight that bodily sensations appear to be a key feature of RSD, which has not been well researched or understood within the literature previously. Only two articles in the SLR referred to the physicality of RSD (Ginapp et al., 2023b; Power, 2024). The studies concluded that bodily responses were perceived as overwhelming and whilst experienced differently, typically presented in the upper body. These findings were replicated in the empirical project. Embodied responses of RSD were commonly described, and there was individual variation in how bodily symptoms manifested. Despite this, most symptoms were again, described in the upper body. The intensity that bodily manifestations were experienced was explained to be related to how “severe” the triggering situation precipitating the RSD felt. A further feature of RSD that corroborated the SLR was that it was a lifelong experience, starting in childhood. Consequently, prior to an ADHD diagnosis the physicality of RSD was commonly misattributed to other physical or mental health conditions, rather than understood as a symptom of RSD. Empirical evidence demonstrates that some symptoms of ADHD (restlessness and forgetfulness) can be misdiagnosed as anxiety and depression (Musullulu, 2025). Thus, providing a possible insight as to why women are likely to have accessed mental health services prior to receiving an ADHD diagnosis (RCP, 2017). Based on the findings of the current study, acute physical manifestations of RSD may contribute to mental health misdiagnoses. Overall, the findings extend the limited research regarding bodily sensations and are suggestive that these are a core component of RSD.

Factors that Exacerbate RSD

It is notable that the findings indicate both an acute stage of RSD, and long-term effects. Furthermore, the narratives of the women demonstrated an array of factors that over time can exacerbate RSD and contribute to emotional suffering, including accumulating rejection, workplace burnout and invalidation from professionals.

Regarding the impact of experiences of RSD accumulating, the participants described feeling “vulnerable to rejection” culminating in long-term effects of RSD for some women lasting up to two or three years. Across the narratives, participants illustrated that RSD felt like “little traumas”, and that their own experiences of being parented modelled how to cope with rejection, which shaped their responses to rejection in later life. Intergenerational trauma was indicated by half of the participants. The intergenerational theory of trauma (Rakoff, 1966) posits that the effects of trauma can be transmitted from one generation to the next (Keaney et al., 2024). Within the empirical literature, intergenerational trauma regarding ADHD is limited. The evidence base is suggestive that there is a complexity between trauma and ADHD, with a possible bi-directional relationship between these two constructs (Boodoo et al., 2022). Intergenerational trauma can have relational implications and negatively affect physical and mental health, which are shaped by structural inequalities (Keaney et al., 2024). The findings could indicate that undiagnosed ADHD and the possible generational transmission regarding RSD justifies a need for earlier identification and support for individuals and families.

A further factor found to exacerbate RSD was burnout, which was often accompanied by masking at work. For some participants, an ADHD diagnosis and becoming aware of RSD initially mediated the negative impacts of masking at work. However, a lack of reasonable adjustments demonstrably worsened RSD and associated burnout. Pre-existing literature has indicated that males disclosing a diagnosis of ADHD in the workplace are viewed more favourably than females sharing the same condition (Asianah, 2023). This may have accounted for this finding in the current study and could be suggestive of why some women are facing gender-based stigma at work. A subset of participants were healthcare professionals or specialising in supporting others with neurodivergent conditions. Research illustrates how there is a lack of support for neurodivergent professionals working in healthcare (Johnson & Ahluwalia, 2025). Furthermore, there is a dearth of understanding or awareness about neurodivergence in the workplace, which perpetuates mental health difficulties in employees (Johnson & Ahluwalia, 2025). Thus, highlighting the need for training on ADHD and RSD for employers.

Pre-existing literature highlights that there is a lack of understanding about ADHD with healthcare professionals, thus perpetuating stigmatising narratives to individuals with this condition seeking support (Mueller et al., 2012). Furthermore, high levels of anticipated rejection from healthcare professionals are demonstrated for adults with ADHD (Masuch et al., 2019), a finding that is corroborated within the present study. For example, women primarily sought mental health support for RSD, which was often reported to be inadequate. Not being believed when sharing distress with others, namely, professionals was perceived as invalidating and contributing to elevated distress. Often, the first person they shared their experiences of RSD with was their GP but were left feeling “they just don’t get it”. This experience was replicated when receiving mental health support. One participant described how they would avoid seeking mental health support from their GP in the future, based on their previous experiences of disclosing RSD. The clinical implication is that enhanced knowledge and awareness of RSD is needed for primary healthcare professionals and for those working in mental health, to provide appropriate and supportive care.

Daily Impacts on Life as a Woman

The women emphasised a strong sense of having to “survive” life pre-ADHD diagnosis and before discovering RSD. The findings revealed that prior to these diagnoses, the women implemented a plethora of techniques to try and navigate life. A major finding was that women are masking their difficulties of RSD. The women in the present study described being “well masked” since childhood, to cope with RSD and to aid “fitting in”. The SLR concluded that masking RSD was evident in young adults and discussed in relation to their early social and academic experiences (Power, 2024). This study extended these findings into an older age range of adults and encompassed masking across workplace settings. Emerging empirical literature commonly denotes how girls mask symptoms which can contribute to receiving a late diagnosis of ADHD. Yet, research explicating the specific camouflaging techniques is less well explored. Understanding how women and girls with a late diagnosis of ADHD mask their symptoms of ADHD and RSD could aid earlier identification of these conditions in this population.

To minimise the chances of RSD, the participants described experiencing a pre-emptive fear of rejection, leading to isolation and withdrawal. Direct attempts to prevent narratives of “you’re just sensitive” created unintended consequences socially and emotionally. The findings further demonstrated that women experienced difficulties with identity formation, which was negatively influenced by self-blame. This is increasingly important as the current consensus in empirical literature is that internalising symptoms can affect self-esteem (Young et al., 2020), which was a finding replicated in the current study. Social and relational avoidance was commonly described across the women, and participants described a plethora of techniques to escape the pain of RSD. This is consistent with pre-existing theoretical literature regarding the experiential avoidance process model (Wang et al., 2024) which denotes that avoidance of painful emotional experiences develops and maintains psychological conditions. Expressive suppression (masking) is explained in this framework as leading to experiential avoidance. Inhibiting thoughts and actions although provides short-term relief, causes a “downward spiral” (Wang et al., 2024). Three subthemes (escape, avoidance and masking) may be explained as processes of emotional regulation techniques. Future research could benefit from further exploring this model with individuals with ADHD and RSD.

The current findings extend previous research that women with a late diagnosis of ADHD experience stigma, a lack of understanding from others, and an internalisation of symptoms (Holthe et al., 2017; Masuch et al., 2019). The findings infer that stigma underpins the implementation of strategies for “survival” to prevent RSD. For the women, stigma originated at school, where they were rejected for being themselves. This appeared to culminate in rejecting experiences becoming internalised, thus reinforcing self-critical narratives. This finding aligns with Goffman’s theory of stigma (1963) which refers to individuals experiencing stigma for an invisible characteristic as "discreditable" whereby can cause difficulty in separating themselves from the stigmatising label. This can create heightened internalised stigma (Cook et al., 2011).

Conceptualisation of RSD Over Time

The women experienced discovering RSD as relieving the burden of blame that had gradually become internalised. The discovery of RSD therefore, often brought hope, a re-consideration of own needs and a renewed way of living, to cultivate a positive life. This replicated the SLR findings that acceptance from others and discovering RSD provides a new vocabulary in which to reframe self-identity. These findings support and extend previous research regarding how ADHD diagnosis can cause a major shift in identity (Bradley et al., 2025). For the women in the present study, discovering RSD had a similar effect. Contrastingly, two participants described grief following finding out about RSD, which is comparable to previous research stating that receiving a diagnosis of ADHD in adulthood can cause feelings of loss (Long & Coats, 2022). Perhaps this poses a second grieving period if RSD is discovered some time after an ADHD diagnosis is provided.

The findings presented some novel methods to alleviate the distress of RSD including ADHD coaching, physical practice and increased self-awareness, workplace adjustments, emotional safety and curating boundaries. ADHD coaching was positively described across the participants. This finding could be explained by the self-determination theory (SDT) for ADHD which describes how the societal environments that foster autonomy, and support skill development can aid self-regulation challenges that otherwise exacerbate the core symptoms of ADHD (inattention, impulsivity and hyperactivity; Champ et al., 2023). This supports the findings and the benefits of moving away from an internalised deficit-based model of 'fixing ADHD' to externalising the condition, where environments and relationships support autonomy and development. A Netherlands-based study investigated why individuals with ADHD prefer to seek privately funded ADHD coaching over public funded mental health support (Schrevel, Dedding & Broerse, 2016). They found participants valued the collaborative, strengths-based approach to problem solving and increased self-awareness.

Furthermore, participants described previously seeking mental health support, (which was experienced negatively) commonly for burnout at work, and depression. Thus, further replicating key findings in the present study, whereby burnout and misdiagnosis were frequently cited experiences across the women's narratives. Further research is needed to examine a strengths-based, neuro-affirmative treatment option to support women receiving a diagnosis of ADHD in adulthood. To date, current research cites neuro-normative therapeutic models which primarily operate from a deficit-based model, focussing on symptom reduction (Champ et al., 2021).

The deficit-based model of ADHD is not only influenced by the medical model, but also socio-political interests that can propagate stigmatising narratives of this population. For example, the UK media post-Covid-19 pandemic experienced a colossal increase in the frequency of outlets reporting there to be an "ADHD surge" (Martin et al., 2025). Spurring harmful narratives only increases the propensity of stigmatising and pathologising narratives around individuals with, or seeking, an ADHD diagnosis in the UK. Empirical evidence states that there is no rising trend of ADHD diagnoses (Martin et al., 2025). Rather, this may indicate that there is a shift moving towards earlier identification of ADHD. This can only be a positive factor, given the overwhelming empirical literature, professional taskforces and guidelines that stipulate the detrimental impacts for women with late-diagnosed ADHD. Despite this, a gap remains within the guidelines and policies. For example, NICE guidelines for ADHD (NICE, 2019) state that there is misdiagnosis and underdiagnosis. Furthermore, NHS England (2025) commissioned an independent ADHD Taskforce, but its report does not discuss RSD, the impacts, detection or support that is required as part of ongoing support for ADHD. Future policies and clinical guidelines, or amendments to, could be further shaped by highlighting the importance of earlier diagnosis and ongoing support for RSD in this population.

Quality Review

Strengths

The main strength of the current study related to its novelty as it is the first study to primarily explore the experience of RSD in women who were diagnosed with ADHD in adulthood.

Semi-structured interviews completed with an IPA, generated a wealth of rich data. The findings are consistent with pre-existing literature regarding late-diagnosed ADHD, and the female experience of this (through the lens of RSD), and adds to the emergent evidence base. Pre-existing literature postulated that women experiencing RSD may be more likely to be diagnosed with the inattentive subtype of ADHD. This was not replicated in the current study. All women endorsed RSD, and diagnoses spanned all three subtypes (inattentive, hyperactive-impulsive, and combined). Furthermore, the empirical project extended findings for the implications of RSD beyond romantic relationship implications and academic underachievement demonstrated in the SLR. The empirical study found that this extended to relationships with work colleagues, managers, workplace teams (HR and occupational health), motherhood, and accessing mental health support. These findings relate to the ongoing daily impacts of RSD in adulthood, and the female ADHD experience, representing a novel contribution to the wider research.

Furthermore, the participants were placed at the centre of the project, with attempts to use the women's own words and language as much as possible. Additionally, the recruitment demonstrated that there is a mass interest in the topic of RSD in women with ADHD wanting to share their narratives and cultivate an empirical evidence base within this area.

Limitations

The main limitations for this study are regarding the generalisability of the findings due to narrow participant characteristics and the number of women interviewed. Due to the adoption of an IPA methodology, whilst lived experience was researched, the aetiology was not (Tuffour, 2017). Whilst this was tentatively hypothesised with some participants, and possible underlying mechanisms were subsequently inferred, this was not the main aim of the study. When combined with the findings of the SLR, the aetiology of RSD remains a gap within the field, which future research would benefit from studying. Furthermore, the pre-interview script included a definition of RSD to minimise bias and ensure fairness. This may have introduced a limitation through the possibility of affecting the depth of richness of participants accounts of, and nuances of RSD.

Furthermore, due to the scope of the empirical study, and its exclusion criteria of males and individuals who received ADHD diagnosis during childhood or adolescence, this affects the external validity of the results regarding the generalisability of the findings within these populations. For example, five out of the six participants identified as White British, with one woman identifying as White and Asian. This bias is evident within the field of ADHD research, as discussed within the SLR. Future research will benefit from a wider diversity of the participants, and it is important to note caution around generalising the findings of this study. Additionally, all the participants were self-selecting through poster advertisement through a gatekeeper, which may introduce a bias to the study's recruitment process. For example, missing demographics such as the views of women who are less connected with support for ADHD or perhaps may identify less strongly with RSD, which may have contributed to a sampling bias. Furthermore, the participants who dropped out of the study prior to interview completion (due to not having the emotional capacity) could be suggestive that there are individuals experiencing RSD or associated burnout more acutely, whose narratives would have been missed. Additionally, the MRP is working under the assumption of how RSD is currently referred to in pre-existing literature (and as demonstrated in the SLR), that it is an ADHD specific experience. In summary, there must be caution as to not overgeneralise the transferability of the findings from these women's narratives.

Clinical Implications and Recommendations

The clinical implications of this study are profound, suggestive of multifaceted recommendations across multiple levels. Based on the findings the first recommendation is for individual psychological therapy to be neuro-affirmative. Strengths-based interventions were well reported by the women to be most helpful. Thus, there is a need for tailored and timely support for RSD. Clinicians need to be aware of the possibility that requiring between-session homework completion in therapy may trigger RSD through feedback (or anticipation of this) as this could have the propensity for individuals to drop out of therapy. Furthermore, the narratives of the women highlighted that at the point of an ADHD diagnosis, RSD was not indicated by professionals (or after). Online social media platforms are being utilised for the information that healthcare providers should be signposting towards and educating about. Perhaps the most essential clinical priority evidenced in this study is increased recognition and awareness of RSD amongst ADHD professionals, primary care providers and mental healthcare workers.

Educating professionals serves the dual purpose of increasing knowledge for the benefit of patients and reducing stigma from healthcare providers to women with ADHD and RSD. This is essential to prevent practices that reinforce psychological harm, contribute to decreased self-esteem and lower quality of life. As part of essential training within this area the current findings are suggestive that it is important for healthcare professionals to not only have an awareness of RSD, but be informed regarding how it presents, manifests and can be supported throughout the lifespan. This may be particularly pertinent after an ADHD diagnosis or women with suspected ADHD present to community mental health teams, or GPs for psychological support. It is imperative to consider what part of the ADHD and RSD journey the individual is on, and support needs to be considered across the lifecycle, in line with the minor finding that transitional ages, particularly the progression to emerging adulthood and perceived responsibility could increase RSD. For example, transitioning between child and adult mental health services, or between educational establishments, may require nuanced support. Previous research corroborates that increased support is needed at these pivotal times of transition (Rasmussen et al, 2024). The women indicated that psychosocial interventions were sought from primary care but often, medication was offered to the participants. There is a clear need within adults with ADHD and RSD that a strengths-based approach to increase their quality of life is essential.

Wider Implications

In the UK there are links between ADHD in adulthood, and social deprivation (McKechnie et al., 2023). Individuals are commonly choosing private assessments over NHS pathways, due to the length of waiting lists (NHS England, 2025). Whilst the Right to Choose pathway forms an intermediary between these two routes, this has the potential to cause disparities in health care equity. It privileges those who are educated and informed of these pathways, or can fund a private assessment, thereby creating social and economic barriers to accessing an ADHD diagnosis, and subsequent support. As a diagnosis of ADHD commonly precedes discovering RSD, untimely diagnosis has the potential to elongate the psychological distress experienced by this population. Whilst policies such as the NHS England (2025) commissioned independent ADHD taskforce report highlight the need for earlier detection of ADHD (and underdiagnosis in women), the concept of RSD remains unacknowledged in professional guidelines. Implementation of this terminology and its effects in wider policy is required.

In addition to increased awareness of RSD in a clinical setting, there is a clear gap in the knowledge of educators and employers. To prevent decreased quality of life outlined previously and given how unemployment further decreases a quality of life, combined with the women in this study leaving jobs due to burnout, it is imperative that associated guidelines and policies are reformed. This would tailor the training that is required. This means resources must recognise RSD as an existing phenomenon. Workplaces (managers, colleagues, HR, occupational health) need to be well-informed to support reasonable adjustments of employees, and to shape awareness in colleagues. Any training materials produced would benefit from being co-produced resources for individuals with RSD, by individuals experiencing RSD.

Furthermore, there is a community implication resulting from this study. Neurodivergent peer groups were commonly cited by the women as being beneficial to their wellbeing and re-valuing of their self-identity. Signposting and sharing community neuro-affirmative resources tailored to women and girls is important for clinicians to be aware of. Additionally, continued funding and support for peer spaces is warranted, as it is evident that these community structures support and maintain long-term wellbeing, at a crucial time when the NHS lacks the resources to maintain support in this way. Collaboration from all systems will benefit care and support moving forwards.

