LUMINOUS PROSPERITY

SECOND EDITION · RSD & ADHD SERIES

RSD & ADHD

Thriving with a Luminous Mind

A cited guide to rejection sensitivity, attention, and the practice of coming back to yourself.

REJECTION SENSITIVITY · ADULT ADHD · SELF-COMPASSION

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WITH WORKBOOK

This book is educational and does not replace individual assessment or treatment. Nothing here is a diagnosis. If you are in crisis, contact local emergency services or a crisis line.

CONTENTS

What is in this book

Every line below is a live link. On paper, the same order holds.

Every chapter's reflection questions and ten photocopiable worksheets live in the companion *RSD & ADHD Workbook*, built to bring into your own sessions. Appendix B gives an overview of every practice taught, so you can skip to it at any point.

One book, one workbook

This book is written for you if you are living with rejection sensitivity, whether or not ADHD is part of your picture. Each chapter opens inside a gold border — a mark this series uses consistently — with a short reflection and a haiku before the chapter itself, then names a mechanism and tells you what the research supports, and how strongly, using the grading scale on the next page.

A box marked **Bringing This to Your Clinician** closes most chapters — a specific, sayable sentence or two, if you see a therapist, psychiatrist, or other professional, for what is worth raising in that room. You never have to use it. It exists so that a conversation which is often rushed has something concrete to start from.

The reflection questions and worksheets that go with each chapter live in the companion ***RSD & ADHD Workbook***, so this book stays clean to read, lend, or revisit, and the workbook stays the one place you write. Twelve questions per chapter — four self-inquiry, four appreciative inquiry, four journal prompts — plus ten one-page worksheets. Bring the workbook, not this book, to your next appointment.

Appendix B, *Practices at a Glance*, summarises every technique taught in this book on a few pages, so you can skip straight to a reminder of how STOPP or the Rejection Reframe works without hunting back through a chapter.

A NOTE ON EVIDENCE AND CITATION

What is known, what is claimed, and how to tell

The first edition of this book asserted a great deal without saying where any of it came from. This edition cites its sources in APA style, and — more importantly — grades them. Where the evidence is strong, you will see it said plainly. Where a widely repeated idea rests on clinical description rather than controlled research, that is said just as plainly, because you deserve to know which floor you are standing on.

Every chapter carries an **Evidence at a glance** panel using this scale. The dots are borrowed from the design language of this series: a dot, never an alarm.

- ● ● ● **Well supported** — replicated randomised trials, meta-analyses, or consensus statements.
- ● ● **Moderately supported** — consistent findings from smaller trials or observational studies.
- ● **Emerging** — pilot studies, qualitative work, case series, single findings.
- ○ **Clinical model** — useful in practice, not yet tested, or actively contested. Held loosely.

Two honesties belong here at the front. First: **rejection sensitive dysphoria is not a diagnosis**. It appears in no edition of the *Diagnostic and Statistical Manual*, including DSM-5-TR (American Psychiatric Association, 2022). It is a clinical description, introduced in the ADHD community and popularised through lay publications, whose first detailed appearance in the scientific literature was a four-person case series (Modestino et al., 2024). Second: the *experience* it names is well attested. Emotion dysregulation in adults with ADHD is robustly documented in meta-analysis (Beheshti et al., 2020) and systematic review (Soler-Gutiérrez et al., 2023), and rejection sensitivity itself is a measurable disposition with three decades of research behind it (Downey & Feldman, 1996). Both things are true: the label is provisional, and your experience is real.

Citations were checked against publisher records or indexed databases. Where a source is a preprint, a case series, a book, or a clinical commentary rather than peer-reviewed empirical research, the reference list says so.

INTRODUCTION

Emotional Whiplash: Where ADHD and Rejection Sensitivity Meet

The speed is the symptom. Not the size of the feeling — the speed of it.

"The storm has a shape. Once you can see the shape, you are no longer only inside it."

Message left unread —
the whole sky rearranges.
Still, the sky returns.

Something happens. A message goes unanswered, a face closes slightly, a manager says "can we talk later." And then, faster than thought, the floor gives way. Not a mood arriving over an afternoon, but a state change in a second or two: heat in the chest, a lurch, and a conclusion already formed — *they are done with me*. Twenty minutes later the evidence looks thin. The damage is already done, because you have already sent the message, or gone silent, or begun rehearsing your resignation.

This is what people with ADHD often mean by emotional whiplash. The clinical literature calls it emotion dysregulation, and the research is no longer ambiguous about its presence. A meta-analysis of adults with ADHD found substantially elevated emotion dysregulation compared with controls (Beheshti et al., 2020). A PRISMA-guided systematic review concluded that adults with ADHD rely more often on non-adaptive emotion-regulation strategies, and that this dysregulation tracks with symptom severity, executive functioning, and comorbidity — leading its authors to argue for emotion dysregulation as a fourth core feature rather than a complication (Soler-Gutiérrez et al., 2023). Others have made the same case from different data (Hirsch et al., 2018; Shaw et al., 2014). Barkley has argued for decades that the emotional dimension was never incidental to the disorder but written out of its diagnostic description (Barkley, 2015).

What the manual still leaves out, the people living it put in. When forty-three young adults with ADHD were asked in focus groups whether the diagnostic criteria described their experience, most said no. They described dysregulated attention rather than absent attention, including hyperfocus; and they described emotional dysregulation, naming rejection sensitivity specifically, as central to what the condition actually feels like (Ginapp et al., 2023).

What rejection sensitivity is, precisely

Rejection sensitivity, as a research construct, is the disposition to anxiously expect rejection, to perceive it readily in ambiguous situations, and to react to it intensely (Downey & Feldman, 1996). It predicts real interpersonal consequences, and it can be measured. Rejection sensitive dysphoria — RSD — is a narrower clinical description that emerged in ADHD practice for the sudden, severe, brief emotional pain that follows perceived rejection, criticism, or failure. It is not in the DSM. Its published empirical base is small: a case series of four adults (Modestino et al., 2024), a handful of qualitative studies including focus-group and interview work (Ginapp et al., 2023; Rowney Smith et al., 2024, preprint), and survey findings linking ADHD symptoms to rejection sensitivity in students (Müller & Pikó, 2024). No validated instrument for RSD yet exists.

Some readers will find that deflating. It should not be. The absence of a measure is a statement about the state of a research field, not about the state of your nervous system. Social rejection is not a metaphorical injury: functional imaging shows that exclusion recruits regions also implicated in physical pain processing (Eisenberger et al., 2003), and later work found overlap with somatosensory representations of pain in intense rejection (Kross et al., 2011). When you say it hurts, you are describing something the brain treats as an injury.

What this second edition changes

Four things. Every substantive claim now carries a citation, and every citation carries a grade. The polyvagal and parts-work chapters have been rewritten to state honestly what is model and what is measured — including the live scientific dispute about polyvagal theory's physiological premises (Grossman, 2023; Porges, 2026). Every exercise from the first edition has become a one-page worksheet you can copy, ten per chapter. And a new final chapter addresses medication, measurement, and how to work with a clinician when the emotional part of ADHD is the part that is hardest to get taken seriously.

BRINGING THIS TO YOUR CLINICIAN

If you have organised your self-understanding around the RSD label, that is a reasonable place to start — and a good thing to say plainly in a first conversation about it: "I've been reading about rejection sensitive dysphoria, and here is what it looks like for me." It is not a diagnosis your clinician will find in their manual, and naming that yourself, once, tends to build trust faster than either defending the label or dropping it. Then move to what can be tracked: how often, how fast, how long, what it stops you doing.

CHAPTER ONE

The Hidden Struggle: Naming Rejection Sensitivity in ADHD

You cannot work with something you have no name for. You can only apologise for it.

"What has a name can be met. What has no name can only be endured."

Not too much, not less —
a nervous system, listening
far too early, hard.

Most people carrying this do not describe it as an emotional problem. They describe it as a character problem. *I am too much. I am too sensitive. I take things the wrong way.* Those are not observations; they are verdicts, absorbed from years of feedback and repeated in the first person. The first task of this chapter is to replace the verdict with a description.

Here is the description. Something registers as rejection. The emotional response arrives at full intensity almost immediately, and — this is the part that separates it from ordinary hurt — it converts into behaviour before deliberation catches up. Barkley and Fischer found that emotional impulsiveness made a unique contribution to impairment across major life activities in hyperactive children followed into adulthood, over and above other symptom dimensions (Barkley & Fischer, 2010). Note what that isolates: not the size of the feeling, but the shortness of the gap between feeling and action. That gap is where every skill in this book operates.

Triggers are ordinary; the amplitude is not

The triggers are usually unremarkable to everyone else: a delayed reply, a colleague's correction, a friend who cancels, a like that does not arrive. What is not unremarkable is the amplitude and the speed. Adults with ADHD report using non-adaptive regulation strategies more often — suppression, rumination, avoidance — and these choices are themselves associated with worse functional outcomes (Bodalski et al., 2019; Soler-Gutiérrez et al., 2023). Two things are therefore happening at once: a stronger initial signal and a thinner set of tools for what comes next. Both are workable. Neither is a flaw in you.

The shame spiral, described mechanically

Shame is not intense guilt. Guilt evaluates an act; shame evaluates the self (Tangney & Dearing, 2002). That distinction matters enormously here, because the spiral runs on the second one. The sequence is reliable enough to be mapped: trigger, instant conclusion about the self, flooding, protective behaviour (withdrawal, over-apology, aggression, or performance), then a second conclusion drawn from the behaviour itself — *and I handled it badly, which proves it*. The loop closes and tightens.

Interrupting it at the fifth link is nearly impossible. Interrupting it at the second is difficult but learnable. That is why Worksheet 1.4 asks you to write out your own chain and choose a link — not the worst link, the earliest realistic one.

Why self-compassion, specifically

Self-compassion is not a mood or a slogan. As operationalised in research it has three components: kindness rather than self-judgement, common humanity rather than isolation, and mindful awareness rather than over-identification with painful thought (Neff, 2003). Adults with high ADHD traits show significantly lower self-compassion than comparison groups, irrespective of diagnostic status and of co-occurring mood conditions, and higher perceived criticism from others explains part of that gap (Beaton et al., 2020). In a later structural model, self-compassion partly accounted for the poorer mental health seen in adults with ADHD (Beaton et al., 2022). Self-compassion interventions in general populations show small-to-moderate benefits across psychosocial outcomes in meta-analysis (Ferrari et al., 2019; Wilson et al., 2019).

Which is why the self-inquiry questions in this book are phrased the way they are. They do not ask you to feel better. They ask you to look at what is happening with the tone you would use for someone you loved — which is, mechanically, the intervention.

EVIDENCE AT A GLANCE

- ●● Emotion dysregulation is elevated in adults with ADHD (Beheshti et al., 2020; Soler-Gutiérrez et al., 2023).
- ●● Rejection sensitivity is a measurable disposition predicting interpersonal outcomes (Downey & Feldman, 1996; Ayduk et al., 2000).
- ●● Lower self-compassion in ADHD, partly explained by perceived criticism (Beaton et al., 2020, 2022).
- ● RSD as a distinct named phenomenon: case series and qualitative reports only (Modestino et al., 2024; Ginapp et al., 2023).
- ○ The five-link shame spiral as drawn here — a clinical map, useful and untested as a model.

BRINGING THIS TO YOUR CLINICIAN

When you describe this to a clinician, latency is more useful than intensity: not just "it was a ten out of ten" but "it hit within about a minute of reading the message." A fast latency points toward delay-and-regulate skills rather than talk-it-through-in-the-moment ones, and naming that speed helps your clinician aim the right tool at it. Worksheet 1.1 in the companion Workbook is built to hand over exactly this.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter One.

CHAPTER TWO

The Full Spectrum: Executive Function, Emotion, Sensory Life

Attention was never the whole story. It was only the part that was easiest to see from outside.

"Attention is not missing. It is asking different questions than the room is asking."

Mind like weather now —
gale, then stillness, then a gale.
Both are the same sky.

ADHD is described in the manual through inattention, hyperactivity, and impulsivity (American Psychiatric Association, 2022). That description is useful and incomplete, and the incompleteness has consequences: it is why so many adults were assessed, found to be paying adequate attention in a quiet room, and sent home.

The wider account begins with executive function — the self-directed capacities of inhibition, working memory, planning, flexibility, and self-monitoring that let a person act on behalf of their own future (Barkley, 1997). Sonuga-Barke's dual-pathway model added a second, partly independent route: altered reward and delay processing, which explains why the same brain can be immovable on a tedious task and unstoppable on an interesting one (Sonuga-Barke, 2003). The World Federation's consensus statement, which distils 208 evidence-based conclusions, documents both the heritability and the functional cost of the condition across the lifespan (Faraone et al., 2021).

Emotion as a core feature, not a side effect

The most significant change in the last decade of adult ADHD research is the reclassification of emotion from complication to core feature. Reviews of the empirical evidence supported emotional dysregulation as intrinsic rather than merely comorbid (Retz et al., 2012; Corbisiero et al., 2013), a position strengthened by later systematic review (Soler-Gutiérrez et al., 2023) and by data arguing for it as a primary symptom (Hirsch et al., 2018). Temperament-based subtyping has identified an irritable profile with distinct outcomes (Karalunas et al., 2014). This matters practically: if emotion is core, then emotional skills are not an optional add-on to ADHD treatment.

Dysregulated, not deficient

When adults with ADHD describe their own attention, they rarely describe a deficit. They describe variability — long stretches of impossibility punctuated by hyperfocus so complete that meals and messages disappear. In focus-group research most participants said the diagnostic criteria did not capture their experience, and proposed *dysregulation* as the more accurate word for both their attention and their emotion (Ginapp et al., 2023). It is a better word. A deficit implies an absence to be filled. Dysregulation implies a signal that needs conditions, not correction — which is what Worksheets 2.2, 2.3, and 2.8 are designed to find.

Sensory life and the moving baseline

Sensory reactivity is not a diagnostic criterion for ADHD, and it is very commonly reported: overlapping voices, fluorescent flicker, a label at the neck. Its relevance here is arithmetic. Every point of sensory load raises the baseline from which a rejection response starts, which shortens the distance to overwhelm. This is why the same remark is survivable at ten in the morning and unbearable at six in the evening in an open-plan office. Mapping your sensory conditions is not fussiness; it is changing the starting number.