Research Implications and Recommendations

Given the limits of generalisability of the current project, further research could benefit from investigating RSD and its nuances in other groups of individuals with ADHD. For example, males and individuals who identify as non-binary as these narratives are missing from the literature on RSD. Additionally, given the narrow demographic characteristics of the sample of the current study (and co-occurring conditions) future research could benefit from investigating this phenomenon with a more ethnically diverse population.

To date, NICE guidelines for the treatment and management of ADHD recommend medication, and to receive regular and supportive psychological support (NICE, 2019). Based on this study, women experiencing a late diagnosis of ADHD are not being offered this support in the UK. RSD continues to be incredibly impactful for these women, which is not routinely being offered adequate support for. Furthermore, much of the pre-existing literature on RSD is informed by the field of American psychiatry. Currently, many treatments are based around medications. Researching strengths-based interventions could be a useful next step for research with this population.

Further research specific to the UK, and incorporating differing lenses, angles, professional occupations and systems would only extend the research within this field. Thus, the current evidence in the SLR and the present study are from the perspectives of the individual with RSD. Future research could benefit from the experiences of romantic partners, family members or employers of individuals with RSD. Alternatively, the findings from the study indicate that future research could benefit from investigating RSD in the workplace which could be completed from the perspective of the individual with RSD. Given the growing empirical base for qualitative research, it is worth considering a larger scale quantitative study and the creation of a validated measure to capture RSD.

Final Reflections

This project has encouraged me to share in the bravery and courage the women in this study took sharing their deeply personal journeys of RSD with me. It felt only right I reflected on my own personal biases and assumptions reflexively throughout, to do the narratives and stories conveyed in this study justice. This topic is not something I held lightly, I felt the importance of this area throughout the project due to its personal relevance and dearth of academic literature investigating this. I end this project remaining hopeful about the future dissemination and further studies within this field in the future.

Conclusion

RSD is a commonly shared phenomenon for individuals with ADHD. The narratives of RSD in women experiencing a diagnosis of ADHD in adulthood captured striking commonalities. The societal stigma around ADHD and RSD in the UK is contributing to the lifelong psychological distress of this population, without any meaningful publicly funded support or intervention that falls out of the realm of medication. It is imperative that the UK shifts towards a social model of disability, to provide support at multiple systemic levels accordingly. One method is to increase self-awareness and aid quality of life. Another is to provide better signposting and support for these women, from childhood. A third is to combat the stigmatising narratives and behaviours of educators, managers, employing companies, academic institutions, and the physical and mental healthcare workers across this country. Finally, it is imperative that research advances an understanding of RSD and the nuances of this in women and girls with ADHD, to help mitigate the harmful gendered narratives that currently dominate not only literature but societal discourse about these conditions.

References

Adams, J., Hillier-Brown, F. C., Moore, H. J., Lake, A. A., Araujo-Soares, V., White, M., & Summerbell, C. (2016). Searching and synthesising ‘grey literature’ and ‘grey information’ in public health: Critical reflections on three case studies. *Systematic Reviews*, *5*(1), 1-11. https://doi.org/10.1186/s13643-016-0337-y

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Armijo, C. (2024). *Leading causes of women going undiagnosed with ADHD and the impacts of going undiagnosed in adulthood* [Master’s thesis, California State University]. Scholar Works. https://scholarworks.calstate.edu/concern/theses/ww72bk49c

Asianah, A. (2023). *Disclosing neurodivergence: The effects of gender and self-disclosure on perceptions of employees with ADHD* [Honors thesis, University of North Carolina]. Carolina Digital Repository. https://doi.org/10.17615/85je-ks62

Attoe, D. E., & Climie, E. A. (2023). Miss. Diagnosis: A systematic review of ADHD in adult women. *Journal of attention disorders*, *27*(7), 645-657. https://doi.org/10.1177/10870547231161533

Auro, K., Holopainen, I., Perola, M., Havulinna, A. S., & Raevuori, A. (2024). Attention-deficit/hyperactivity disorder diagnoses in Finland during the COVID-19 pandemic. *JAMA Network Open*, *7*(6), Article e2418204. https://doi.org/10.1001/jamanetworkopen.2024.18204

Babinski, D. E., Kujawa, A., Kessel, E. M., Arfer, K. B., & Klein, D. N. (2019). Sensitivity to peer feedback in young adolescents with symptoms of ADHD: Examination of neurophysiological and self-report measures. *Journal of Abnormal Child Psychology*, *47*(4), 605–617. https://doi.org/10.1007/s10802-018-0470-2

Babinski, D. E., & Libsack, E. J. (2025). Adult diagnosis of ADHD in women: A mixed methods investigation. *Journal of Attention Disorders*, *29*(3), 207-219. https://doi.org/10.1177/10870547241297897

Baig, S. K. (2024). *"I felt like a broken person": The experiences of women navigating a late ADHD diagnosis in the UK*. (Doctoral thesis, City, University of London). City Research Online. https://openaccess.city.ac.uk/id/eprint/34238/

Barclay, I., Sayal, K., Ford, T., John, A., Taylor, M. J., Thapar, A., Langley, K., & Martin, J. (2024). Investigating the reasons behind a later or missed diagnosis of attention-deficit/hyperactivity disorder in young people: A population cohort study. *JCPP Advances*, *5*(3), Article e12301. https://doi.org/10.1002/jcv2.12301

Beaton, D. M., Sirois, F., & Milne, E. (2020). Self-compassion and perceived criticism in adults with attention deficit hyperactivity disorder (ADHD). *Mindfulness*, *11*(11), 2506-2518. https://doi.org/10.1007/s12671-020-01464-w

Beaton, D. M., Sirois, F., & Milne, E. (2022). Experiences of criticism in adults with ADHD: A qualitative study. *PLOS ONE*, *17*(2), Article e0263366. https://doi.org/10.1371/journal.pone.0263366

Bedrossian, L. (2021). Understand and address complexities of rejection sensitive dysphoria in students with ADHD. *Disability Compliance for Higher Education*, *26*(10), 4. https://doi.org/10.1002/dhe.31047

Beheshti, A., Chavanon, M. L., & Christiansen, H. (2020). Emotion dysregulation in adults with attention deficit hyperactivity disorder: A meta-analysis. *BMC Psychiatry*, *20*,(1), Article 120. https://doi.org/10.1186/s12888-020-2442-7

Berenson, K. R., Gyurak, A., Ayduk, Ö., Downey, G., Garner, M. J., Mogg, K., Bradley, B. P., & Pine, D. S. (2009). Rejection sensitivity and disruption of attention by social threat cues. *Journal of Research in Personality*, *43*(6), 1064-1072. https://doi.org/10.1016/j.jrp.2009.07.007

Bhaskar, R. (1975). A Realist Theory of Science. Taylor & Francis.

Błaszczak, A. (2023). The Comorbidity of Attention Deficit/Hyperactivity Disorder and Rejection Sensitive Dysphoria as an Impediment in Foreign Language Learning. Acta Humanitatis, 1(2), 93–106. https://doi.org/10.5709/ah-01.02.2023-01

Boeije, H.R., Van Wesel, F., & Alisic, E. (2011). Making a difference: Towards a method for weighing the evidence in a qualitative synthesis. *Journal of Evaluation in Clinical Practice*, *17*(4), 657-663. https://doi.org/10.1111/j.1365-2753.2011.01674.x

Bondü, R., & Esser, G. (2015). Justice and rejection sensitivity in children and adolescents with ADHD symptoms. *European Child & Adolescent P*sychiatry, *24*(2), 185-198. https://doi.org/10.1007/s00787-014-0560-9

Boodoo, R., Lagman, J. G., Jairath, B., & Baweja, R. (2022). A review of ADHD and childhood trauma: Treatment challenges and clinical guidance. *Current Developmental Disorders Reports*, *9*(4), 137-145. https://doi.org/10.1007/s40474-022-00256-2

Bradley, S., Parzych, I., Platts, J., & Powell, L. (2025). Understanding and harnessing differences in women with ADHD: A qualitative study. *Neurodiversity*, *3*, 1-12. https://doi.org/10.1177/27546330251317199

British Psychological Society. (2021). *Ethics guidelines for internet-mediated research*. https://doi.org/10.53841/bpsrep.2021.rep155

Brunson, L., Lauzier-Jobin, F., Olson, B., & Côté, L. P. (2025). Seven key insights from critical realism and their implications for ecological thinking and action in community psychology. *Journal of Community Psychology*, *53*(1), Article e23054. https://doi.org/10.1002/jcop.23054

Bürger, I., Erlandsson, K., & Borneskog, C. (2024). Perceived associations between the menstrual cycle and Attention Deficit Hyperactivity Disorder (ADHD): A qualitative interview study exploring lived experiences. *Sexual & Reproductive Healthcare*, *40*, Article 100975. https://doi.org/10.1016/j.srhc.2024.100975

Canu, W. H., & Carlson, C. L. (2007). Rejection sensitivity and social outcomes of young adult men with ADHD. *Journal of Attention Disorders*, *10*(3), 261-275. https://doi.org/10.1177/1087054706288106

Cassidy, E., Reynolds, F., Naylor, S., & De Souza, L. (2011). Using interpretative phenomenological analysis to inform physiotherapy practice: An introduction with reference to the lived experience of cerebellar ataxia. *Physiotherapy Theory and Practice*, *27*(4), 263-277. https://doi.org/10.3109/09593985.2010.488278

Champ, R. E., Adamou, M., & Tolchard, B. (2021). The impact of psychological theory on the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults: A scoping review. *PLOS ONE*, *16*(12), Article e0261247. https://doi.org/10.1371/journal.pone.0261247

Champ, R. E., Adamou, M., & Tolchard, B. (2023). Seeking connection, autonomy, and emotional feedback: A self-determination theory of self-regulation in attention-deficit hyperactivity disorder. *Psychological Review*, *130*(3), 569-603. https://psycnet.apa.org/doi/10.1037/rev0000398

Charrois, T. L. (2015). Systematic reviews: What do you need to know to get started? *The Canadian Journal of Hospital Pharmacy*, *68*(2), 144-148. https://doi.org/10.4212/cjhp.v68i2.1440

Cohen, J. (1960). A Coefficient of Agreement for Nominal Scales. *Educational and Psychological Measurement*, *20*(1), 37–46. https://doi.org/10.1177/001316446002000104

Cook, J. E., Arrow, H., & Malle, B. F. (2011). The effect of feeling stereotyped on social power and inhibition. *Personality and Social Psychology Bulletin*, *37*(2), 165-180. https://doi.org/10.1177/0146167210390389

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10), 1435-1443. https://doi.org/10.1177/1049732312452938

Cooper, C., Booth, A., Varley-Campbell, J., Britten, N., & Garside, R. (2018). Defining the process to literature searching in systematic reviews: A literature review of guidance and supporting studies. *BMC Medical Research Methodology*, *18*(1), Article 85. https://doi.org/10.1186/s12874-018-0545-3

Cox, C., Ludlow, A., & Whyatt, C. (2025). Children and Adults with ADHD experiences of rejection sensitive dysphoria (RSD): A systematic review and narrative analysis. (PROSPERO registration No. CRD420250638010). PROSPERO. https://www.crd.york.ac.uk/PROSPERO/view/CRD420250638010

Critical Appraisal Skills Programme. (2018). *CASP Qualitative Studies Checklist*. https://casp-uk.net/casp-tools-checklists/

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy*, *10*(1), 45-53. https://doi.org/10.1177/135581960501000110

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Dodson, W. (2016). *Emotional regulation and rejection sensitivity*. *CHADD*. https://chadd.org/wp-content/uploads/2016/10/ATTN_10_16_EmotionalRegulation.pdf

Dodson, W. (2025a, January). How ADHD Ignites RSD: Meaning & Medication Solutions. *ADDitude.* https://www.additudemag.com/rejection-sensitive-dysphoria-and-adhd/?srsltid=AfmBOoqbc5OI1UkWDc032qb97QQ5QWw7IfqnxpWwLKP63nsUc4j57Jtr

Dodson, W. (2025b, September 5). New Insights Into Rejection Sensitive Dysphoria. *ADDitude*. https://www.additudemag.com/rejection-sensitive-dysphoria-adhd-emotional-dysregulation/?srsltid=AfmBOorbjInpsRYb-elqRRpusUB1ByYeuzCQCKgeMCMh0MR4_D7X2TXd

Dodson, W. W. (2006, November 1). Real-World Office Management of ADHD in Adults. *Psychiatric Times*, *23*(13), 67-76. https://www.psychiatrictimes.com/view/real-world-office-management-adhd-adults

Dodson, W. W., Modestino, E. J., Ceritoğlu, H. T., & Zayed, B. (2024). Rejection sensitivity dysphoria in attention-deficit/hyperactivity disorder: A case series. *Neurology*, *7*(8), 23-30.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. In, C. Willig & W. Stainton-Rogers (Eds.), *Handbook of qualitative research in psychology* (2nd ed., pp. 193-209). Sage. https://us.sagepub.com/en-us/nam/the-sage-handbook...

Frick, M. A., Brandt, A., Hellund, S., & Grimell, J. (2025). ADHD and identity formation: Adolescents' experiences from the healthcare system and peer relationships. *Journal of Attention Disorders*, *29*(7), 541-553. https://doi.org/10.1177/10870547251318484

Friio, S. S. (1999). *The experiences of adolescents with ADHD: a phenomenological study* [Unpublished doctoral thesis]. The University of Calgary.

Gilbert, M., Boecker, M., Reiss, F., Kaman, A., Erhart, M., Schlack, R., Westenhöfer, J., Döpfner, M., & Ravens-Sieberer, U. (2025). Gender and age differences in ADHD symptoms and co-occurring depression and anxiety symptoms among children and adolescents in the BELLA study. *Child Psychiatry & Human Development*, *56*(4), 1162-1172. https://doi.org/10.1007/s10578-023-01622-w

Ginapp, C. M., Greenberg, N. R., MacDonald-Gagnon, G., Angarita, G. A., Bold, K. W., & Potenza, M. N. (2023a). "Dysregulated not deficit": A qualitative study on symptomatology of ADHD in young adults. *PLOS ONE*, *18*(10). Article e0292721 https://doi.org/10.1371/journal.pone.0292721

Ginapp, C. M., Greenberg, N. R., Macdonald-Gagnon, G., Angarita, G. A., Bold, K. W., & Potenza, M. N. (2023b). The experiences of adults with ADHD in interpersonal relationships and online communities: A qualitative study. *SSM. Qualitative Research in Health*, *3*, Article 100223. https://doi.org/10.1016/j.ssmqr.2023.100223

Ginapp, C. M., Macdonald-Gagnon, G., Angarita, G. A., Bold, K. W., & Potenza, M. N. (2022). The lived experiences of adults with attention-deficit/hyperactivity disorder: A rapid review of qualitative evidence. *Frontiers in Psychiatry*, *13*, Article 949321. https://doi.org/10.3389/fpsyt.2022.949321

Groves, N. B., Kofler, M. J., Wells, E. L., Day, T. N., & Chan, E. S. (2020). An examination of relations among working memory, ADHD symptoms, and emotion regulation. *Journal of Abnormal Child Psychology*, *48*(4), 525-537. https://doi.org/10.1007/s10802-019-00612-8

Gusenbauer, M., & Gauster, S. P. (2025). How to search for literature in systematic reviews and meta-analyses: A comprehensive step-by-step guide. *Technological Forecasting and Social Change*, *212*, Article 123833. https://doi.org/10.1016/j.techfore.2024.123833

Hansson Halleröd, S. L., Anckarsäter, H., Råstam, M., & Hansson Scherman, M. (2015). Experienced consequences of being diagnosed with ADHD as an adult – A qualitative study. *BMC Psychiatry*, *15*, Article 31. https://doi.org/10.1186/s12888-015-0410-4

Harrison, H., Griffin, S. J., Kuhn, I., & Usher-Smith, J. A. (2020). Software tools to support title and abstract screening for systematic reviews in healthcare: An evaluation*. BMC Medical Research Methodology*, 20, Article 7. https://doi.org/10.1186/s12874-020-0897-3

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world*? Behavioral and Brain Sciences*, *33*(2-3), 61-83. https://doi.org/10.1017/S0140525X0999152X

Henry, E., & Hill Jones, S. (2011). Experiences of older adult women diagnosed with attention deficit hyperactivity disorder. *Journal of women & aging*, *23*(3), 246-262. https://doi.org/10.1080/08952841.2011.589285

Hirsch, O., Chavanon, M., Riechmann, E., & Christiansen, H. (2018). Emotional dysregulation is a primary symptom in adult Attention-Deficit/Hyperactivity Disorder (ADHD). *Journal of Affective Disorders*, *232*, 41-47. https://doi.org/10.1016/j.jad.2018.02.007

Holthe, M. E. G., & Langvik, E. (2017). The strives, struggles, and successes of women diagnosed with ADHD as adults. *SAGE Open*, *7*(1). https://doi.org/10.1177/2158244017701799.

Htong Kham, S. (2024). Outsider from within, insider from without: Negotiating researcher positionality in comparative social research. *International Journal of Qualitative Methods*, *23*. https://doi.org/10.1177/16094069241254004.

Hussain, A. (2024). Social-emotional outcomes in emerging adults with ADHD: The influence of self-compassion on peer rejection, rejection sensitivity, and psychological distress. [Master's thesis, Wilfrid Laurier University]. Scholars Commons @ Laurier. https://scholars.wlu.ca/cgi/viewcontent.cgi?article=3778&context=etd

Huynh, K. V., Glass, I. V., & Zanarini, M. C. (2024). Increasing prevalence of attention-deficit/hyperactivity disorder in patients with borderline personality disorder. *Journal of Personality Disorders, 38*(5), 493-502. https://doi.org/10.1521/pedi.2024.38.5.493

Jastrowski, K. E., Berlin, K. S., Sato, A. F., & Davies, W. H. (2007). Disclosure of attention-deficit/hyperactivity disorder may minimize risk of social rejection. *Psychiatry*, *70*(3), 274-282. https://doi.org/10.1521/psyc.2007.70.3.274

Johnson, J. A., & Ahluwalia, S. (2025). Neurodiversity in the healthcare profession. *Postgraduate Medical Journal*, *101*(1192), 167-171. https://doi.org/10.1093/postmj/qgae108

Katzman, M. A., Bilkey, T. S., Chokka, P. R., Fallu, A., & Klassen, L. J. (2017). Adult ADHD and comorbid disorders: Clinical implications of a dimensional approach. *BMC psychiatry*, *17*(1), 302.
https://doi.org/10.1186/s12888-017-1463-3

Keaney, J., Byrne, H., Warin, M., & Kowal, E. (2024). Intergenerational trauma. In M. Pentecost, J. Keaney, T. Moll, & M. Penkler (Eds.), *The handbook of DOHaD & society* (pp. 166-173). Cambridge University Press. https://doi.org/10.1017/9781009201704.016

Kistler, R. (2022). *Trouble sitting still disorder: ADHD through the social model of disability* [Honors thesis, Western Washington University]. WWU Honors College Senior Projects.
https://cedar.wwu.edu/cgi/viewcontent.cgi?article=1580&context=wwu_honors

Kleppesto, T. H., Eilertsen, E. M., Van Bergen, E., Sunde, H. F., Zietsch, B., Nordmo, M., Eftedal, N. H., Havdahl, A., Ystrom, E., & Torvik, F. A. (2024). Intergenerational transmission of ADHD behaviors: Genetic and environmental pathways. *Psychological Medicine*, *54*(7), 1309-1317.

Kooij, J. J. S., De Jong, M., Agnew-Blais, J. C., Amoretti, S., Bang Madsen, K., Barclay, I., Bölte, S., Borg Skoglund, C., Broughton, T., Carucci, S., van Dijken, D. K. E., Ernst, J., French, B., Frick, M. A., Galera, C., Groenman, A. P., Kopp Kallner, H., Kerner Auch Koerner, J., Kittel-Schneider, S., …

Wynchank, D. S. (2025). Research advances and future directions in female ADHD: The lifelong interplay of hormonal fluctuations with mood, cognition, and disease. *Frontiers in Global Women's Health*, 6, https://doi.org/10.3389/fgwh.2025.1613628.

Kulkarni, A. V., Aziz, B., Shams, I., & Busse, J. W. (2009). Comparisons of citations in Web of Science, Scopus, and Google Scholar for articles published in general medical journals. *JAMA*, *302*(10), 1092-1096. https://doi.org/10.1001/jama.2009.1307

Larkin, M., & Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 99-116). Wiley. https://doi.org/10.1002/9781119973249.ch8

Lauder, K. M. (2021). *A critical examination of the evidence for effective reasonable adjustments for adults with attention deficit hyperactivity disorder in the workplace* (Doctoral thesis, Birkbeck, University of London). Birbeck Institutional Research Online. https://eprints.bbk.ac.uk/id/eprint/46080/

Lawani, A. (2021). Critical realism: What you should know and how to apply it. *Qualitative Research Journal*, *21*(3), 320–333. https://doi.org/10.1108/QRJ-08-2020-0101

Lee, L. Y. K., Tiu, M. M. H., Low, L. P. L., Cheng, V. S., Yau, S. Y., & Akingbade, O. (2025). Navigating challenges in using interpretative phenomenological approach with photovoice: A systematic review. *International Journal of Qualitative Methods*, *24*. https://doi.org/10.1177/16094069251337582.

Lefebvre, C., Glanville, J., Briscoe, S., Littlewood, A., Marshall, C., Metzendorf, M. I., Noel-Storr, A., Rader, T., Shokraneh, F., Thomas, J., Wieland, L.S. (2019). Searching for and selecting studies. In J. P. T. Higgins, J. Thomas, J. Chandler, M. Cumpston, T. Li, M. J. Page, & V. A. Welch

(Eds.), *Cochrane handbook for systematic reviews of interventions* (2nd ed., pp. 67-107). Wiley. https://doi.org/10.1002/9781119536604.ch4

Lensing, M. B., Zeiner, P., Sandvik, L., & Opjordsmoen, S. (2015). Quality of life in adults aged 50+ with ADHD. *Journal of Attention Disorders*, *19*(5), 405-413. https://doi.org/10.1177/1087054713480035

Li, T., Higgins, J. P., & Deeks, J. J. (2019). Collecting data. In J. P. T. Higgins, J. Thomas, J. Chandler, M. Cumpston, T. Li, M. J. Page, & V. A. Welch (Eds.), *Cochrane handbook for systematic reviews of interventions* (2nd ed., pp. 109-141). Wiley. https://doi.org/10.1002/9781119536604.ch5

Lim, W. M. (2025). What is qualitative research? An overview and guidelines. *Australasian Marketing Journal*, *33*(2), 199-229. https://doi.org/10.1177/14413582241264619

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Long, N., & Coats, H. (2022). The need for earlier recognition of attention deficit hyperactivity disorder in primary care: A qualitative meta-synthesis of the experience of receiving a diagnosis of ADHD in adulthood. *Family Practice*, *39*(6), 1144-1155. https://doi.org/10.1093/fampra/cmac038

Lunde, A. (2019). *Lived social experiences of young adults with Tourette syndrome comorbid with ADHD.* [Unpublished doctoral thesis]. Grand Canyon University.

MacFarlane, A., Russell-Rose, T., & Shokraneh, F. (2022). Search strategy formulation for systematic reviews: Issues, challenges and opportunities. *Intelligent Systems with Applications*, *15*. https://doi.org/10.1016/j.iswa.2022.200091

Macklem, G. L. (2008). *Practitioner's guide to emotion regulation in school-aged children*. Springer. https://doi.org/10.1007/978-0-387-73851-2_2

Martin, A. F., Rubin, G. J., Rogers, M. B., Wessely, S., Greenberg, N., Hall, C. E., Pitt, A., Logan, P. E., Lucas, R., & Brooks, S. K. (2025). The changing prevalence of ADHD? A systematic review. *Journal of Affective Disorders*, *388*. https://doi.org/10.1016/j.jad.2025.119427

Masuch, T. V., Bea, M., Alm, B., Deibler, P., & Sobanski, E. (2019). Internalized stigma, anticipated discrimination and perceived public stigma in adults with ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, *11*(2), 211-220. https://doi.org/10.1007/s12402-018-0274-9

Maxwell, J. A. (2012). *A realist approach for qualitative research*. SAGE.

Maya Beristain, C., & Wiener, J. (2020). Finding true friendships: The friendship experiences of adolescents with attention-deficit/hyperactivity disorder. *Canadian Journal of School Psychology*, *35*(4), 280-298. https://doi.org/10.1177/0829573520931679

McKechnie, D. G., O'Nions, E., Dunsmuir, S., & Petersen, I. (2023). Attention-deficit hyperactivity disorder diagnoses and prescriptions in UK primary care, 2000–2018: Population-based cohort study. *BJPsych Open*, *9*(4), Article e121. https://doi.org/10.1192/bjo.2023.512

McKenzie, J. E., & Brennan, S. E. (2019). Synthesizing and presenting findings using other methods. In J. P. T. Higgins, J. Thomas, J. Chandler, M. Cumpston, T. Li, M. J. Page, & V. A. Welch (Eds.), *Cochrane handbook for systematic reviews of interventions* (2nd ed., pp. 321-347). Wiley. https://doi.org/10.1002/9781119536604.ch12

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: A comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*, *14*, Article 579. https://doi.org/10.1186/s12913-014-0579-0

Morgan, J. (2024). Exploring women’s experiences of diagnosis of ADHD in adulthood: A qualitative study. *Advances in Mental Health*, *22*(3), 575-589. https://doi.org/10.1080/18387357.2023.2268756

Mrug, S., Molina, B. S., Hoza, B., Gerdes, A. C., Hinshaw, S. P., Hechtman, L., & Arnold, L. E. (2012). Peer rejection and friendships in children with attention-deficit/hyperactivity disorder: Contributions to long-term outcomes. *Journal of Abnormal Child Ps*ychology, *40*(6), 1013–1026. https://doi.org/10.1007/s10802-012-9610-2

Mueller, A. K., Fuermaier, A. B. M., Koerts, J., & Tucha, L. (2012). Stigma in attention deficit hyperactivity disorder. *ADHD Attention Deficit and Hyperactivity Disorders*, *4*(3), 101–114. https://doi.org/10.1007/s12402-012-0085-3

Müller, V., Mellor, D., & Pikó, B. F. (2024). Associations between ADHD symptoms and rejection sensitivity in college students: Exploring a path model with indicators of mental well-being. *Learning Disabilities Research & Practice*, *39*(4), 223-236. https://doi.org/10.1177/09388982241271511

Musullulu, H. (2025). Evaluating attention deficit and hyperactivity disorder (ADHD): A review of current methods and issues. *Frontiers in Psychology*, *16, Article 1466088*. https://doi.org/10.3389/fpsyg.2025.1466088

Muthukrishna, M., Bell, A. V., Henrich, J., Curtin, C. M., Gedranovich, A., McInerney, J., & Thue, B. (2020). Beyond western, educated, industrial, rich, and democratic (WEIRD) psychology: Measuring and mapping scales of cultural and psychological distance. *Psychological Science*, *31*(6), 678-701. https://doi.org/10.1177/0956797620916782

NHS England. (2025). *NHS England Report of the independent ADHD Taskforce: Part 1*. https://www.england.nhs.uk/long-read/report-of-the-independent-adhd-taskforce-part-1/

National Institute for Health and Care Excellence. (2019). *Attention deficit hyperactivity disorder: Diagnosis and management* (NICE guideline NG87). https://www.nice.org.uk/guidance/ng87

Njardvik, U., Wergeland, G. J., Riise, E. N., Hannesdottir, D. K., & Öst, L. G. (2025). Psychiatric comorbidity in children and adolescents with ADHD: A systematic review and meta-analysis. *Clinical Psychology Review*, *118*, Article 102571. https://doi.org/10.1016/j.cpr.2025.102571

Noon, E. J. (2018). Interpretive phenomenological analysis: An appropriate methodology for educational research? *Journal of Perspectives in Applied Academic Practice*, *6*(1), 75-83. https://doi.org/10.14297/jpaap.v6i1.304

Office for National Statistics. (n.d.). *Ethnic group, national identity and religion*. Office for National statistics. https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion

Oliver, M., & Sapey, B. (1983). Social work and disability: Old and new directions. In Social Work with disabled people (pp. 1-32). London: Macmillan Education UK. https://link.springer.com/chapter/10.1007/978-1-349-14823-3_1

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Tea*cher, *45*(3), 241-251. https://doi.org/10.1080/0142159X.2022.2057287

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. The *BMJ*, *372*(71). https://doi.org/10.1136/bmj.n71

Page, M. J., Shamseer, L., & Tricco, A. C. (2018). Registration of systematic reviews in PROSPERO: 30,000 records and counting. *Systematic Reviews*, *7*, Article 32. https://doi.org/10.1186/s13643-018-0699-4

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence-based nursing*, *22*(1), 7-9. https://doi.org/10.1136/ebnurs-2018-103017

Petticrew, M., & Roberts, H. (2008). *Systematic reviews in the social sciences: A practical guide*. John Wiley & Sons. https://doi.org/10.1002/9780470754887

Polanin, J. R., Pigott, T. D., Espelage, D. L., & Grotpeter, J. K. (2019). Best practice guidelines for abstract screening large-evidence systematic reviews and meta-analyses. *Research Synthesis Methods*, *10*(3), 330-342. https://doi.org/10.1002/jrsm.1354

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews*: *A product from the ESRC methods programme*. ESRC Methods Programme. https://www.researchgate.net/publication/233866356_Guidance_on_the_conduct_of_narrative_synthesis_in_systematic_reviews_A_product_from_the_ESRC_Methods_Programme

Power, A. (2024). *A Qualitative Exploration of Adult ADHD: Masking, Academic and Psychosocial Self-Concept and Functioning*. [Unpublished honours thesis]. Dun Laoghaire Institute of Art, Design and Technology.

Rakoff, V. (1966). A long-term effect on the concentration camp experience. *Viewpoints*, *1*, 17–20.

Rapoport, I. L., & Groenman, A. P. (2025). A review of sex and gender factors in stimulant treatment for ADHD: Knowledge gaps and future directions. *Journal of Attention Disorders*, *29*(8), 602-616. https://doi.org/10.1177/10870547251315601

Rasmussen, I. L., Schei, J., & Ørjasæter, K. B. (2024). “A bit lost” - Living with attention deficit hyperactivity disorder in the transition between adolescence and adulthood: an exploratory qualitative study. *BMC Psychology*, *12*(1), 20. https://doi.org/10.1186/s40359-024-01522-1

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, *123*(3), A12-A13. https://doi.org/10.7326/ACPJC-1995-123-3-A12

Ridge, D., Bullock, L., Causer, H., Fisher, T., Hider, S., Kingstone, T., Gray, L., Riley, R., Smyth, N., Silverwood, V., Spiers, J., & Southam, J. (2023). ‘Imposter participants’ in online qualitative research, a new and increasing threat to data integrity? *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *26*(3), 941-944. https://doi.org/10.1111/hex.13724

Robling, K., Cosby, C., Parent, G., Gajjar, S., Chesher, T., Baxter, M., & Hartwell, M. (2023). Person-centered language and pediatric ADHD research: A cross-sectional examination of stigmatizing language within medical literature. *Journal of Osteopathic Medicine*, *123*(4), 215-222. https://doi.org/10.1515/jom-2022-0126

Rowney-Smith, A., Sutton, B., Quadt, L., & Eccles, J. A. (2024). *The lived experience of rejection sensitivity in ADHD-a qualitative exploration*. medRxiv. https://doi.org/10.1101/2024.11.16.24317418

Ruslin, R., Mashuri, S., Rasak, M. S. A., Alhabsyi, F., & Syam, H. (2022). Semi-structured Interview: A methodological reflection on the development of a qualitative research instrument in educational studies. *IOSR Journal of Research & Method in Education*, *12*(1), 22-29.

Schrevel, S. J., Dedding, C., & Broerse, J. E. (2016). Why do adults with ADHD choose strength-based coaching over public mental health care? A qualitative case study from the Netherlands. *SAGE Open*, *6*(3). https://doi.org/10.1177/2158244016662498

Schrevel, S. J., Dedding, C., van Aken, J. A., & Broerse, J. E. (2016). ‘Do I need to become someone else?’ A qualitative exploratory study into the experiences and needs of adults with ADHD. *Health Expec*tations, *19*(1), 39-48. https://doi.org/10.1111/hex.12328

Shaw, P., Stringaris, A., Nigg, J., & Leibenluft, E. (2014). Emotion dysregulation in attention deficit hyperactivity disorder. The *American Journal of Psychiatry*, *171*(3), 276-293. https://doi.org/10.1176/appi.ajp.2013.13070966

Shipp, C. (2025). *An examination of the factors contributing to a delayed diagnosis of ADHD in adults* [Doctoral thesis, Angelo State University]. Angelo State University Digital Repository. https://hdl.handle.net/2346.1/41431

Sim, J., & Waterfield, J. (2019). Focus group methodology: Some ethical challenges. *Quality & quantity*, *53*(6), 3003-3022. https://doi.org/10.1007/s11135-019-00914-5

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J.A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, method and research. Sage.

Smith, J. A., Flowers., & P Larkin, M. (2022). Interpretative phenomenological analysis: Theory, method and research (2nd ed.). Sage.

Smith, M. (2017). Hyperactive around the world? The history of ADHD in global perspective. *Social History of Medicine*, *30*(4), 767-787. https://doi.org/10.1093/shm/hkw127

Smith, M. C., Mukherjee, R. A., Müller-Sedgwick, U., Hank, D., Carpenter, P., & Adamou, M. (2024). UK adult ADHD services in crisis. *BJPsych Bulletin*, *48*(1), 1-5. https://doi.org/10.1192/bjb.2023.88

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research*, *104*, 333-339. https://doi.org/10.1016/j.jbusres.2019.07.039

Stoll, C., Izadi, S., Fowler, S., Green, P., Suls, J., & Colditz, G. A. (2019). The value of a second reviewer for study selection in systematic reviews. *Research Synthesis Methods*, *10*(4), 539–545. https://doi.org/10.1002/jrsm.1369

Stutchbury, K. (2022). Critical realism: An explanatory framework for small-scale qualitative studies or an ‘unhelpful edifice’? *International Journal of Research & Method in Education*, *45*(2), 113-128. https://doi.org/10.1080/1743727X.2021.1966623

Todzia-Kornaś, A., Szczegielniak, A., & Gondek, T. M. (2024). Suicidality and nonsuicidal self-injury in females diagnosed with attention-deficit hyperactivity disorder – A narrative review. *Current Opinion in Psychiatry*, *37*(1), 38-42.