The laziness explanation, and why it fails

Laziness is a moral explanation for a mechanical event. It predicts nothing and it treats nothing. What is actually happening at the moment of not-starting is some combination of impaired initiation, poor time representation, low working-memory availability, and an activation threshold that interest and urgency can cross but obligation cannot (Barkley, 1997; Sonuga-Barke, 2003). Adults with ADHD describe an outsized effort cost that is invisible to observers and therefore easily read as indifference. Replacing the moral account with the mechanical one reduces shame and — this is the part worth insisting on — it also gives you something to change.

EVIDENCE AT A GLANCE

- ●● ● Executive-function involvement in ADHD, and its lifespan functional cost (Barkley, 1997; Faraone et al., 2021).
- ●● Emotion dysregulation as a core rather than incidental feature (Retz et al., 2012; Hirsch et al., 2018).
- ●● Altered reward and delay processing as a second pathway (Sonuga-Barke, 2003).
- ● Hyperfocus and dysregulated attention as described by adults themselves (Ginapp et al., 2023).
- ○ Sensory load as a direct amplifier of rejection response — plausible, clinically consistent, not directly tested.

BRINGING THIS TO YOUR CLINICIAN

If your own self-description feels globally negative — "I'm bad at everything" — try bringing a domain-by-domain picture instead: which specific areas (starting, planning, switching, finishing) are hard, and which are actually fine. That distinction is more useful to a clinician than a global verdict, and it is worth pairing with a validated executive-function scale (Barkley, 2011) rather than self-report alone.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Two.

CHAPTER THREE

How Rejection Sensitivity Shapes Everyday Life

It rarely shows up as a scene. It shows up as a narrowing — of what you attempt, ask for, and say.

"The bravest thing some days is the email you finally send."

Unsent for a week —
three words waiting in the draft.
Send it. See what stays.

The dramatic episodes are not where most of the damage lives. The damage lives in the accumulated small edits: the application not sent, the question not asked, the friendship allowed to lapse rather than repaired, the email drafted nine times and deleted. Rejection sensitivity predicts interpersonal difficulty precisely because anxious expectation changes behaviour before any rejection has occurred (Downey & Feldman, 1996; Ayduk et al., 2000).

Feedback at work, and the two-hour tax

Constructive feedback is designed to be separable from the person receiving it. That separation is exactly what fails here. What arrives is not a note about a document; it is a verdict about a self. The measurable costs are downstream — hours lost to recovery, avoidance of the person who gave the feedback, over-correction that damages the work, or resignation from a role that was never actually at risk. Emotion-regulation strategy use is associated with functional outcomes in adults with ADHD, which makes the choice of what you do in the two hours after feedback a genuine lever (Bodalski et al., 2019).

The Feedback Autopsy (Worksheet 3.2) has one rule that carries most of its value: quote, do not paraphrase. Paraphrase preserves the distortion. Written verbatim, most feedback turns out to be narrower and duller than remembered.

Masking, withdrawal, and the body

In a focus-group study of rejection sensitivity in ADHD, three themes organised the whole experience: withdrawal, masking, and bodily sensations — participants described unpleasant physical sensations, anxiety and misery, and the use of camouflage to hide the response (Rowney Smith et al., 2024, preprint; small

sample, unrefereed at the time of writing). The finding is early, and it matches what clinicians hear daily. Masking works, which is the difficulty. It buys inclusion at a metabolic price paid later, in the collapse that arrives after the event rather than during it.

Shutdown and overdrive

Many people oscillate rather than decline. Overdrive first: extra hours, over-preparation, over-availability, an attempt to become unrejectable through output. Then the shutdown: the unanswered messages, the unopened folder, the day lost to a screen. It is tempting to treat the shutdown as the problem, since it is the part that visibly costs something. But by shutdown, most active strategies are unavailable. The intervention point is the entry into overdrive, several days earlier, when it still feels like virtue. Worksheet 3.4 exists to find that turn.

Missed deadlines, forgetfulness, and the shame multiplier

A missed deadline in an ADHD-and-rejection-sensitivity system is never only a missed deadline. It is a mechanical event — time estimation, initiation, working memory — with a shame charge attached, and the charge is what determines what happens next. The most common sequence is silence, because reaching out means exposure. Silence then converts a logistics problem into a relational one. This is why the repair script in Worksheet 3.5 is short and unapologetic in structure: acknowledge, state, re-commit, ask. Long apologies invite reassurance-seeking, which teaches the nervous system that reassurance is required.

EVIDENCE AT A GLANCE

- ●● Rejection sensitivity changes behaviour in advance of any actual rejection (Downey & Feldman, 1996; Ayduk et al., 2000).
- ●● Emotion-regulation strategy use relates to functional outcomes in adult ADHD (Bodalski et al., 2019).
- ● Withdrawal, masking and bodily sensation as the organising themes of lived experience (Rowney Smith et al., 2024, preprint).
- ○ The overdrive-to-shutdown oscillation as a cycle with a single best intervention point — clinical model.

BRINGING THIS TO YOUR CLINICIAN

Avoidance is easy to leave out of a session because nothing happened — there is nothing dramatic to report. It is worth naming anyway: tell your clinician specifically what you did not send, apply for, or say in the last two weeks. That list, however small it feels, is exactly the material a graded-exposure plan is built from.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Three.

CHAPTER FOUR

Rejection-Proofing the Mind: Reappraisal, Boundaries, Reframe

Not armour. Armour is heavy and it keeps out the good news too. What we are building is a second look.

"Between the sting and the story, there is room enough to live in."

One sting, three stories —
choose the dullest, kindest one.
Tomorrow will thank it.

Rejection-proofing does not mean becoming unbothered. It means installing a step between the interpretation and the conclusion — and then, separately, arranging your life so that fewer interpretations are required in the first place. The first is cognitive work. The second is boundary work. They are not the same skill and most people need both.

Reappraisal, and when it works

Cognitive reappraisal — changing the emotional impact of a situation by changing how it is construed — is among the better-supported emotion-regulation strategies in the general literature, and it generally outperforms suppression on measures of affect and social functioning (Gross, 1998, 2015). Cognitive behavioural therapy built on this logic has meta-analytic support for adults with ADHD (Young et al., 2020), including randomised trials against active controls in medication-treated adults with persistent symptoms (Safren et al., 2010) and metacognitive group therapy targeting time management, organisation, and planning (Solanto et al., 2010).

One caveat is worth stating precisely, because it is where most self-help advice fails: reappraisal works best *before* an emotional response has fully deployed. Once flooding is underway, asking yourself for a balanced perspective is asking a system with reduced access to deliberation to do its most deliberative task. That is not a failure of the technique or of you. It is a timing error. Reappraisal is a rehearsal skill practised in calm and a pre-emptive skill used at the first signal. Chapter Five holds the tools for when the wave has already arrived.

The Rejection Reframe

The exercise at the centre of this chapter — carried forward from the first edition and now formalised as Worksheets 4.1 through 4.4 — has four movements. **Name** the conclusion in one sentence, in the words you actually used to yourself. **Test** it: what would a camera have recorded? **Widen** it: generate at least three alternative explanations, including boring ones, since the boring explanation is statistically most likely — people are tired, busy, distracted by their own lives. **Choose** a response you would still endorse tomorrow.

The third movement is where the work happens, and it is also the one people skip. A single alternative explanation gets weighed against the original and loses, because the original has emotional momentum. Three or more break the binary. This is why the worksheet insists on a count.