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, *11*(1), 80-96. https://doi.org/10.1177/1473325010368316

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), Article 52. http://dx.doi.org/10.4172/2472-1654.100093

Tyndall, J. (2010). AACODS checklist. Flinders University. https://fac.flinders.edu.au/dspace/api/core/bitstreams/e94a96eb-0334-4300-8880-c836d4d9a676/content

Tyrer, P. (2018). Comorbidity, consanguinity and co-occurrence. *BJPsych Advances*, *23*(3), 167-168. https://doi.org/10.1192/apt.bp.116.016444

Wallin, K., Wallin Lundell, I., Hanberger, L., Alehagen, S., & Hultsjö, S. (2022). Self-experienced sexual and reproductive health in young women with Attention Deficit Hyperactivity Disorder: A qualitative interview study. *BMC Women's Health*, *22*(1), Article 289. https://doi.org/10.1186/s12905-022-01867-y

Wang, Y., Tian, J., & Yang, Q. (2024). Experiential avoidance process model: A review of the mechanism for the generation and maintenance of avoidance behavior. *Psychiatry and Clinical Psychopharmacology*, *34*(2), 179-190. https://doi.org/10.5152/pcp.2024.23777

Webster, N. (2018). *ADHD in adulthood: A qualitative study of lived experience, self-esteem, diagnosis and service provision in the UK*. [Unpublished Master's thesis]. University of Derby. https://www.researchgate.net/publication/326960440_ADHD_in_adulthood_A_qualitative_study_of_lived_experience_self-esteem_diagnosis_and_service_provision_in_the_UK

Willig, C. (2016). Constructivism and 'the real world': Can they co-exist? *QMiP Bulletin*, *1*(21). https://doi.org/10.53841/bpsqmip.2016.1.21.33

Willig, C. (2019). What can qualitative psychology contribute to psychological knowledge? *Psychological Methods*, *24*(6), 796-804. https://doi.org/10.1037/met0000218

Young, S., Adamo, N., Ásgeirsdóttir, B. B., Branney, P., Beckett, M., Colley, W., Cubbin, S., Deeley, Q., Farrag, E., Gudjonsson, G., Hill, P., Hollingdale, J., Kilic, O., Lloyd, T., Mason, P., Paliokosta, E., Perecherla, S., Sedgwick, J., Skirrow, C., … Woodhouse, E. (2020). Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/hyperactivity disorder in girls and women. *BMC Psychiatry*, *20*(1), Article 404. https://doi.org/10.1186/s12888-020-02707-9

Young, Z., Tickle, A., Gillott, A., & Groom, M. (2019). Psychological impact of an adult ADHD diagnosis: "A blessing and a curse?" *Life Span and Disability*, *22*(2), 173-203. https://doi.org/10.13140/RG.2.2.36110.72006

Appendices

Appendix A

Table for non-empirical RSD resources.

Author/ Organisation	Resource	Year	Title	URL
ADHDADULTUK	Website	2025	Co-existing Conditions Evidence-based information about adult ADHD	https://www.adhdadult.uk/comorbidities/
Henry Shelford, Shyamal Mashru – ADHD UK	Podcast	2024	Episode 4: Deep Dive into Rejection Sensitivity Dysphoria with Henry Shelford and Dr. Shyamal Mashru	https://adhduk.co.uk/deep-dives/https-adhduk-co-uk-deep-dives-episode-4-deep-dive-into-rejection-sensitivity-dysphoria-with-henry-shelford-and-dr-shyamal-mashru/
Hope Gillette – Psych Central	Website	2021	What Is Rejection Sensitive Dysphoria?	https://daisychainproject.co.uk/rejection-sensitivity-dysphoria/
James Brown – Focus on Adult ADHD	Website	2021	Rejection sensitive dysphoria (RSD) and ADHD: What you need to know	https://focusmag.uk/rejection-sensitive-dysphoria-adult-adhd-adhd-mental-health/
Kate Moryoussef – ADHD Women's Wellbeing	Podcast	2024	Episode 111: Understanding RSD alongside ADHD with Marcy Caldwell	https://www.adhdwomenswellbeing.co.uk/adhd-podcast/ep111-adhd-rsd
ND Digital Library – NHS Children's and Young People services, Norfolk and Waverly	Health Resource	2025	Rejection Sensitive Dysphoria	https://www.justonenorfolk.nhs.uk/nd-digital-library/related-health-conditions/rejection-sensitive-dysphoria/

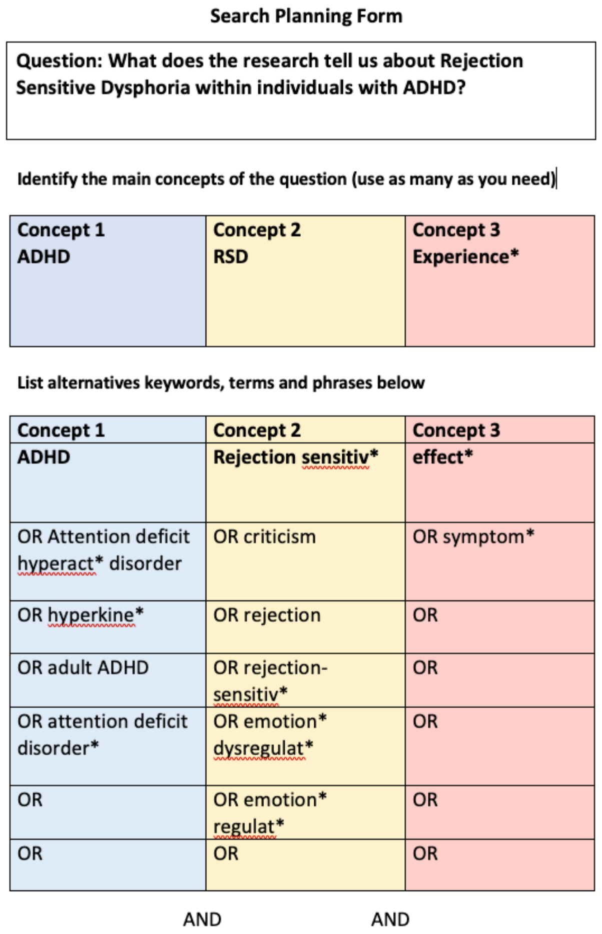
NHS – Berkshire Healthcare	Health Resource	2024	From ‘dopamining’ to ‘squirreling’ – A guide to ADHD terminology	https://www.berkshirehealthcare.nhs.uk/news/news-archive/from-dopamining-to-squirreling-a-guide-to-adhd-terminology/
NHS – Kent Community Health	Health Resource	2025	ADHD information and support services	https://www.kentcht.nhs.uk/service/adult-neurodevelopmental-service/adhd-information-and-support-services/
Sarah Gaunt – Unstoppable Girls	Blog	2023	ADHD and Rejection Sensitivity Dysphoria	https://unstoppablegirls.org.uk/adhd-and-rejection-sensitivity-dysphoria/
The ADHD Centre	Website	2018	Get To Know Them – 3 Features That Truly Define ADHD	https://www.adhdcentre.co.uk/know-the-3-features-defines-adhd/
Vicki George – The ADHD Nurse	Website	2021	Understanding the link between ADHD and Rejection Sensitive Dysphoria	https://theadhdnurse.co.uk/rejection-sensitive-dysphoria/
Victoria Barclay-Timmis – Independent	Newspaper	2025	What is RSD? The condition often linked with ADHD – and how to manage it	https://www.independent.co.uk/life-style/health-and-families/rsd-adhd-symptoms-rejection-sensitive-dysphoria-b2813055.html

Note. All URLs were last accessed as of October 2025.

Appendix B

UH Search planning tool

Search terms generated with the UH search planning tool.



Search Planning Form

Question: What does the research tell us about Rejection Sensitive Dysphoria within individuals with ADHD?

Identify the main concepts of the question (use as many as you need)

Concept 1 **ADHD**	**Concept 2** **RSD**	**Concept 3** **Experience***

List alternatives keywords, terms and phrases below

Concept 1	**Concept 2**	**Concept 3**
ADHD	**Rejection sensitiv***	**effect***
OR Attention deficit hyperact* disorder	OR criticism	OR symptom*
OR hyperkine*	OR rejection	OR
OR adult ADHD	OR rejection-sensitiv*	OR
OR attention deficit disorder*	OR emotion* dysregulat*	OR
OR	OR emotion* regulat*	OR
OR	OR	OR

AND AND

Appendix C

SLR Data Extraction Table

It is important to note that within the table the terms utilised are reflective of the terminology that is used within each paper. Terminology use varies between countries, areas, and may even reflect epistemological and ontological positions, and it is important for this review to adhere to the terminology recorded in papers so as to not misconstrue their original meanings.

Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Ginapp et al. (2023a) The experiences of adults with ADHD in interpersonal relationships and online communities: A qualitative study. Peer reviewed. Country: USA.	43 participants, aged 18-35 years. 7 male, 36 female. Diagnosed with ADHD by a clinician & corroborated with a medical provider where possible (63%). All scored above the clinical cut off (scoring 23+) in the adult ADHD self-report scale. Age of diagnosis: 5-34 years. 26% in childhood and 74% in adulthood. Co-occurring conditions: Depression (51%), Anxiety (49%), Autism (9%), None (26%).	Aim: to better understand how young adults with ADHD interpret their experiences interacting with society, managing interpersonal relationships, and building community. Including to understand potential benefits and drawbacks of online	Recruitment: Online, Facebook, CHADD, Reddit. Data analysis: IPA Research design: Semi-structured focus groups (3-6 participants in each).	Participants reported the value of learning a new vocabulary for symptoms, namely RSD, describing hypersensitivity to social exclusion. The theme ‘difficulty with online communication’ described several participants pre-emptively worrying that they would be ignored or rejected leading to refraining from engaging with others online. RSD would be triggered if they posted content that did not receive a response.	Researcher's possible biases named and discussed. Research confirms results from previous studies, whilst providing a novel area of exploration.	Sample - predominantly white women in US, diagnosed in adulthood with inattentive ADHD subtype, which may represent the online communities they were recruited from. Caution in generalising results to men, individuals with other ADHD subtype, and those diagnosed in childhood. The high level of non-response among participants who initially completed the screening survey means this a self-selecting group of people.

	Control group: N/A. Ethnicity: White (72%), Black/African American (9%), Asian (14%), Other [Hispanic/Latino] (5%).	communities for young adults with ADHD.				
Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Rowney-Smith et al. (2024) 'The lived experience of rejection sensitivity in ADHD - a qualitative exploration'. Pre-print (not certified by peer review yet). Country: UK.	5 undergraduate students at the University of Sussex. Status of diagnosis: All with formal ADHD diagnosis. Co-occurring conditions: Not stated. Control group: N/A Age of diagnosis: Inferred in childhood but not explicitly stated. Age: Not stated Sex/gender: Not stated Ethnicity/Race: Not stated.	Aim: 'to provide rich accounts of rejection sensitivity in an ADHD population'.	Recruitment: Flyers distributed across the university campus Research design: Qualitative Method used: Two focus groups (one with 2 participants and one with 3 participants). Data analysis: Thematic analysis.	Rejection Sensitivity as a multidimensional experience. Three themes: Masking, Withdrawal and Bodily sensations. Withdrawal: from relationships, university and avoiding job applications to prevent rejection. Expectation of rejection led to withdrawal to prevent rejection. Assessing relationships for rejection preventing number of meaningful relationships. One participant described neurodivergent friendships to mitigate this. Some participants stated purposefully submitting poor or late work to pre-empt disappointment. Participants described feeling unworthy of good university grades or successful job applications. Masking: Difficulties differentiating between jokes and critiques, leading to asking for reassurance and masking to prevent being labelled as 'oversensitive'. This leads to	Suggests how the findings contribute to previous research findings.	Findings do not elucidate aetiology of rejection sensitivity. Small sample size and not collecting information on co-occurring conditions, despite 2 individuals disclosing Autism and 1 disclosing Dyslexia, limits generalisability and validity.

				disconnecting from emotions, with 1 participant seeking therapy. Two participants described others assuming they are not affected by rejection or criticism, causing a vicious cycle. Social withdrawal reinforcing beliefs that they deserve to be rejected. Bodily sensations: Overwhelming. Many individual differences in location of bodily experience, only stomach was a commonality.		

Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Beaton et al. (2022). 'Experiences of criticism in adults with ADHD: A qualitative study'. Peer-reviewed. Country: UK.	Conducted in UK but participants were further reaching. UK & Ireland (109), USA & Canada (34), Europe (10), Australia/New Zealand (3). 162 participants Age range: 18–62 years (M = 33.80, SD = 10.60). Sex/gender: 109 females, 52 males and 1 person who identified as other.	Participants with ADHD and high ADHD traits were asked about their experiences of criticism from other people.	Recruitment: Recruited via online ADHD forums, social media, university disability services and posters displayed publicly. Design: Administered online through Qualtrics, participants answered a series of questionnaires (detailed in an additional journal article) provided a written response to an open-text question asking about their	Theme: 'Everything I do' is criticised. Criticism from others, self, people pleasing, sensitivity to criticism ('criticism wounds me deeply even if it is not intended'), leading to altered self-perceptions. Criticism was reported to have negative consequences for self-worth and wellbeing. To cope, some participants avoided criticism or changed how they reacted, including trying to accept themselves as they are. The responses indicated that receiving understanding from others played an important role in whether criticism was perceived. Overall, the findings highlight the need for more knowledge, understanding and	Using an open text question has allowed for an unbiased and comprehensive insight into the incidents of criticism that adults with ADHD frequently experience. A particular strength of the study is that the responses were unguided and completely anonymous, which increases confidence that the results are free of any potential sampling,	Unable to ask follow up questions/prompts limited further discussion. Participants were not screened for co-occurring conditions, it relied on self-report, and they may not have disclosed. As participants who did disclose co-occurring conditions provided data but were later removed from the study, this has the potential to limit the generalisability of the wider population of ADHD. ADHD diagnosis was not verified by a professional,

	Ethnicity/race: 141 'Caucasian', 8 'mixed ethnicity', 7 'other'. Status of diagnosis: 96 participants self-reported that they had a clinical diagnosis of ADHD, remaining 66 participants did not report a diagnosis of ADHD but their Adult ADHD Self-report Scale V1.1 (ASRS-V1.1) scores indicated high traits consistent with ADHD. Age of diagnosis: Not reported, but inferred some would be in childhood and others, adulthood due to age range of participants. People with co-occurring conditions were excluded from the dataset. Control group: N/A.		experiences of criticism from other people. Analysis: Thematic Analysis.	acceptance towards neurodiversity from the general population. The findings highlight the need to consider what individuals with ADHD perceive as criticism, how they respond to criticism, and what potential effects this may have on their wellbeing. The results also identify several gaps in the literature and directions for future research, including how neurotypical people perceive neurodiverse individuals; if people with ADHD are inherently reactive to criticism or if sensitivity to criticism is a consequence of environmental factors; and, whether changing how people with ADHD respond to criticism improves levels of wellbeing and/or educational and occupational outcomes. Importantly, the study demonstrates that levels of understanding are a fundamental factor in the negative evaluations that others have of people with ADHD. In turn, the results suggest that improving understanding may lead to more positive and supportive relationships, and that the level of knowledge and understanding that neuro-typical people have of ADHD may help to reduce criticism towards those with the condition. The current findings also highlight the importance of advocating for a more flexible society that is accepting of individuality and neurodiversity.	procedural, response, or interviewer bias.	again relying on self-reports which may lack external validity and an inclusion of participants who would not have been diagnosed with ADHD by a clinician.
Year, Authors & General Context	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**

Peer-reviewed or grey? Country	diagnosis, comorbidities, control group used					
Friio (1999) The experiences of adolescents with ADHD: A phenomenological study Grey literature: unpublished doctoral thesis. Country: Canada.	Six adolescents, 14-19 yrs, 1 female, 5 male. Ethnicity/race: Not stated. Numbers of participants with ADHD formal diagnosis, awaiting assessment or self-diagnosis: Not stated, inferred formal diagnosis. Age of diagnosis: childhood. Co-occurring conditions: Not stated. Control group used: N/A.	To explore the lived experiences of adolescents with ADHD.	Recruitment: Recruited from 3 high schools. Research design: Semi-structured interviews. Data analysis: Content analysis.	Theme: 'rejection by teachers' experienced by each participant. Due to unrealistic teacher expectations, underestimating effects of their actions/impressions on students. One participant described feeling powerless. Participants described finding teachers uncaring, too busy or disinterested in them. Theme: 'nobody is listening'. Related to teachers, schools, parents and counsellors. Leading to feelings of mistrust. Powerlessness described by one participant.	A novel approach to under-researched group (adolescents with ADHD) and contributing where it reports is a dearth of qualitative research in this group. Numerous and broad findings.	Has a limitations section, discussing generalisability of 6 participants. Acknowledges limits of interpretations in its descriptions.
Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Ginapp et al. (2023b)	Conducted in US but as online study, 31 participants were from US, 6 from Canada and 7 from 'other' (Australia,	Lived experience of young adults with ADHD and how they	Recruitment: Online (Facebook, CHADD, Reddit).	Most participants felt that the diagnostic criteria does not capture the full ADHD experience. Most had experienced	Research confirms results from previous studies, whilst providing a novel area of	Sample - predominantly white, well-educated women in US, diagnosed in adulthood with inattentive ADHD