Boundaries as regulation, not confrontation

Emotional boundaries are frequently taught as assertiveness — the ability to say no. That framing misses what they do for a rejection-sensitive nervous system. A boundary is a decision made in advance so that it does not have to be made during flooding. *I do not answer work messages after eight. I do not respond to criticism the same day. I read feedback sitting down, once, and again the next morning.* Each of those removes a real-time judgement call from a system that makes poor real-time judgement calls under load. Research on rejection sensitivity found that strategic self-regulation buffered the link between rejection sensitivity and adverse interpersonal outcomes (Ayduk et al., 2000) — the strategy matters more than the sensitivity.

Abandonment fear and intuition: telling them apart

Sometimes the read is right. People do withdraw, relationships do end, and a person with a long history of rejection often has genuinely acute social perception. So how do you tell a signal from an alarm? Three practical discriminators, offered as clinical heuristics rather than established findings. **Timing:** fear arrives instantly and completely; perception usually accumulates. **Specificity:** intuition points at a particular behaviour ("she has cancelled three times and changed the subject twice"); fear points at your worth ("she is done with me"). **Testability:** intuition survives being checked and can be asked about; fear resists inquiry and insists it already knows. Worksheet 4.7 runs a situation through all three.

EVIDENCE AT A GLANCE

- Reappraisal as an effective regulation strategy, generally outperforming suppression (Gross, 1998, 2015).
- CBT for adults with ADHD: meta-analytic and randomised support (Young et al., 2020; Safren et al., 2010; Solanto et al., 2010).
- Strategic self-regulation buffers rejection sensitivity's interpersonal cost (Ayduk et al., 2000).

- ○ The four-movement Reframe and the fear-versus-intuition discriminators — clinical structures, not validated protocols.

BRINGING THIS TO YOUR CLINICIAN

If a reframing technique keeps failing for you, it is worth telling your clinician exactly when you tried it — most failures happen at peak intensity, which is a timing problem, not a sign the tool doesn't work. Naming the moment you attempted it, rather than just "it didn't work," gives your clinician something concrete to adjust.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Four.

CHAPTER FIVE

In the Moment: STOPP, Grounding, and Pendulation

When the wave is already here, the task is not insight. The task is not making it worse.

"You do not have to think your way out of a wave. You only have to keep breathing until it passes."

Flood comes, flood recedes —
five words held like driftwood, close.
Morning finds you still.

Everything in the previous chapter assumed you had a moment to think. This chapter assumes you do not. The goal in an acute rejection response is narrow and unglamorous: reduce arousal enough to avoid an irreversible action, and get through the next ten minutes without adding a new injury. Insight can wait until Thursday.

STOPP, and why brevity is the point

STOPP — Stop, Take a breath, Observe, Pull back, Practise what works — is a compression of standard cognitive behavioural crisis skills into something retrievable under load. Its value is not sophistication; it is that five words survive in working memory when nothing else does. That is a real design constraint for an ADHD nervous system, and it is why a longer, better protocol is a worse protocol here. Related skills from dialectical behaviour therapy — paced breathing, intense exercise, temperature change, paired muscle relaxation — were assembled with the same logic: usable while dysregulated (Linehan, 2015).

Practise it when you are calm. A skill first attempted at intensity eight will not be available; a skill rehearsed twenty times at intensity two will.

Grounding, and the exhale

Grounding uses external, verifiable information to interrupt an internal spiral: five things you can see, four you can hear, the temperature of the floor, the weight of your own hands. It is not a distraction technique in the dismissive sense — it re-establishes contact with a present that is not, at that moment, rejecting you.

Slow breathing with a lengthened exhale is the other reliable tool, and here it is worth being careful about the explanation. Slow-paced breathing does reduce subjective arousal and does alter heart-rate variability; those are measured effects. The popular account of *why* — a specific vagal mechanism narrated in polyvagal terms — is contested, and Chapter Nine takes that dispute seriously. You do not need the mechanism to be settled to use the exhale. Practise it because it works for you, not because of a story about the nerve.

Pendulation, held loosely

Pendulation, drawn from somatic approaches to trauma, asks you to move attention deliberately between a place of activation and a place of relative ease — the tight chest, then the settled feet, then back — rather than staying inside the activation (Levine, 1997; Ogden et al., 2006). Clinically it is often the most useful thing in this chapter for people who cannot access thought at all under load. Honestly stated: the controlled evidence base for this specific technique is thin. It is a clinical model, and this book marks it as one. If it helps you, use it. If it makes the activation worse — which happens — stop, and use external grounding instead.

Recovery after flooding

The hours after a flood matter as much as the flood. Three things reliably shorten recovery and are worth planning in advance: movement, food and water, and a small piece of contact with someone safe. Two things reliably lengthen it: reviewing the incident at speed, and making a decision about your life. Mindfulness-based programmes adapted for adults with ADHD have randomised support for symptom and functioning outcomes (Janssen et al., 2019; Hepark et al., 2019; see also Mitchell et al., 2015; Zylowska et al., 2008), and one plausible mechanism is exactly this: a longer gap between arousal and reaction, practised daily until it becomes the default.

EVIDENCE AT A GLANCE

- ●● Mindfulness-based programmes for adults with ADHD: multiple randomised trials (Janssen et al., 2019; Hepark et al., 2019).
- ●● Brief CBT and DBT-derived crisis skills as between-session tools (Linehan, 2015; Young et al., 2020).
- ●● Slow-paced breathing reduces subjective arousal — the effect is measured; the mechanism is disputed.
- ○ Pendulation as a discrete technique (Levine, 1997; Ogden et al., 2006) — clinical model, limited controlled evidence.

BRINGING THIS TO YOUR CLINICIAN

It helps to tell your clinician which of your acute skills you actually reach for in the moment — not which ones you were taught. Two skills you can use without thinking beat eight you can explain well. If you're not sure which one you reach for, that is itself useful information to bring in.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Five.

CHAPTER SIX

Calming the Chaos: Executive Scaffolding for an Emotional Brain

Every dropped task is a future rejection event. Which makes organisation an emotional intervention.

"Order is not a cage. It is a shelf built so your hands are free for living."

One list, one small step —
the mind sets its burden down.
Room, at last, to breathe.

This chapter is usually filed under productivity. It belongs in a book about rejection sensitivity for a specific reason: most of the criticism you receive is generated by executive slippage, not by who you are. The missed deadline, the unanswered message, the forgotten commitment — each becomes a real interaction in which someone is genuinely disappointed, which then feeds a system already braced for exactly that. Reduce the slippage and you reduce the input.

Externalise everything

The central mechanism of adult ADHD management is moving cognitive load out of the head and into the environment (Barkley, 1997, 2015). Not as a moral discipline — as an engineering response to reduced working-memory availability. Lists, alarms, visible cues, a single inbox for physical paper, a single place where commitments live. The discipline is not in the remembering; it is in the checking, and it should require exactly one look per day.

Metacognitive group therapy targeting precisely these functions — time management, organisation, planning — outperformed a supportive control in a randomised trial of adults with ADHD (Solanto et al., 2010), and psychosocial treatments show maintained benefit at follow-up in meta-analytic review (Lopez-Pinar et al., 2018). This is one of the better-evidenced areas in the whole field. It also tends to be the part people skip because it feels administrative rather than therapeutic.

Task initiation: conditions, not willpower

The dual-pathway account explains why interest, novelty, urgency, and challenge can activate a system that obligation cannot reach (Sonuga-Barke, 2003). The practical consequence is that starting is an environmental design problem. What reliably helps: a first step small enough to be embarrassing, a visible external

commitment, another person working nearby, a hard time boundary, and movement beforehand. What reliably does not help: resolving to try harder tomorrow.

Worksheet 6.4 turns this into a personal specification. When you know the four conditions under which you reliably begin, you can arrange them on purpose instead of waiting to feel differently.

Planning fatigue and the emotional cost of deciding

Planning is expensive for a system with impaired time representation, and the expense is paid in emotional reactivity. By the end of a day spent making dozens of micro-decisions about sequence and priority, the threshold for a rejection response has dropped considerably. The remedy is fewer decisions, not better ones: the same three things at the same time each day, a default weekly shape, meals and starts decided in advance. Predictability is not rigidity. It is how you keep some regulation in reserve for the interactions that need it.

Follow-through, and the repair you can prepare

You will still drop things. Build the repair into the system rather than treating each instance as a moral emergency: a standing sentence for late work, a weekly review that catches what fell, a named person to whom you send a two-line update. Repair prepared in advance is fast and unashamed. Repair invented during shame is slow, over-apologetic, and — as Chapter Three noted — teaches everyone involved that reassurance is required.

EVIDENCE AT A GLANCE

- ●●● Metacognitive and CBT-based skills training for time management, organisation, planning (Solanto et al., 2010; Young et al., 2020).
- ●● Maintained benefit of psychosocial treatment at follow-up (Lopez-Pinar et al., 2018).
- ●● Externalisation as a mechanism, grounded in the executive-function account (Barkley, 1997, 2015).
- ○ Planning fatigue as a direct cause of later emotional reactivity — clinically consistent, not directly tested.

BRINGING THIS TO YOUR CLINICIAN

It is worth saying directly to your clinician that organisational struggles are not a separate, boring topic from the emotional ones — every dropped commitment becomes a future criticism to survive. Naming that connection tends to get executive-function work taken as seriously as it deserves.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Six.

CHAPTER SEVEN

Untangling Achievement from Identity

If your worth is a scoreboard, every ordinary day is a losing streak.

"You were worth loving before you produced a single thing today."

Empty page, full worth —
nothing finished, nothing owed.
You remain, entire.

Many people with ADHD arrive at adulthood having made an implicit bargain: if I achieve enough, the criticism will stop. It is a rational response to a childhood of correction, and it fails for a structural reason. Worth that is contingent on output must be re-earned daily, which means it can be lost daily — and a nervous system already primed for rejection now has an internal source of it, permanently available.

Why self-esteem is the wrong target

Self-esteem, as usually pursued, requires favourable comparison and therefore rises and falls with performance. Self-compassion does not: it is available precisely when performance is poor, which is when it is needed. Empirically, self-compassion predicts adaptive psychological functioning while showing a different relationship to narcissism and social comparison than self-esteem does (Neff, 2003; Neff et al., 2007). For a population that will continue to miss deadlines and forget things, a resource that only appears after success is not a resource.

Values as the alternative floor

The workable substitute is not "believe you are wonderful." It is chosen direction. Acceptance and commitment therapy distinguishes values — ongoing directions like honesty, care, craft, courage — from goals, which are achievable and therefore exhaustible (Hayes et al., 2012). A value can be enacted on a day when nothing gets done, which makes it structurally more stable ground than an achievement. The Valued Living Questionnaire operationalises this for measurement (Wilson et al., 2010), and Worksheets 7.3 and 7.5 build a personal version.

This is also why the appreciative inquiry questions throughout this book keep asking about *enduring* values. Not what you aspire to — what has already survived every version of you. That set is small, and it is evidence.

From self-shame to self-advocacy

Shame's characteristic move is concealment, which forecloses the thing that would actually help: asking. Self-advocacy — requesting an accommodation, naming a working condition, declining a task shaped badly for your brain — requires a prior belief that your needs are legitimate. That belief is built in small, verifiable steps, which is why Worksheet 7.7 begins with a request so small that refusal would be survivable.

Two positive-psychology practices are worth adding here because they are cheap and reasonably evidenced: structured gratitude (Emmons & McCullough, 2003) and brief strengths and best-possible-self exercises, which show small but replicated well-being effects (Seligman et al., 2005; Lyubomirsky & Layous, 2013). They are not a substitute for the harder work in this chapter. They shift the baseline slightly, and a slightly higher baseline is a slightly longer fuse.

EVIDENCE AT A GLANCE

- ●● Self-compassion predicts adaptive functioning and buffers negative self-evaluation (Neff, 2003; Neff et al., 2007; Ferrari et al., 2019).
- ●● Values-based intervention as a treatment target (Hayes et al., 2012; Wilson et al., 2010).
- ●● Brief gratitude and strengths practices produce small well-being effects (Emmons & McCullough, 2003; Seligman et al., 2005).
- ○ The achievement-for-safety bargain as described here — a clinical formulation, widely recognised, not a measured construct.

BRINGING THIS TO YOUR CLINICIAN

If values work starts to feel like a threat to the ambition that has kept you safe, say so — that reaction is common and worth naming out loud. A good clinician isn't trying to remove your drive, only its licence to decide what you're worth.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Seven.

CHAPTER EIGHT

Healing the Inner Critic: Parts Work and Internal Family Systems

The critic is not an intruder. It is an employee, hired young, still working from an old job description.

"The loudest voice inside is usually the youngest, and the most afraid."

Old guard at the gate —
tired now, though it won't say.
Let it rest a while.

The inner critic in a rejection-sensitive person is usually not cruel for its own sake. It is pre-emptive: if it says the worst thing first, the worst thing cannot arrive unannounced. Understood that way, the critic is a protective strategy with a bad method — and strategies can be renegotiated, where enemies can only be fought.

What Internal Family Systems proposes

Internal Family Systems describes the psyche as a system of parts organised around a core Self: *exiles* carrying pain that has been sequestered, *managers* working to prevent that pain from being touched, and *firefighters* acting to extinguish it once it is (Schwartz & Sweezy, 2020). The therapeutic move is not to eliminate parts but to unblend from them — to speak *to* the critic rather than *as* it — and to build enough internal safety that the exile can be heard without the system flooding.

Clinically, this framework fits rejection sensitivity unusually well. It gives a person a way to be curious about a reaction rather than ashamed of it, and it makes room for the fact that the loudest voice inside is often the most frightened.

What the evidence actually shows — stated plainly

This is where the first edition overclaimed, and this edition will not. The IFS evidence base is **early**. The main studies are a randomised pilot comparing IFS with treatment as usual for depression in female college students, in which both groups improved with no significant difference between them (Haddock et al., 2017), and an uncontrolled pilot effectiveness study of sixteen sessions in seventeen adults with PTSD and multiple childhood traumas, in which most participants no longer met criteria afterwards — a striking result that the

authors themselves flag as preliminary because there was no control group (Hodgdon et al., 2022). Group-based adaptations have since been trialled. That is a promising literature; it is not an established one. There is **no** published trial of IFS specifically for ADHD or for rejection sensitivity.