“Dysregulated not deficit”: A qualitative study on symptomatology of ADHD in young adults Peer-reviewed. Country: USA.	Suriname, Czechia and the UK). 43 participants, 18-35 yrs (7 male, 36 female) Ethnicity/race: White (72%), Black/African American (9%), Asian (14%), Other [Hispanic/Latino] (5%) 63% had formal diagnosis corroborated. Those who did not provide these still took part. All completed adult ADHD self-report scale and scored above threshold. Age of diagnosis: 5-34 years. 26% in childhood and 74% in adulthood. Co-occurring conditions: Depression (51%), Anxiety (49%), Autism (9%), None (26%). Control group: N/A.	perceive the current diagnostic criteria, including how their symptoms have changed over time.	Methods - Nine online focus groups (3-6 people per group). Data analysis – IPA.	misdiagnosis of mental health conditions prior to experiencing ADHD diagnosis. 'Emotions' theme - subtheme of emotional lability, difficulty expressing intensity of emotions to others or feeling unable to conceal reactions. Another subtheme of RSD, ruminating over negative emotions, self-blame, somatization of emotional distress following perceived rejection by others. Some believed it was a learned response to repeated rejection due to communication issues and navigating social norms. Others thought that people with ADHD pick up on social cues that others do not and thus interpret as rejection. Common triggers: excluded from social situations by peers, perceived abandonment from loved ones, receiving negative feedback about work, academic underperformance, perceived rejection in online spaces. Disproportional to the situation but unable to control responses. Consequences: retreating from person who instigated rejection, avoiding social situations through anticipating rejection. Coping skills: reminding self not to take things personally, learning about RSD. Three participants did not experience RSD and hypothesised strong social support. One participant repeatedly placed themselves in situations that would lead to them being rejected.	exploration as this is the first study of knowledge to the research team exploring adults with ADHD's experiences with RSD. Researcher's possible biases named and discussed.	subtype with access to technology to engage in the study. Caution in generalising results to men, individuals with other ADHD subtype, and those diagnosed in childhood. Focus group methodology may have risked conformity. Structure of directive questions may have influenced responses, and questions were not systemically asked to each participant. The high level of non-response among participants who initially completed the screening survey means this a self-selecting group of people.
Year, Authors &	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race,	**Summary of study**	**Methodology** Recruitment method, research design,	**Findings & Conclusions**	**Strengths**	**Limitations**

General Context Peer-reviewed or grey? Country	status of diagnosis, age of diagnosis, comorbidities, control group used		methods used (data analysis)			
Henry and Jones (2011) Experiences of Older Adult Women Diagnosed with Attention Deficit Hyperactivity Disorder. Peer-reviewed. Country: US.	9 participants, 62 years and above, all females. Ethnicity/race: Caucasian (78%), Hispanic (22%). Formal diagnosis through a psychiatrist at single mental health organisation. All diagnosed over the age of 60. 62–70 (56%), 71–80 (33%), 91+ (11%). Co-occurring conditions: All 9 experienced depression, 2 experienced bipolar in addition to this, and 7 with anxiety disorder(s). Unclear if other mental health, or any neuropsychological conditions were enquired about. Control group: N/A.	The aim is an exploration of the experiences of older women who were diagnosed with ADHD during late adulthood to ascertain how it presents and what the effects of being late-diagnosed are.	Recruitment: Convenience sampling through a psychiatrist at a single mental health organisation, who had been diagnosed with ADHD for 1 to 2 years and taken part in a weekly group therapy focussed on living with ADHD. Method: Semi-structured interviews. Data analysis: unclear.	One theme: Peer rejection was identified across the lifespan in 7/9 participants. Also, responding to observing others being rejected was discussed in 3/9 participants. 'Feeling different' theme described years of guilt and shame. Rejecting children was discussed, and short-term marriages followed by a long-term second marriage was described. ‘Stormy relationships’, living separately from spouses, disagreement with children leading to not speaking with children for 2 years. Others described supportive and understanding relationships with their children. Switching jobs often described, reasons not further expanded on. Shame, anxiety, and depression appeared to lessen, replaced with feelings of pride as they learnt about ADHD and viewed their “disorder” as strength.	Captured subjective experiences of a population under-researched within ADHD literature. Built on findings about women and girls with ADHD and their experiences, in addition to late diagnosis.	A small, homogenous convenience sample with limited cultural diversity and a small geographic area covered. In addition, the presence of coexisting disorders renders it difficult to determine the effects of ADHD versus other disorders.

Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Wallin et al. (2022) Self-experienced sexual and reproductive health in young women with Attention Deficit Hyperactivity Disorder: A qualitative interview study. Peer-reviewed.	15 participants, age 15-29, all female. Ethnicity/race: Not stated. Status of diagnosis: All recruited from the psychiatric hospital had diagnoses from the psychiatrist or psychologist there, all other participants this information was self-reported and unable to be verified. Participant age of diagnosis: 7-29 years. Co-occurring conditions: Depression (2 participants), Anxiety (4 participants), OCD	Aim: to identify and describe self-experienced sexual and reproductive health in young women with ADHD.	Recruitment: Recruited from 2 psychiatric outpatient clinics, 2 youth centers in public health care specialising in sexual and reproductive health) and Facebook pages of 3 interest groups for people with ADHD. Method: One focus group with 3 participants & 12 individual interviews. Data analysis: Reflexive thematic analysis.	Theme 'Living with intense emotions' - details shame after feeling rejected from sharing sexual experiences with others, which leads to fear of sharing with others, including obtaining medical support. Theme 'comfortable with my sexuality' details several women struggling to feel comfortable with this due to negative self-image and low self-esteem and lifelong accumulated perception of failure leading to concerns in rejecting others in sexual situations. Perception of words or looks during sex was also reported as insecurities making them question their body or performance and fear of rejection from a partner.	Criteria for following qualitative research utilised (COREQ). Findings add to body of literature. Interviews allowed for rich data to be collected. To the authors, no qualitative study has examined sexual and reproductive health in young women with ADHD.	Combining focus group and individual interviews. Transferability of findings given the age range of women, in addition to differing subtypes of ADHD, and four participants having occurring Autism.

Country: Sweden.	(1 participant), eating disorder (1 participant). Control group: N/A					
Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Webster (2018) ADHD in adulthood: A qualitative study of lived experience, self-esteem, diagnosis and service provision in the UK. Grey literature: University of Derby research assistant. Country: UK.	23 adults (20 female, 3 male), age range 21-56 years. Status of diagnosis: Not stated Age of diagnosis: 21 to 51 years. Ethnicity: Not stated. Comorbidities: Not stated. Control group: N/A.	Aim: to explore lived experiences of individuals diagnosed with ADHD in adulthood, with a focus on diagnosis, treatment and self-esteem.	Recruitment: Purposive sampling used to recruit participants from an online adulthood ADHD forum (AADD-UK) and Facebook support group (ADHD Wise UK). Design: Semi-structured interviews. Data Analysis: Thematic analysis (TA).	Theme 1: a whole life impact – subtheme 'the emotional world of ADHD': RSD mentioned. One participant described 'it's the emotional element that has the biggest impact'. A lifetime of being criticised through school, feeling different to peers and frequently experiencing social rejection. Heightened empathy described. Anxiety and depression sometimes a secondary diagnosis and other times a misdiagnosis due to emotional experiences of ADHD.	Identifies that exploratory research into RSD is required.	Criticised TA for its lack of epistemological stance. Only one person coded the data therefore potential for researcher bias discussed.

Lunde (2019) Lived Social Experiences of Young Adults with Tourette Syndrome Comorbid with ADHD. Grey literature: Doctor of Education. Country: USA.	6 participants (18-24 years) living in Texas (3 male, 3 female). Ethnicity/race: Not stated. Inferred all had formal ADHD diagnosis. All had co-occurring Tourette Syndrome. No other conditions seemingly enquired about. Inferred diagnoses gained in childhood.	Aim: to gain insight and understanding into how young adults, aged 18 to 24, with Tourette Syndrome comorbid with ADHD explain their lived social experiences.	Recruitment: Purposive sampling. Recruited through Texas Charter of Tourette Association of America. Executive director as gatekeeper. Design: Semi-structured interviews. Data Analysis: Thematic analysis (TA).	Theme: changes in social self over time – subtheme ‘isolation’: Refer to both self-imposed and peer rejection. Reported by all participants. Several stated that they worried less about peer rejection in adulthood than adolescence. Two participants continued to experience isolation in adulthood (both females). One experienced this significantly more than other participants. Fear of judgement described. Theme 4 – family social dynamics, subtheme ‘most impact on social experiences’ all listed parents, two participants had never been in a dating relationship due to fear of rejection, and also described fear of rejection of employment. Subtheme: ”extended family” also preceded fear of rejection and led to decreased self-esteem, anxiety and depression.	Generalisable to 18-24 year olds from Texas. The study met its intended purpose, gathering rich data about the target population’s experiences.	Small sample size means not generalisable beyond Texas. Data obtained provides a snapshot of experiences in time. Possibility of researcher bias influencing data collection and analysis. Being largely web-based in terms of recruitment, this may have prevented some participants from engaging with the research. Cannot prise experiences of Tourette Syndrome from ADHD.
Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**
Power (2024) A Qualitative Exploration of Adult ADHD: Masking,	22 ‘participants’ 5 male, 13 Female, 4 ‘unknown’.	The current study aimed to examine the relationship between early academic and	Recruitment: Online subreddit blogs identified with search terms.	The two: relationship difficulties – subtheme ‘rejection sensitivity – described masking as a method of preventing social rejection. Secondary school was a particularly tough period in terms of rejection. Exhaustion and burnout disrupt masking abilities and	Strength in design, including ‘ethnically diverse’ data from worldwide participants.	Limits around no verification of ADHD diagnosis, and that the sample may have included self-diagnosed participants.

Academic and Psychosocial Self-Concept and Functioning. Country: Republic of Ireland.	Age range: 20-'early 30's, with 10 participant ages 'unknown'. Ethnicity: Not stated Status of ADHD diagnosis: Assumed formal diagnosis. Age of ADHD diagnosis: 14 diagnosed as adults, 1 diagnosed in childhood, and 7 'unknown' whether childhood or adulthood. Co-occurring diagnosis: Not stated. Control group: N/A.	social experiences, masking behaviours, and academic and psychosocial self-concept in adults with ADHD.	Research Design: Qualitative (examining blog posts). Data Analysis: Thematic Analysis.	academic and psychosocial self-concept are challenged. Masking triggers anxiety, depression, burnout, self-esteem and self-concept issues.	Transparency of study as indicator of replicability. Contributes to research.	Not generalisable to whole ADHD population.
Maya Beristain and Wiener (2020) Finding True Friendships: The Friendship Experiences of Adolescents With Attention-Deficit/Hyperactivity Disorder. Peer-reviewed. Country: Canada.	9 adolescents (16-18 yrs) with ADHD (4 boys, 5 girls). Ethnicity: Not stated. Status of diagnosis: All provided by psychologist or psychiatrist under DSM-IV. Age of diagnosis: childhood. Co-occurring conditions: Five (4 boys, 1 girl) were previously diagnosed with a learning disability, 3 girls were diagnosed with anxiety or depression. Control group: N/A.	Aim: to gain rich, detailed information to improve the social competence and adjustment of adolescents with ADHD. Three objectives: 1) to explore the views of adolescents with ADHD of the characteristics of a close friend and the difficulties they might encounter in their friendships and	Recruitment: Recruited from a larger sample of adolescents who had previously participated in a study on family and peer relationships of adolescents with ADHD. Research design: Semi-structured interviews. Data Analysis: Grounded Theory.	Theme 1: seen as "kind of weird" at school – sub themes 'exclusion by peers' and 'bullied by friends': Common experiences of social rejection. Less peer-rejection reported in secondary school compared to middle school. In middle school, both boys and girls described incidents that involved relational aggression. These negative experiences were emotionally distressing, and resulted in feelings of despair and hopelessness for the majority of participants (7). Not letting others get close to prevent rejection, thus preventing further emotional distress. In fact, they lost trust in themselves, became wary of their peers, and became resigned to being friendless in adolescence. The transition to secondary school, however, seemed to facilitate friendship development for adolescents with ADHD in this study,	This approach was helpful in obtaining rich information. The adolescents' narratives provide valuable information about the trajectory of friendship in children and adolescents with ADHD and the impact of friendship on their psychological wellbeing.	Caution should be taken with respect to the transferability of the proposed theory to other adolescents with ADHD, as the proportion of females and of participants diagnosed with a learning disability or mood disorder were higher in the sample than is typical in the population of individuals with ADHD. The experiences of participants in this study might differ from those of adolescents from diverse linguistic and cultural backgrounds or who live in rural communities.

		social relationships. 2) to explore their perspectives on their current and past peer relations including whether they had friends, when/how they met, the characteristics of their friends, how often they interact, and the quality of their relationships. 3) to learn about thoughts and experiences of previous supports / interventions to improve their social relationships.		compared to middle school. Reported experiencing less peer rejection and isolation, finding more like-minded peers in special education classes. Although, 2 remained friendless at school throughout most of their secondary education. Some girls stated that parental stress due to academic performance on top of school social issues precipitated anxiety and depression. School and mental health professional input viewed as overlooking social struggles and peer relations.		
Year, Authors & General Context Peer-reviewed or grey? Country	**Participant Characteristics** Number, age range, sex/gender, ethnicity/race, status of diagnosis, age of diagnosis, comorbidities, control group used	**Summary of study**	**Methodology** Recruitment method, research design, methods used (data analysis)	**Findings & Conclusions**	**Strengths**	**Limitations**

Baig (2024) "I felt like a broken person": The experiences of women navigating a late ADHD diagnosis in the UK. Grey literature: Unpublished doctoral thesis. Country: UK.	8 female, 25-55 years (lower and upper age bracket limits). Ethnicity: 6 White British, 2 Asian/Asian British (South Asian). Diagnosis status: 8 formal diagnosis within NHS. Age of diagnosis. All in adulthood (Mid 20s - Late 40s approximately). Co-occurring diagnoses: Not stated. Control group: N/A.	To explore the experiences of women diagnosed with ADHD in adulthood, in the UK. Two main questions: 1. How do women diagnosed with ADHD in adulthood describe their experience of being diagnosed in the UK? 2. How has their ADHD diagnosis impacted their identity and daily life functioning?	Recruitment: Flyers posted in Facebook groups & contacting charities (no response). Research Design: Semi-structured interviews. Data Analysis: Reflexive Thematic Analysis (RTA).	Theme: receiving an ADHD diagnosis - subtheme: reframing of past experiences through the lens of RSD. ADHD diagnosis enabling a language for previous experiences they previously attributed to 'personality flaws'. This knowledge helped to regulate emotions. Moving from a narrative of judgement and shame to understanding and self-compassion.	Attends to an important group in research: late-diagnosed women in the UK. Heterogeneity of NHS diagnosis. A qualitative method added depth and richness, and examined differences in female experiences, previously examine din quantitative methods. Participants from across the UK, with 2 participants from Asian/Asian British background which remains underrepresented in late diagnosis in women research.	Recruitment on Facebook may have missed those who do not use the platform. The researcher wondered whether posting the advert in safe spaces created a sense of being 'targeted' by researchers and professionals. The findings do not reflect the e3xperiences of those diagnosed outside of the NHS, or privately in the UK. Time lapse since diagnosis ranged 6 months – 8 years which may have influenced reflections. Smaller sample size for RTA highlighted.