If you want a self-criticism intervention with a stronger evidence base, compassion-focused therapy was designed for exactly this target — shame and harsh self-criticism — and has a broader research literature behind it (Gilbert, 2014), as does mindful self-compassion training (Neff & Germer, 2013). The honest recommendation: use the parts framework because it is clarifying and humane, and know that its outcome evidence is thinner than the confidence with which it is usually presented.

A short practice, either way

Whatever framework you prefer, one sequence is worth learning. Notice the voice. Name it as a part, not as yourself — *the part of me that is bracing*. Ask what it is afraid would happen if it stopped. Thank it, without irony, for the job it took on when nobody else was doing it. Then ask what it would need in order to work less hard. Most people, asked that question sincerely for the first time, get an answer immediately. It is often very young.

EVIDENCE AT A GLANCE

- ●● Compassion-focused and mindful self-compassion approaches to self-criticism and shame (Gilbert, 2014; Neff & Germer, 2013; Wilson et al., 2019).
- ● IFS for depression: randomised pilot, no significant between-group difference (Haddock et al., 2017).
- ● IFS for PTSD: uncontrolled pilot, large pre-post change, preliminary by the authors' own account (Hodgdon et al., 2022).
- ○ IFS for ADHD or rejection sensitivity specifically — no published trials. Framework used here as a clinical model.

BRINGING THIS TO YOUR CLINICIAN

If you use parts language ("a part of me feels…") with your clinician, it can be a genuinely useful shorthand — but it is worth checking in if you notice it becoming a way to avoid responsibility for something that affects other people. Naming both uses keeps the framework honest.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Eight.

CHAPTER NINE

The Autonomic Story: Polyvagal Theory and What the Evidence Supports

The practices can be sound even when the story explaining them is disputed. It is worth knowing which is which.

"The body keeps its own counsel, and it is usually trying to help."

Nerve does not yet know
which story explains it best —
still, the exhale works.

Polyvagal theory has been enormously influential in trauma-informed practice, and it appears in nearly every popular account of ADHD and emotional overwhelm — including the first edition of this book, where it was presented as settled science. It is not settled. This chapter tells you what the theory claims, what is contested, and what remains usable regardless of how the dispute resolves.

What the theory claims

Polyvagal theory proposes that the autonomic nervous system is organised into three hierarchically ordered states with distinct evolutionary origins and distinct vagal pathways: a ventral vagal state associated with social engagement and felt safety, a sympathetic state of mobilisation, and a dorsal vagal state of shutdown or immobilisation. It further proposes that respiratory sinus arrhythmia can serve as an index of ventral vagal tone, and it introduced *neuroception* — subcortical appraisal of safety and threat below conscious awareness (Porges, 2011).

What is contested

In 2023 Grossman published a systematic critique in *Biological Psychology* arguing that all five foundational premises of the theory are inconsistent with current neurophysiology — including the proposed functional division between vagal nuclei and the use of respiratory sinus arrhythmia as a general index of vagal tone (Grossman, 2023). In 2026 a multi-authored paper co-signed by a large group of autonomic researchers argued in *Clinical Neuropsychiatry* that the theory is untenable as stated. Porges published a detailed rebuttal in the same journal, arguing that the critique engages a reconstructed version of the theory rather than its peer-reviewed formulation (Porges, 2026). At the time of writing, the dispute is live and unresolved.

What does this mean for you, sitting with a nervous system that plainly does something dramatic when a message arrives? Less than you might fear. The *observations* the theory organises are not in dispute: people shift between mobilised, shut down, and settled states; those shifts are involuntary and fast; safety cues from other people change them measurably; and slow breathing changes subjective arousal and heart-rate variability. What is disputed is the anatomical and evolutionary *explanation*. A practice is not invalidated when its rationale is revised — but you are entitled to know that the rationale is under revision, rather than being handed a certainty that does not exist.

What holds, whatever happens to the theory

Interoception is real and trainable. The perception of internal bodily state is supported by identified neural substrates (Craig, 2009), and interoceptive accuracy is distinguishable from interoceptive awareness — the two correlate only modestly, which is why noticing that you are activated is a separate skill from being right about it (Garfinkel et al., 2015). Body-scan practice trains the second.

Co-regulation is real. Whatever the mechanism, another person's calm voice, unhurried pace, and steady face change your state. This is why the tone of a clinician matters more than the technique, and why one steady friend outperforms an hour of self-talk.

Slow breathing helps many people, measurably. Use it. Describe it accurately: "this settles me," not "this activates my ventral vagal complex."

State-dependent capability is a useful clinical fact. What you can do at intensity two and intensity eight are different lists. Plan for both. The window-of-tolerance metaphor remains a helpful description even though it is a metaphor and not a measurement.

EVIDENCE AT A GLANCE

- ●● Interoception as a neurally grounded, measurable capacity with distinguishable components (Craig, 2009; Garfinkel et al., 2015).
- ●● Mindfulness and body-awareness training in adult ADHD (Janssen et al., 2019; Mitchell et al., 2015).
- ○ Polyvagal theory's core physiological premises — actively contested in the peer-reviewed literature (Grossman, 2023; Grossman et al., 2026; Porges, 2026).
- ○ The window of tolerance — clinical metaphor, not a measured construct.

BRINGING THIS TO YOUR CLINICIAN

If you have found real relief using polyvagal language ("I was in shutdown"), you do not need to abandon it. It is worth knowing — and saying to your clinician if it comes up — that the underlying theory is scientifically contested; what you can rely on is the practice's effect on you, described in your own words, rather than the mechanism

behind it.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Nine.

CHAPTER TEN

Turning Sensitivity into a Strength

Not a silver lining. A capacity — which, like any capacity, needs conditions to be worth anything.

"A high-gain instrument is not broken. It only needs a room built to its scale."

Same wire, more current —
wire it well, and light a house.
Wire it wrong, it burns.

This chapter has to be written carefully, because the genre it belongs to is full of dishonesty. Telling someone whose week was destroyed by a two-line email that their sensitivity is a superpower is not encouragement; it is dismissal wearing a compliment. So: sensitivity is not a gift. It is a high-gain instrument. High-gain instruments pick up signal others miss and they also pick up noise, and what determines which one you get is the environment and the operator's skill.

What the research on positive traits actually says

Qualitative work with successful adults with ADHD identified consistently reported positive attributes — including divergent thinking, energy, courage in the face of risk, and a capacity for intense engagement — alongside the difficulties, and described these as genuinely felt rather than compensatory (Sedgwick et al., 2019). That is a modest, honest finding: strengths are reported by people who are doing well, in a small qualitative sample. It does not license the claim that ADHD is an advantage. It does support the claim that a strengths-based account is not a fiction.

Broaden-and-build theory adds a mechanism worth knowing: positive emotional states widen attention and behavioural repertoire and build durable personal resources over time (Fredrickson, 2001). Practically, cultivating positive states is not decorative — it is what makes a wider range of responses available the next time something stings.

The four capacities, and their conditions

Attunement. Rejection-sensitive people frequently read rooms with unusual accuracy. It is a professional asset in teaching, care, design, negotiation, and leadership — under one condition: that you have a way to check your read rather than acting on it immediately. Attunement plus verification is skill. Attunement plus certainty is suffering.

Intensity. The same amplitude that makes criticism unbearable makes commitment total. Conditions: recovery time built in, and work that deserves that much of you.