Appendix D

CASP Dual Review Scoring Table

Study ID	Section A: Are the results valid?						Section B: What are the results?			Section C: Will the results help locally?	Total score (out of 20)
	Aims clearly stated	Is qualitative methodology appropriate?	Does the design address the aims?	Is recruitment appropriate to aims?	Is data collected addressing the research issue?	Was the research participant relationship considered?	Have ethical issues been considered?	Was data analysis rigorous?	Is there a clear statement of findings?	Is this research valuable to the current review?	
Baig, 2024 Reviewer 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Reviewer 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Beaton, 2022 Reviewer 1	✓	✓	?	?	✓	?	✓	✓	✓	✓	17
Reviewer 2	✓	✓	?	?	✓	?	✓	✓	✓	✓	17
Friio, 1999	✓	✓	?	?	✓	?	✓	✓	✓	✓	17

Reviewer 1											
Reviewer 2	✓	✓	?	?	✓	✓	✓	✓	✓	✓	18
Ginapp et al 2023a Reviewer 1	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19
Reviewer 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Ginapp et al 2023b Reviewer 1	✓	✓	?	?	✓	✓	✓	✓	✓	✓	18
Reviewer 2	✓	✓	?	✓	✓	✓	✓	✓	✓	✓	19
Henry & Jones 2011 Reviewer 1	✓	✓	?	?	✓	?	?	?	?	✓	14
Reviewer 2	✓	✓	?	?	✓	✓	?	?	✓	✓	16
Lunde, 2019 Reviewer 1	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19

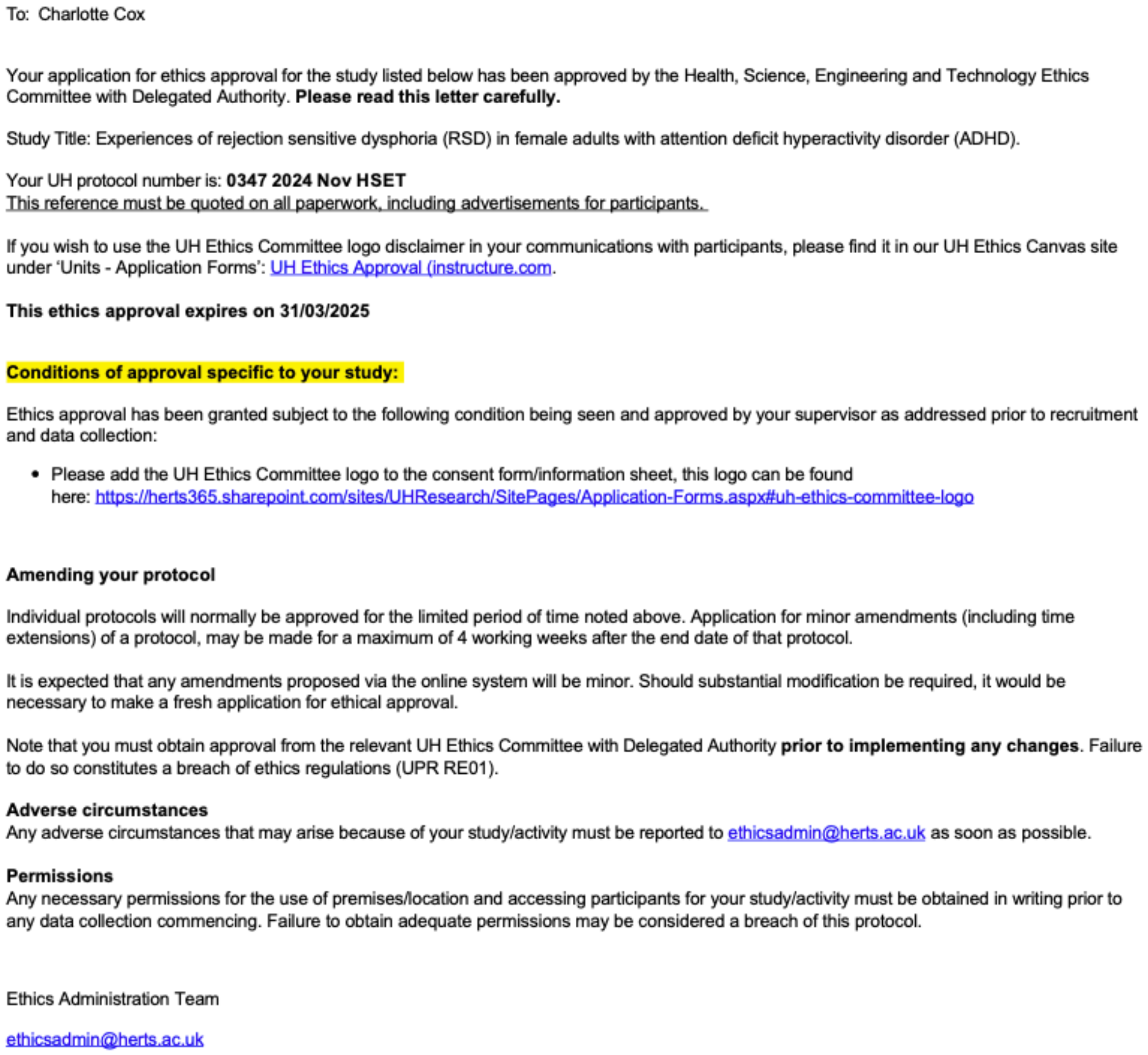
Reviewer 2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	20
Maya Beristain & Wiener, 2020 Reviewer 1	✓	✓	✓	?	?	?	✓	?	✓	✓	16
Reviewer 2	✓	✓	✓	?	?	?	✓	?	✓	✓	16
Power, 2024 Reviewer 1	✓	?	?	?	?	?	✓	?	?	✓	13
Reviewer 2	✓	✓	✓	?	?	?	✓	?	?	✓	15
Rowney-Smith et al, 2024 Reviewer 1	✓	✓	✓	?	✓	?	✓	?	✓	✓	17
Reviewer 2	✓	✓	✓	?	✓	?	✓	?	✓	✓	17
Wallis et al, 2022 Reviewer 1	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19
Reviewer 2	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19

Webster, 2018 Reviewer 1	?	✓	✓	?	✓	✓	✓	?	✓	✓	17
Reviewer 2	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	19

Appendix E

Letter(s) Concerning Ethical Approval and Amendments

A.1. Ethical Approval Letter



To: Charlotte Cox

Your application for ethics approval for the study listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).

Your UH protocol number is: **0347 2024 Nov HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 31/03/2025

Conditions of approval specific to your study:

Ethics approval has been granted subject to the following condition being seen and approved by your supervisor as addressed prior to recruitment and data collection:

- Please add the UH Ethics Committee logo to the consent form/information sheet, this logo can be found here: https://herts365.sharepoint.com/sites/UHResearch/SitePages/Application-Forms.aspx#uh-ethics-committee-logo

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

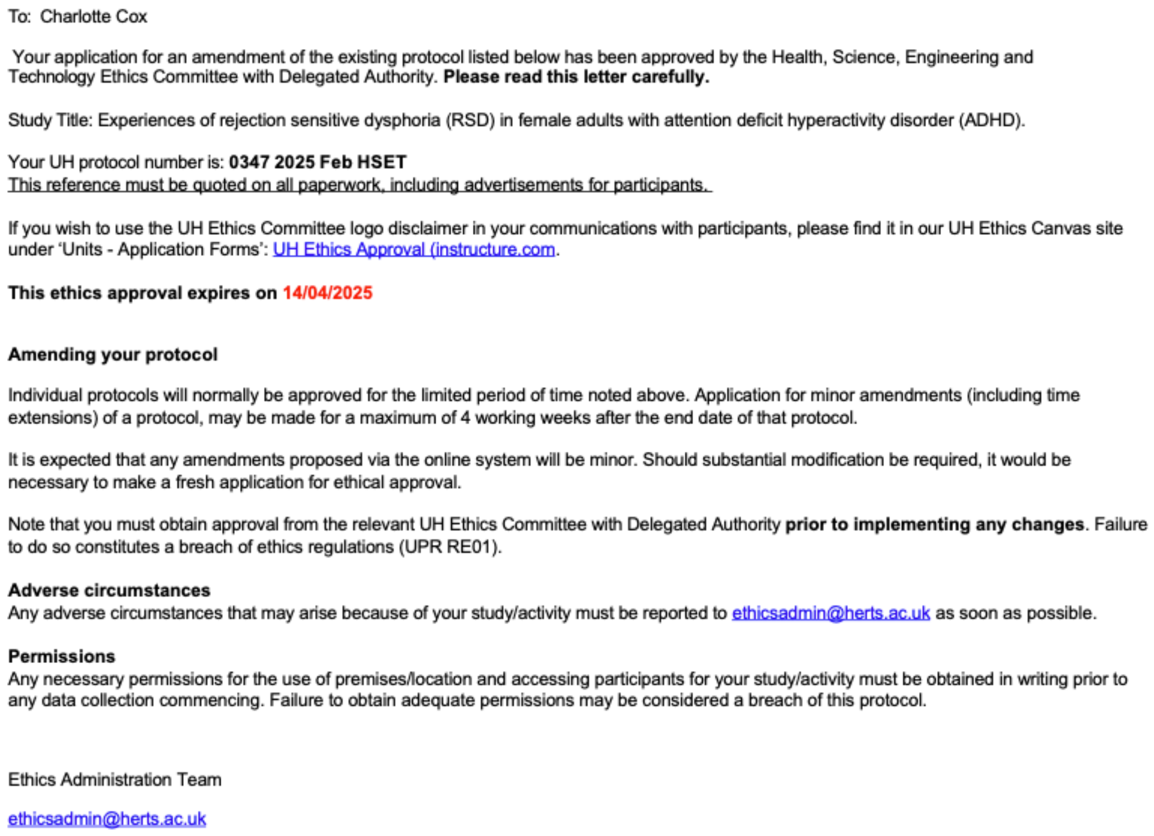
Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

A.2 Ethics Amendment Letter 1



To: Charlotte Cox

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).

Your UH protocol number is: **0347 2025 Feb HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 14/04/2025

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

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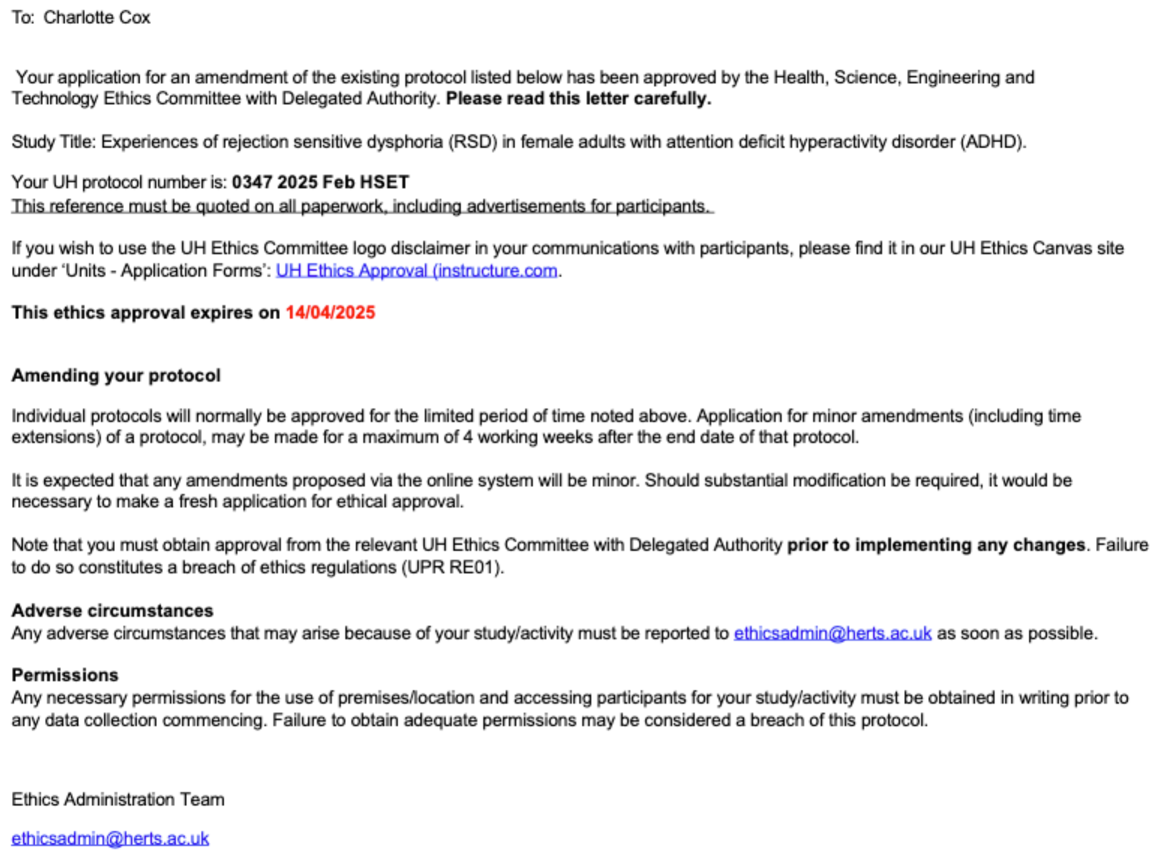
Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

A.3 Ethics Amendment Letter 2



To: Charlotte Cox

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).

Your UH protocol number is: **0347 2025 Feb HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 14/04/2025

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

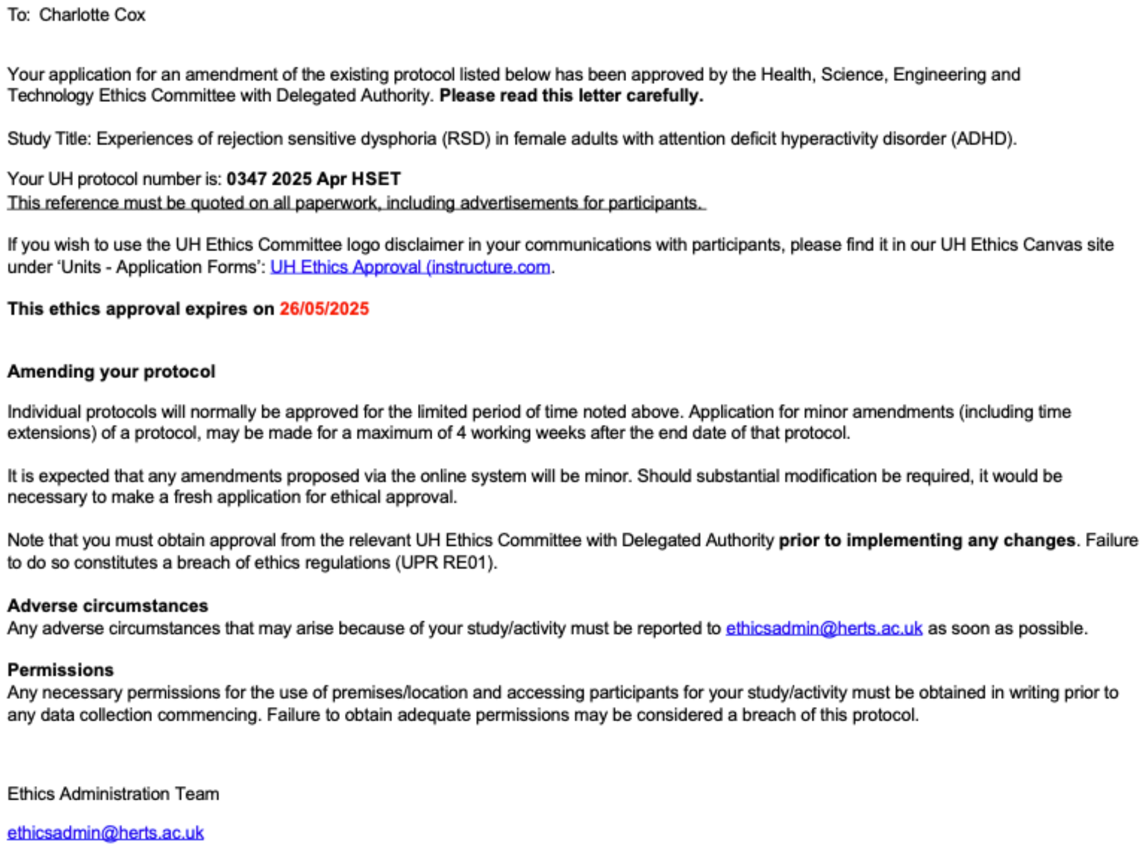
Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

A.4 Ethics Amendment Letter 3



To: Charlotte Cox

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).

Your UH protocol number is: **0347 2025 Apr HSET**
This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 26/05/2025

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

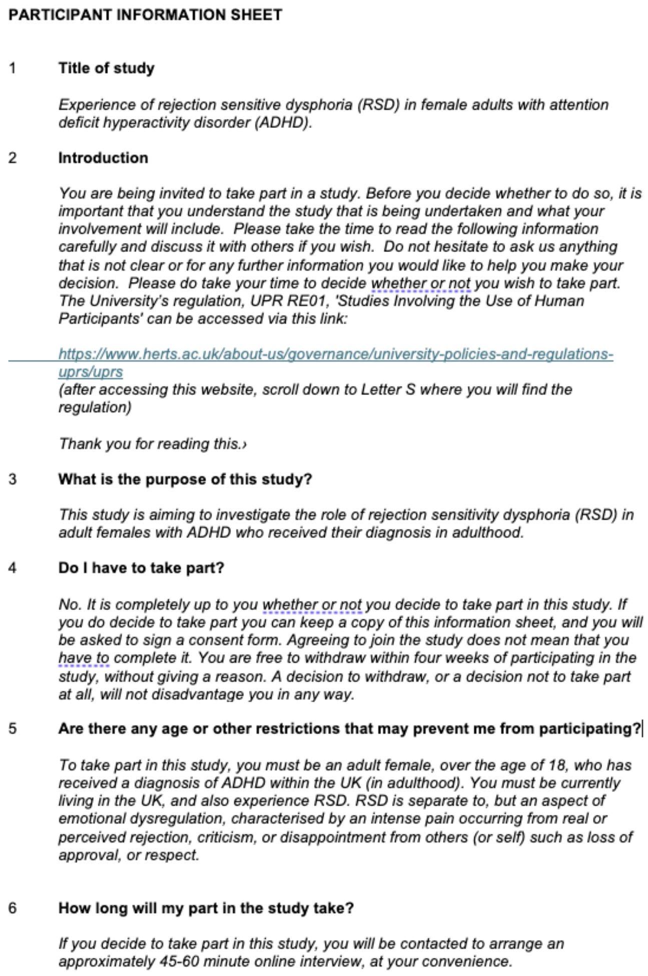
Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix F

Interview Resources

F.1. Participant Information Sheet



PARTICIPANT INFORMATION SHEET

1 **Title of study**

Experience of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.›

3 **What is the purpose of this study?**

This study is aiming to investigate the role of rejection sensitivity dysphoria (RSD) in adult females with ADHD who received their diagnosis in adulthood.

4 **Do I have to take part?**

No. It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you can keep a copy of this information sheet, and you will be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw within four weeks of participating in the study, without giving a reason. A decision to withdraw, or a decision not to take part at all, will not disadvantage you in any way.

5 **Are there any age or other restrictions that may prevent me from participating?**

To take part in this study, you must be an adult female, over the age of 18, who has received a diagnosis of ADHD within the UK (in adulthood). You must be currently living in the UK, and also experience RSD. RSD is separate to, but an aspect of emotional dysregulation, characterised by an intense pain occurring from real or perceived rejection, criticism, or disappointment from others (or self) such as loss of approval, or respect.

6 **How long will my part in the study take?**

If you decide to take part in this study, you will be contacted to arrange an approximately 45-60 minute online interview, at your convenience.

7 What will happen to me if I take part?

The first thing to happen will be completing some demographic information (i.e. age, gender, country of residence, details about your diagnoses, ethnicity) during this pre-screener. If you meet the inclusion criteria I will invite you to an online interview via email. During the interview I will ask you about your experiences of RSD. I will only ask you to share what information you feel comfortable sharing, and you can choose to stop the interview at any point you wish. You can email me before and/or after the interviews with any questions.

8 What are the possible disadvantages, risks or side effects of taking part?

Given the nature of the topic exploring ADHD and rejection sensitivity dysphoria (RSD) this may possibly lead to feelings of discomfort, stress, or emotional distress. However, you do not have to answer any questions you do not feel comfortable answering. Additionally, you will not receive immediate feedback about the study. However, there is an option to indicate if you wish to receive feedback about the overall project findings, upon its completion.

9 What are the possible benefits of taking part?

Your participation will contribute to the body of research about late diagnosed ADHD in females and experiences of RSD, which is an under researched area to date. Participating may offer you insights into your own thoughts, behaviours, and mental processes. As aforementioned, there is an option to indicate if you wish to receive feedback about the overall project findings, upon its completion. The hope is that this research will help inform the support that is offered to adults with ADHD experiencing RSD.

10 How will my taking part in this study be kept confidential?

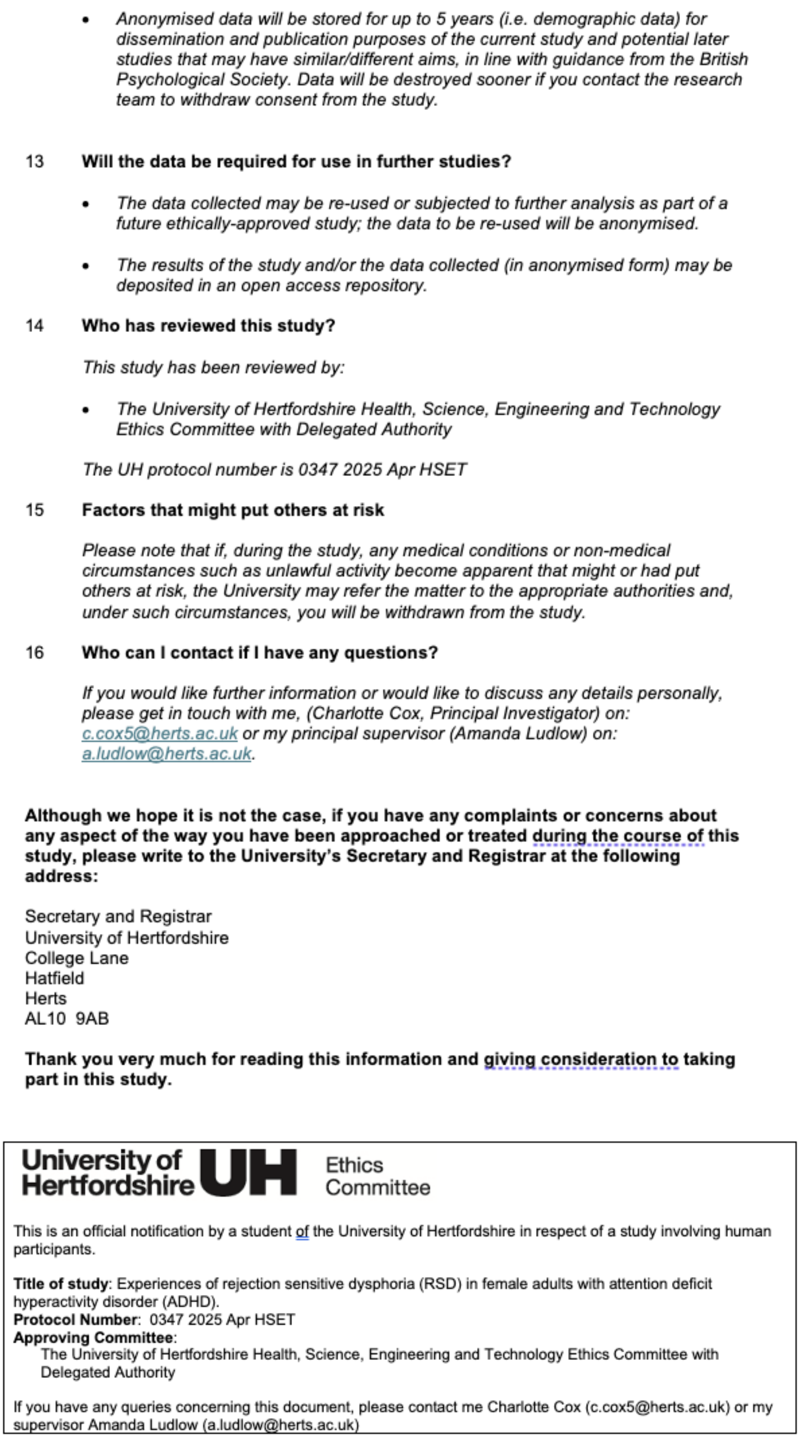
The data collected will be stored electronically, rather than hard copy. Data will be stored on a private (password protected) computer in a password-protected document, until intended project completion (September 2025), for documents with identifying information, in line with course requirements.

11 Audio-visual material

The interview will be audio-recorded, and the recording will be typed up word-for-word afterwards, to allow me to effectively analyse the interview. These will be kept on a password-protected document, on a password-protected laptop, and only the research team will have access to the interview information. I will change any personal information about you so that the information is not identifiable (such as names, specific places, ages etc.) when shared with the research team or for field group work. However, in writing the information in my thesis or for publication or wider dissemination, verbatim quotes will be incorporated, which means anonymity cannot be guaranteed.

12 What will happen to the data collected within this study?

- *The data will be anonymised prior to storage.*



- *Anonymised data will be stored for up to 5 years (i.e. demographic data) for dissemination and publication purposes of the current study and potential later studies that may have similar/different aims, in line with guidance from the British Psychological Society. Data will be destroyed sooner if you contact the research team to withdraw consent from the study.*

13 **Will the data be required for use in further studies?**

- *The data collected may be re-used or subjected to further analysis as part of a future ethically-approved study; the data to be re-used will be anonymised.*
- *The results of the study and/or the data collected (in anonymised form) may be deposited in an open access repository.*

14 **Who has reviewed this study?**

This study has been reviewed by:

- *The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority*

The UH protocol number is 0347 2025 Apr HSET

15 **Factors that might put others at risk**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with me, (Charlotte Cox, Principal Investigator) on: c.cox5@herts.ac.uk or my principal supervisor (Amanda Ludlow) on: a.ludlow@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

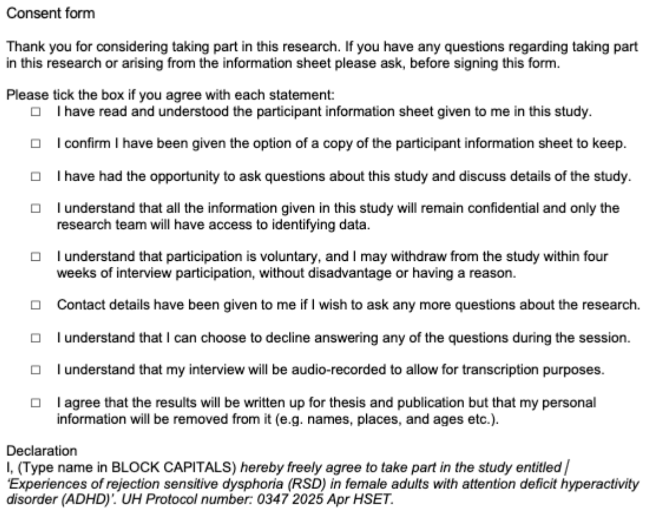
University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).
Protocol Number: 0347 2025 Apr HSET
Approving Committee:
The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Charlotte Cox (c.cox5@herts.ac.uk) or my supervisor Amanda Ludlow (a.ludlow@herts.ac.uk)

F.2. Consent Form



Consent form

Thank you for considering taking part in this research. If you have any questions regarding taking part in this research or arising from the information sheet please ask, before signing this form.

Please tick the box if you agree with each statement:

- ☐ I have read and understood the participant information sheet given to me in this study.
- ☐ I confirm I have been given the option of a copy of the participant information sheet to keep.
- ☐ I have had the opportunity to ask questions about this study and discuss details of the study.
- ☐ I understand that all the information given in this study will remain confidential and only the research team will have access to identifying data.
- ☐ I understand that participation is voluntary, and I may withdraw from the study within four weeks of interview participation, without disadvantage or having a reason.
- ☐ Contact details have been given to me if I wish to ask any more questions about the research.
- ☐ I understand that I can choose to decline answering any of the questions during the session.
- ☐ I understand that my interview will be audio-recorded to allow for transcription purposes.
- ☐ I agree that the results will be written up for thesis and publication but that my personal information will be removed from it (e.g. names, places, and ages etc.).

Declaration

I, (Type name in BLOCK CAPITALS) *hereby freely agree to take part in the study entitled 'Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD)'. UH Protocol number: 0347 2025 Apr HSET.*

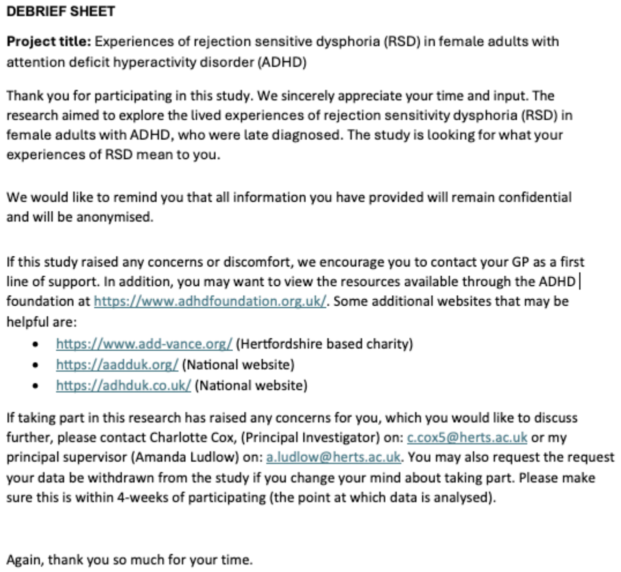
University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).
Protocol Number: 0347 2025 Apr HSET
Approving Committee:
The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Charlotte Cox (c.cox5@herts.ac.uk) or my supervisor Amanda Ludlow (a.ludlow@herts.ac.uk)

F.3. Debrief



DEBRIEF SHEET

Project title: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD)

Thank you for participating in this study. We sincerely appreciate your time and input. The research aimed to explore the lived experiences of rejection sensitivity dysphoria (RSD) in female adults with ADHD, who were late diagnosed. The study is looking for what your experiences of RSD mean to you.

We would like to remind you that all information you have provided will remain confidential and will be anonymised.

If this study raised any concerns or discomfort, we encourage you to contact your GP as a first line of support. In addition, you may want to view the resources available through the ADHD foundation at https://www.adhdfoundation.org.uk/. Some additional websites that may be helpful are:

- https://www.add-vance.org/ (Hertfordshire based charity)
- https://aadduk.org/ (National website)
- https://adhduk.co.uk/ (National website)

If taking part in this research has raised any concerns for you, which you would like to discuss further, please contact Charlotte Cox, (Principal Investigator) on: c.cox5@herts.ac.uk or my principal supervisor (Amanda Ludlow) on: a.ludlow@herts.ac.uk. You may also request the request your data be withdrawn from the study if you change your mind about taking part. Please make sure this is within 4-weeks of participating (the point at which data is analysed).

Again, thank you so much for your time.

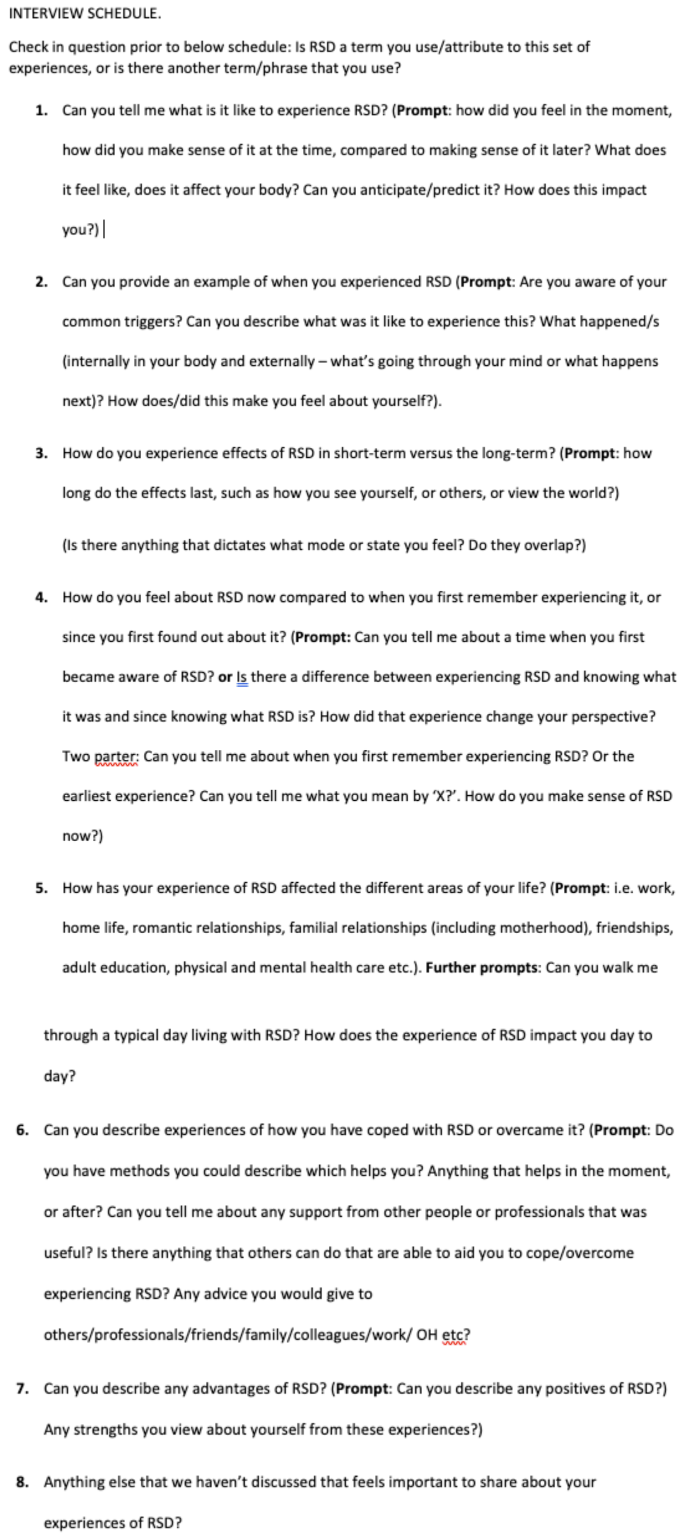
University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).
Protocol Number: 0347 2025 Apr HSET
Approving Committee:
The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Charlotte Cox (c.cox5@herts.ac.uk) or my supervisor Amanda Ludlow (a.ludlow@herts.ac.uk)

F.4 Interview Guide



INTERVIEW SCHEDULE.

Check in question prior to below schedule: Is RSD a term you use/attribute to this set of experiences, or is there another term/phrase that you use?

1. Can you tell me what is it like to experience RSD? (**Prompt**: how did you feel in the moment, how did you make sense of it at the time, compared to making sense of it later? What does it feel like, does it affect your body? Can you anticipate/predict it? How does this impact you?)

2. Can you provide an example of when you experienced RSD (**Prompt**: Are you aware of your common triggers? Can you describe what was it like to experience this? What happened/s (internally in your body and externally – what's going through your mind or what happens next)? How does/did this make you feel about yourself?).

3. How do you experience effects of RSD in short-term versus the long-term? (**Prompt**: how long do the effects last, such as how you see yourself, or others, or view the world?)

   (Is there anything that dictates what mode or state you feel? Do they overlap?)

4. How do you feel about RSD now compared to when you first remember experiencing it, or since you first found out about it? (**Prompt:** Can you tell me about a time when you first became aware of RSD? **or** Is there a difference between experiencing RSD and knowing what it was and since knowing what RSD is? How did that experience change your perspective? Two parter: Can you tell me about when you first remember experiencing RSD? Or the earliest experience? Can you tell me what you mean by 'X?'. How do you make sense of RSD now?)

5. How has your experience of RSD affected the different areas of your life? (**Prompt**: i.e. work, home life, romantic relationships, familial relationships (including motherhood), friendships, adult education, physical and mental health care etc.). **Further prompts**: Can you walk me

   through a typical day living with RSD? How does the experience of RSD impact you day to day?