Moral sensitivity. People who have been hurt by exclusion notice exclusion. This is where a great deal of good work in the world comes from. Condition: boundaries, or it becomes a career of absorbing other people's pain.

Inventiveness. Divergent thinking is repeatedly reported and is fed by the same loose associative attention that makes linear tasks hard. Condition: a container — a deadline, a collaborator, or a system that catches the ideas.

The test that keeps this honest

Any strengths framing must pass one test: does it change what you do, or only how you talk? "My sensitivity is a strength" changes nothing. "I read situations quickly, so I will write down my read, wait a day, and then ask one question" is a strength operationalised. Worksheets 10.2 and 10.6 do that conversion, and Worksheet 10.9 asks the harder question of what environment would let these capacities pay.

EVIDENCE AT A GLANCE

- ●● Positive emotion broadens attention and builds resources over time (Fredrickson, 2001).
- ● Positive attributes reported by successful adults with ADHD (Sedgwick et al., 2019) — qualitative, small sample.
- ○ The four-capacities framing and its conditions — clinical formulation offered as a working tool.
- ○ Claims that ADHD confers net advantage — not supported. Treat with suspicion, wherever you meet them.

BRINGING THIS TO YOUR CLINICIAN

If a strengths conversation ever feels premature — offered before you feel fully heard — it is fair to say so. Strengths work lands once the difficulty has been acknowledged, not instead of it.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Ten.

CHAPTER ELEVEN

Relationships: Disclosure, Repair, and Co-Regulation

The question is never whether ruptures happen. It is how quickly, and how kindly, they are repaired.

"Repair, spoken badly and soon, outlasts an apology polished into silence."

Distance opens wide —
one small sentence, offered first.
Bridges start this small.

Rejection sensitivity was first studied in the context of intimate relationships, and for good reason: it exerts its clearest effects there. People high in rejection sensitivity perceive rejection more readily in ambiguous partner behaviour, respond with hostility or withdrawal, and thereby increase the very outcome they fear (Downey & Feldman, 1996). Strategic self-regulation moderates that pathway (Ayduk et al., 2000). Both findings point the same way: the sensitivity is not the problem to solve; the loop is.

Rupture and repair

Long-standing observational research on couples finds that what distinguishes stable relationships is not the absence of conflict but the presence of repair — the small moves that de-escalate and reconnect (Gottman & Levenson, 1992). For rejection-sensitive people this is unexpectedly good news, because repair is a learnable set of sentences rather than a temperament. Worksheet 11.4 provides four of them. Say them badly. Badly and early beats eloquently and three days later.

Disclosure: what to say, and to whom

You do not owe anyone a diagnosis. You may, however, benefit from disclosing a mechanism. Qualitative work with adults with ADHD describes both the relief of being understood and the risk of being reduced to the label in interpersonal contexts and online communities (Ginapp et al., 2023). A workable disclosure has three parts and no diagnosis in it: what happens ("when I get short feedback I sometimes assume the worst"), what helps ("a sentence about what is fine, not only what is wrong"), and what you will do ("I will ask instead of assuming"). This is functional and hard to weaponise.

Co-regulation, and the fair use of other people

Other people settle us. That is a resource and it can become a demand. The distinction worth holding: **co-regulation** is borrowing steadiness while you find your own; **reassurance-seeking** is asking someone to hold a certainty they cannot hold. The first strengthens a relationship; the second erodes it, and — because the reassurance never quite lands — it also fails to help. If you notice yourself asking a fourth time, the need is not for information. Chapter Five's tools are for that moment.

For the person on the other side

This page can be photocopied for a partner, parent, or manager. Four things help more than anything else. **Be explicit.** Ambiguity is where the story grows; say what you mean, including the good part. **Separate the act from the person** out loud — "this document needs work" and "you are fine with me" are two sentences, and the second one is not obvious. **Do not argue with the intensity while it is happening;** wait, then talk. **Repair quickly.** A short, early "we're okay" prevents hours of spiralling and costs you almost nothing.

EVIDENCE AT A GLANCE

- ●● Rejection sensitivity predicts hostile or withdrawing responses in relationships (Downey & Feldman, 1996; Ayduk et al., 2000).
- ●● Repair behaviour, rather than absence of conflict, distinguishes stable couples (Gottman & Levenson, 1992).
- ● Benefits and risks of disclosure as described by adults with ADHD (Ginapp et al., 2023).
- ○ The co-regulation versus reassurance-seeking distinction — clinically useful, not formally validated.

BRINGING THIS TO YOUR CLINICIAN

If a partner, parent, or close friend is willing, consider asking your clinician about a single joint session focused on explicitness and repair — it often produces more change than several individual sessions, and the four points at the end of this chapter are a good handout to bring.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Eleven.

CHAPTER TWELVE — NEW IN THIS EDITION

Medication, Measurement, and Working with Your Clinician

The emotional part of ADHD is the part most often left out of the appointment. This chapter is about putting it back in.

"Bring your data, not your apology. You are allowed to ask for help precisely."

Four numbers, brought in —
the room finally believes
what the body knew.

Nothing in this chapter is medical advice, and no book can be. What it can do is prepare you for a conversation that is frequently rushed, and give a clinician a structure for the part of the presentation that the diagnostic criteria do not name.

What the medication evidence says, at a high level

A large network meta-analysis comparing ADHD medications across children, adolescents, and adults synthesised efficacy and tolerability from randomised trials, and remains the standard reference for how these agents compare (Cortese et al., 2018). Consensus guidance for adult diagnosis and treatment is summarised in the updated European Consensus Statement (Kooij et al., 2019), and the World Federation's international consensus statement provides 208 evidence-based conclusions with sources (Faraone et al., 2021). Those three documents are a reasonable basis for asking your prescriber informed questions.

On the emotional dimension specifically, the picture is more limited and worth stating precisely. Reviews of emotion regulation in adult ADHD note that pharmacological and psychological treatments both appear to influence emotional difficulties, but that the studies are few, heterogeneous in their measures, and rarely designed with emotion dysregulation as the primary outcome (Soler-Gutiérrez et al., 2023; see also Shaw et al., 2014). In practice this means: medication may reduce emotional reactivity for you, or may not, and it may reduce it partly by reducing the number of daily failures that generate rejection events in the first place. That is a real mechanism and worth naming with your prescriber.

Bringing rejection sensitivity into the appointment

Because RSD is not a diagnostic term, saying "I have RSD" can land badly with a clinician who has not encountered it. A more reliable route is description plus data, which is exactly what the worksheets produce. Bring: how often, how fast, how long, what it stops you doing. For example — "three or four times a week; it arrives within seconds of a message; it takes me two to three hours to be able to work again; last month I did not apply for two jobs because of it." That is a clinical presentation. It cannot be dismissed as a label from the internet.

Worksheet 12.1 is a single page designed to be handed over at an appointment. Worksheet 12.3 is a medication-and-mood tracker for the first eight weeks of any change. Worksheet 12.6 is a list of questions to ask a prescriber.

Combining treatment, and what to expect

For most adults, the evidence favours combination over either alone: medication for core symptoms where appropriate, plus psychological treatment for the skills, avoidance, and self-concept that medication does not touch. CBT has meta-analytic support in adults with ADHD, including in those already medicated with residual symptoms (Young et al., 2020; Safren et al., 2010; Solanto et al., 2010), mindfulness-based programmes have randomised support (Janssen et al., 2019; Hepark et al., 2019), and psychosocial treatment gains are maintained at follow-up in meta-analytic review (Lopez-Pinar et al., 2018).