6. Can you describe experiences of how you have coped with RSD or overcame it? (**Prompt**: Do you have methods you could describe which helps you? Anything that helps in the moment, or after? Can you tell me about any support from other people or professionals that was useful? Is there anything that others can do that are able to aid you to cope/overcome experiencing RSD? Any advice you would give to others/professionals/friends/family/colleagues/work/ OH etc?

7. Can you describe any advantages of RSD? (**Prompt**: Can you describe any positives of RSD?) Any strengths you view about yourself from these experiences?)

8. Anything else that we haven't discussed that feels important to share about your experiences of RSD?

Appendix G

Poster Advertisement

PARTICPANTS NEEDED

PROJECT TITLE

Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD)

ARE YOU?

- 18+
- Diagnosed with ADHD (during adulthood)
- Female

DO YOU EXPERIENCE RSD?

For example:

- Do you find it difficult or painful to receive feedback?
- Do you often feel judged, criticised or rejected by others?
- Do you experience sudden overwhelming emotions when facing situations similar to the above?

If so we would welcome you to share your experiences for this study.

WHAT'S INVOLVED?

- This is a study exploring how adults with ADHD experience rejection.
- You will be asked to particpate in this study if you match the criteria.
- You will be invited to take part in a Microsoft Teams/Zoom interview for approximately 1 hour.

CONTACT

If you want to register to take part or have any queries, please contact:

c.cox5@herts.ac.uk

University of Hertfordshire UH Ethics Committee

This is an official notification by a student of the University of Hertfordshire in respect of a study involving human participants.
Title of study: Experiences of rejection sensitive dysphoria (RSD) in female adults with attention deficit hyperactivity disorder (ADHD).
Protocol Number: 0347 2025 Apr HSET
Approving Committee: The Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.
If you have any queries concerning this document, please contact me Charlotte Cox (c.cox5@herts.ac.uk) or my supervisor Amanda Ludlow (a.ludlow@herts.ac.uk)

Appendix H

Reflexive Documents

H.1. Research Diary Extracts

January 2025

I feel invigorated after speaking to X (EbE consultant). She was so generous with her thoughts around the project and I am left feeling the importance to represent the views of the population within research and studying something that is meaningful. I left the meeting though realising that an area of life I had neglected was consideration of motherhood, given that I am not a parent. It made me reflect on how this could be replicated in the interviews, with my lens affecting what areas I may consider to ask about. Equally, there may be some areas that the participants are drawn to, or feel more relevant than others. This got me thinking about the important of convergence and divergence between individuals. I have decided to complete a reflexive exercise to ensure I am aware of other blind spots prior to the interviews and analyses.

February 2025

I completed my pilot interview earlier today and I am left realising that both the participant and I felt drained. I will need to space these interviews out accordingly, and make sure they are not scheduled for too late in the evening. I also realised that I need to change around some of my prompts so that they are not recapping too similar concepts. The participant also said that long-term memory recall was difficult, so rather than asking for too many examples from childhood, I tried to delve more into how they have made sense of things now compared to their ‘in the moment’ childhood experiences. I also noticed that I needed to take some notes mid interview to remember what to follow up on or what aspects had been missed - and realised I will need to add this explanation to participants in my interview script in order not to summarise and to record verbatim particular words and phrases so I can repeat these back to the participant. I asked the participant for feedback, and they suggested the first time I refer to RSD, calling it its full name rather than acronym. I will amend the interview script prepared.

February 2025

Today I have encountered difficulties with recruitment. I felt absolutely overwhelmed with interest for the study, but shocked that so many people do not meet the criteria for the study. Many of the first people I have contacted with inclusion and exclusion criteria have said that they actually sought private diagnosis as NHS and right to choose pathways were too long. I raised concerns with Amanda that this is not representative of the current issues with NHS diagnosis in the UK. We decided to submit an ethics amendment to change the inclusion and exclusion criteria for the study. This means changing the participant information sheet, and Qualtrics questionnaire, too. It will push the project further behind, but is a necessity. I emailed those who had commented they had no choice to seek private assessment, outside of the NHS or Right to Choose pathways, to keep them updated, but await what happens with ethics.

H.2. Reflexive exercise

Appendix I

I.1. Extract from interview transcript including experiential statement development and initial coding

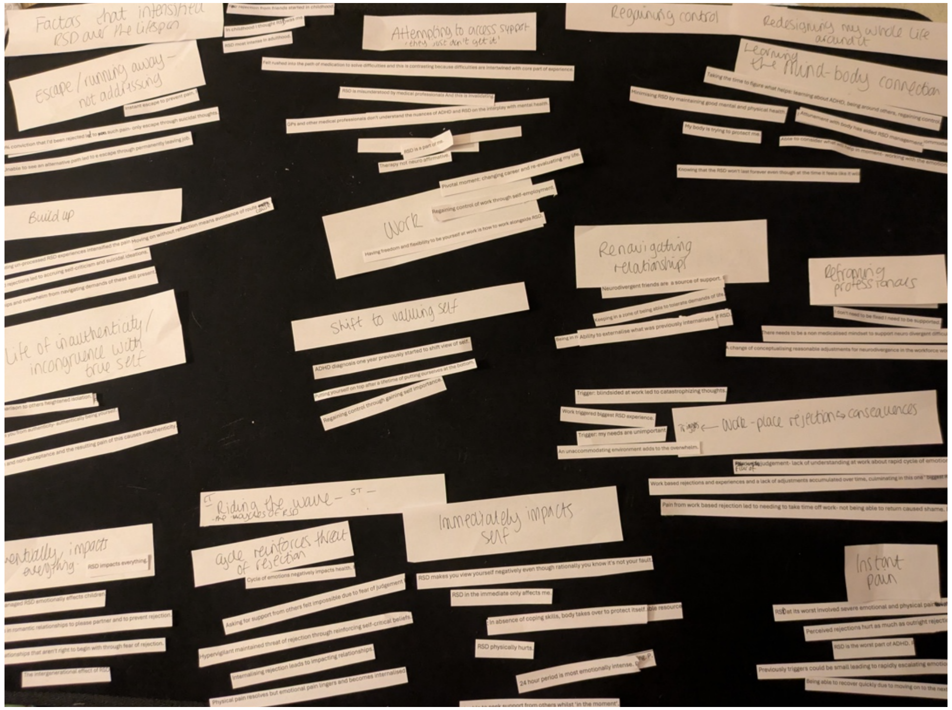
Experiential Statement	Transcript	Exploratory Notes
	Interviewer 15:47 What was going through your mind at the time?	
Ruminating on (unexpected) criticism from others became internalised in the long term. P10.	Participant 15:51 101 things as there always is with my mind, but I'd say a large proportion of those thoughts were very negative. Very criticising lots of heavy voices, a lot of the voices. I don't mean it from like a psychosis perspective, but a lot of the voices were criticisms repeating themselves that that, that those staff had said to me. The betrayal that they've been saying everything was going well and then he put me in a meeting where it wasn't. Erm Because those thoughts kept going again and again, they became fact I wasn't good enough at what I do, I'll never be good enough at what I do. Erm You are worthless, a waste of space, nobody wants you. Erm (*Pauses*) You should just end it now. Some of the thoughts. Never did. There was always a small 10% at the time. Like it'll be worth it there's a reason you're here. There's a reason to do this. And that's what kept me going. But actually, yeah, the thoughts were very self-depreciated, very self-harming, very self-critical.	Preoccupation with mostly negative thoughts. Internalised criticisms from others. Blindsided by work/management as trigger of RSD. Self-fulfilling prophecy from judgement/criticism or hard to see an alternative narrative. Repeat – internalised criticism from others. Hopelessness as consequence of rejection.
	Interviewer 16:52 How did that make you feel about yourself?	
In darkest times thoughts of hope persisted but lack of action often reinforced negative self-beliefs. P11.	Participant 16:55 Like a say the piece of shit on the bottom of someone's shoe is probably the best way I could describe. I felt I felt like scum. Erm I really did. I felt like I, felt like I. That was the other part of the time. So I always felt like I've got potential. I've always got potential. I've all I could do it. I can do it because I dream big. Then my actions weren't mirroring the thought, so therefore it's just adding adding to it. I just felt worthless. I felt like horrible. I felt like a waste of space.	Glimmers of hope for future remained, alongside ability to self-soothe and reframe. What does repetition say? Emphasis/intensity/emotional processing? Core part that's unresolved? Repetition of self-critical thoughts. Thoughts of hope persisted. Blamed self for lack of action. Reinforced negative beliefs of self.
	Interviewer 17:33 And how do you experience the effects of RSD in the short term versus the long term?	

Reactive short term response to self soothe through food to cope. P12. RSD critical thoughts still activate but can be counter balanced and less long lasting. P12	Participant 17:44 So do you, would you prefer it as if I spoke about RSD now or back then when it was the most intense? Or do you want me to talk about both because they are very different. So I guess if we go back to that, the context of those XXXXX years, it was intense. So in the short term, it was very reactive. It was very much right, my I've been rejected. I'm useless. My urge is to, run away or eat food or self-depreciate. I'm going to do that because if I'm thinking it and my action, it urges to do that, I'm gonna do it. So in the long term, back then, the rejection completely ruined my life. Whereas now having done all the work that have done, if I get rejected still in the intermediary, it's it's really Erm sharp, it's very sharp. It's like, ohh, ohh, the emotion, the tears come. In fact, that's another physical tears god, do I cry. (*Chuckles*) The the the rejection I was still comes as a shock sometimes, but then I can quickly counter balance it like yeah, it is a rejection. It's gonna hurt, but you're not gonna make yourself suffer anymore. So in the longer term, now rejection 9 out of 10 times. (*Pauses*) There's nothing. It ends at the short term. It doesn't follow me until long term anymore to an extent. Sometimes it (*Chuckles*) it still hurts us to think about it or still ruminate on it, or I'll have those kind of invisible arguments, I'll go on a walk, and there, I should have said this, I should have done that and I'm like actually, how well is this working for me right now? It's not, it's making me feel shit. So I'm gonna stop. So they're the two different now.	Did not leave time to answer question. Short-term reactive responses. Self-criticism/responsibility felt. Three reactive short-term responses: escape, self-soothe or negative self-talk. Attempts to cope/feel better Repetition from earlier – life ruined. Sudden emotions still experienced now (crying). Laughing at physiological responses. This is repeated throughout interview. Is it incongruence to protect self/ distance from pain? Feeling shame/vulnerable/internalised stigma about responses to RSD? Can now counterbalance negative thoughts associated with RSD. Emphasising this is different to historical responses – effects are not as long lasting. Walking as positive coping strategy. Able to counter-balance self-critical thought.
	Interviewer 19:35 Thinking about now, how long do the effects last for you?	
Presence of RSD in romantic relationship diminished. P13. Coping through validation from others and being provided safe spaces for exploration and emotional processing. P14.	Participant 19:42 Depending on the context of the situation, so say eh (*Pauses*) depends how emotionally invested I am in something. So if it I'm really emotionally invested in XXXXXX, you know XXXXXX, but also you do get attached to certain XXXXXX. I'll take that and I'll hold that for a couple of hours. If it's just no, no you. Erm (*Chuckles*) I'm trying to think of a really short term rejection that bothers me now. Erm Take my partner for example. 'XXXXXX, can we have a conversation about let's have a catch up? No, not right now, XXXXXX. Historically, I would have seen that as rejection abandonment. I would have then got really angry, took out on him. Now I don't. I'm like, OK. And it's about hits me. Oh, that was a rejection. But it's now to the point where I don't even notice it. It's just OK, deal with that later.	Length of effects of RSD dependent on emotional investment to rejecting scenario. RSD experienced more short-term now. Stark contrast in length effected by RSD compared to years ago. RSD present in romantic relationships. Is proximity/closeness of relationship affecting length of time RSD lasts?
	Interviewer 20:39	

	What was that change in you 'cause you speak differently compared to say that time all those years ago compared to now?	
ADHD diagnosis plus an understanding of RSD precipitated a change in valuing self-enough to protecting self. P14. Ongoing self-care to mitigate being vulnerable to receiving rejection.P15 Mourning past self's painful experiences. P16.	Participant 20:49 I couldn't attribute it to a singular thing that changed. It was kind of a plethora of things I'm erm trying to figure out how to say it in a short, short story long. Erm (*Pauses)* I didn't know what I was doing until I learned what erm the skills that I'd used in XXXXXXX. I was already doing them. I just didn't know. So elements that help improve rejection sensitivity for me was being around empowering people to my partner was incredibly supportive and incredibly validating. Someone who could, he held space for when I was rejected, so he just let me vent it out and process it. Like, why do you feel rejected because of this? Isn't this? But what does that mean? Well, because of this, this and this, how does it feel? This, this and this? So it was allowed space. So that was definitely one. (*Pauses*) Two is noticing when I was dysregulated and when I was therefore gonna be vulnerable to potential rejection. So not putting myself in situations where I could potentially be rejected when I'm in that vulnerable mindset. ….. So although I was having invisible arguments for myself, pretending that I could potentially be rejected, I was doing that before, and it was a skill. Whereas now it's like, OK, I'm going to present this XXXXX. Are they gonna be accepted? Probably not. And I really want to help this XXXXX. That's going to upset me, so I need to make sure one, I'm in a very calm headspace, and two when I am rejected, it's going to hurt, like here it's going to hurt. It's going to hurt me. So what am I gonna do after? (*Pauses)* So things like that, have really helped, just regulating my emotions and in general, so making sure that, I (*Pauses*) exercise. I go for walks every morning. I make sure that I'm not hungry (*Chuckles*) or tired to the best of my ability. Erm basically, I don't leave myself vulnerable to it. Erm and then the one of the biggest things that helped was actually receiving the diagnosis of ADHD, not for any reason, like I didn't want to have it as an excuse, but it does validate that all these years where I thought I was maybe overly sensitive erm, or too reactive, you know, actually there's a chemical reason for that. So all of those are the main things I could think of that's changed.	Multiple causes/gradual change in experiences of effects of RSD. Being given space for rejection, to experience this. Dialogue around experiences of rejection. Increased awareness of the experience of emotional dysregulation. Avoidance? Protecting self from further distress. Protective strategy 'cope ahead'. Pride in having skills to cope. Strengths-based language in response to RSD (first time in transcript?) Now has awareness of triggers to rejection and resulting RSD. Protecting self with positive coping skills and self-care. Preparing how to cope with RSD. Responsibility to look after emotions/pre-empt them. Exercise as protective coping skill. Taking care of physical self as barrier to vulnerability to rejection. ADHD diagnosis validated experiences and previous personality flaws/narratives of 'too sensitive'. Internalised stigma around ADHD diagnosis – concern this will be experienced negatively? Noticed increased rejection sensitivity. Externalises responses to RSD – factual/scientific reason for this.
	Interviewer 23:26 Can you tell me more about that time where you were diagnosed with ADHD?	
	Participant 23:32	Burnout precipitates seeking ADHD diagnosis. Awaited assessment of ADHD for years.

Shared resonance with others enabled revolution of identify. P16. The time where medication was most needed, has passed. P17.	Yeah, it was, it was XXXXXX. It was only a XXXXXX, so it took XXXXXX years and it was actually following a period of burnout. XXXXXX years ago, I worked, I've worked in XXXXXXX for a while, and my colleague was like, have you considered ADHD? I was like, no. (*Chuckles*) I'm not a not a little boy running around hyperactive in the playground, and actually then when I started to look down the pathway of it then I was on the waiting list. The more I learned, the more I was like, yeah, I really resonate with a lot of these experience experiences. When I got the when I was assessed. Erm (*Pauses)* I mean, the assessment was just an assessment, it didn't really validate as many people say it does for me, but I already knew it. It was just basically, yeah, you are right in what you're thinking. So. (*Pauses*) It does create. It did create and it still does. Erm its not Erm remorse Erm mourning? I had I have a period of mourning of all, like for example, that XXXXXX -year period where as if I was maybe diagnosed at an earlier age or it was spoken about more, maybe I wount have to go into a substantive amount of debt. Maybe I'd still be in that career. I don't regret it because I love my job and I'm in a way better career path now. But. Could have found little things a little bit better.	Took a while for colleagues to notice ADHD. Male stereotype of ADHD/own self-stigma. Contradicts claim about validating experience of diagnosis. Could it be because they had already had years considering/accepting ADHD diagnosis? Why is mourning presented as a question? Mourning for past self, hardship, and possible alternative life path. Grief of debt/time/silence of ADHD/career change/experiencing emotionally hard times.

I.2. Further information detailing the process of arriving at PETS



Appendix J

GETS occurrence across the participants

GETs	Subthemes	Jenna	Toni	Claudia	Lucy	Nicole	Mabel
1) "RSD ruined my life": Strategies for survival	Moulding self since childhood		X	X	X		X
	Avoiding rejection at all costs	X	X		X	X	X
	Escaping the pain of RSD	X	X			X	X
2) "Riding the wave": The immediate emotionality of RSD	Acute bodily changes	X	X	X		X	X
	Rapid emotional shifts	X	X	X	X	X	X
3) The reinforcing cycles of rejection	Accumulating rejection	X		X	X	X	X
	Work based burnout	X	X		X	X	X
	The self-critical nature of RSD	X	X	X		X	X
4) "A 360" in valuing self: The pivotal moment of discovering RSD	Re-authoring my narrative	X	X	X	X		X
	Invalidation through RSD being unknown	X	X	X	X	X	X
	Alleviating the intensity of RSD	X	X	X	X	X	X