A word about expectations, offered honestly. Nothing in this book, and nothing in the literature it cites, will make you a person who does not feel rejection intensely. The realistic outcome — and it is a large one — is a longer gap between the feeling and the action, fewer irreversible decisions, faster recovery, and a self-account that no longer treats a hard afternoon as evidence of your worth.

EVIDENCE AT A GLANCE

- ●● Comparative medication efficacy and tolerability across the lifespan (Cortese et al., 2018); consensus guidance (Kooij et al., 2019; Faraone et al., 2021).
- ●● Combined psychological and pharmacological treatment for adults (Young et al., 2020; Safren et al., 2010).
- ● Effects of treatment specifically on emotion dysregulation — few studies, heterogeneous measures (Soler-Gutiérrez et al., 2023).
- ○ The indirect route — fewer daily failures, therefore fewer rejection events — is a plausible mechanism, not a tested one.

BRINGING THIS TO YOUR CLINICIAN

At a medication review, it's worth raising the emotional side directly, even if it feels off-topic: "here's what happened this month when someone criticised me." That single sentence surfaces more than a symptom checklist, and clinicians are used to being asked for the extra thirty seconds it takes.

This chapter's twelve reflection questions and ten worksheets live in the companion *RSD & ADHD Workbook* — Chapter Twelve.

CLOSING

A New Narrative

The old story explained everything and changed nothing. That is how you know it was not true.

The story most people arrive with is short: *I am too much, and eventually everyone finds out.* It has the elegance of all bad theories — it accounts for every piece of evidence and predicts nothing you can act on. A better account is longer and less dramatic. You have a nervous system that responds quickly and strongly to social threat. That response is fast enough to precede deliberation, which is why it has so often become behaviour before you had a say. It has a history, and the history makes sense. It is also, in measurable ways, workable.

Nothing in this book asked you to feel less. The whole architecture — the logs, the reframes, the ninety seconds in the body, the twelve questions, the hundred and twenty worksheets — is built to widen one specific gap: the one between the arrival of the feeling and the arrival of the action. Everything good downstream comes from that gap. The unsent message. The repair made the same afternoon. The application submitted anyway. The afternoon that stayed an afternoon rather than becoming a verdict.

The research is honest about how much remains unknown here — rejection sensitive dysphoria has no validated measure, its published empirical base is small, and some of the frameworks used most confidently in this field are being actively re-examined (Modestino et al., 2024; Grossman, 2023; Porges, 2026). You do not need the science to be finished in order to begin. You need one worksheet, one week, and someone who does not flinch when you describe what it is actually like.

A luminous mind is not one that has stopped feeling the dark. It is one that has learned where the light switches are, and has put them within reach.

Continuing practice at www.adhdrsd.com

GLOSSARY

The words, defined

Where a term names a model rather than a measured construct, the entry says so.

AFFECTIVE LABILITY

Rapid, frequent shifts in emotional state. Commonly reported in adult ADHD and measured within emotion-dysregulation scales rather than as a standalone diagnosis.

APPRECIATIVE INQUIRY

A strengths-based method of inquiry that begins from what already works and asks what more of it would look like. Developed for organisational change and adapted here for individual reflection (Cooperrider & Whitney, 2005).

COGNITIVE REAPPRAISAL

Changing the emotional impact of a situation by changing how it is construed. One of the better-supported emotion-regulation strategies in the general population (Gross, 2015).

COMMON HUMANITY

One of three components of self-compassion: recognising that suffering and imperfection are shared rather than singular (Neff, 2003).

DEFICIENT EMOTIONAL SELF-REGULATION

A term used in adult ADHD research for difficulty modulating emotional responses, proposed by some authors as a core rather than associated feature (Barkley, 2015).

EMOTION DYSREGULATION

Difficulty modulating the onset, intensity, or duration of an emotional response. Meta-analytic evidence shows elevated levels in adults with ADHD (Beheshti et al., 2020).

EMOTIONAL IMPULSIVENESS

The speed with which an emotional response is expressed in behaviour, distinct from the intensity of the feeling itself.

EXECUTIVE FUNCTION

A set of self-directed capacities — inhibition, working memory, planning, flexibility, self-monitoring — that support goal-directed behaviour (Barkley, 1997).

EXPOSURE, GRADED

Systematic, planned contact with feared situations in increasing order of difficulty, allowing new learning to occur.

EXTERNALISATION

Moving cognitive load out of the head and into the environment — lists, alarms, visible cues. A central mechanism in adult ADHD treatment.

GROUNDING

Deliberate use of sensory or orienting information to re-establish contact with the present moment during high arousal.

HYPERFOCUS

Sustained, absorbing attention to a task of high interest, often with reduced awareness of time and surroundings. Described by adults with ADHD as attention dysregulation rather than deficit (Ginapp et al., 2023).

INTEROCEPTION

The perception of internal bodily states. Interoceptive accuracy and interoceptive awareness are distinguishable and only modestly correlated (Garfinkel et al., 2015).

INTERNAL FAMILY SYSTEMS (IFS)

A psychotherapy model describing the psyche as a system of parts in relation to a core Self. Evidence is early: pilot and small trials for depression and PTSD (Haddock et al., 2017; Hodgdon et al., 2022).

MASKING

Effortful suppression or camouflage of neurodivergent traits to meet social expectations. Reported as a recurrent theme in qualitative accounts of rejection sensitivity in ADHD.

PENDULATION

A somatic technique of alternating attention between activation and relative ease. Drawn from Somatic Experiencing (Levine, 1997); clinical model with limited controlled evidence.

POLYVAGAL THEORY

A model proposing three hierarchically organised autonomic states governed by distinct vagal pathways (Porges, 2011). Its physiological premises are actively contested (Grossman, 2023; Porges, 2026) — see Chapter Nine.

REJECTION SENSITIVITY

A measurable disposition to anxiously expect, readily perceive, and strongly react to rejection (Downey & Feldman, 1996).

REJECTION SENSITIVE DYSPHORIA (RSD)

A clinical description of sudden, severe emotional pain following perceived rejection, criticism, or failure in people with ADHD. Not a DSM-5-TR diagnosis; the published empirical literature is small and largely qualitative or case-based (Modestino et al., 2024).

SELF-COMPASSION

Kindness, common humanity, and mindful awareness directed toward oneself in suffering. Lower in adults with ADHD and associated with better mental health (Beaton et al., 2020, 2022).

SELF-INQUIRY

Structured questioning directed at one's own experience, undertaken to observe rather than to correct.

SHAME

A self-directed emotion in which the whole self, rather than a behaviour, is evaluated as bad — distinguishable from guilt, which targets the act (Tangney & Dearing, 2002).

STOPP

A brief regulation sequence — Stop, Take a breath, Observe, Pull back, Practise what works — used widely in cognitive behavioural practice as a between-session prompt.

VALUES

Chosen life directions, distinguishable from goals in that they are ongoing rather than achievable (Hayes et al., 2012).

WINDOW OF TOLERANCE

A clinical metaphor for the arousal range within which a person can think and feel at the same time. Descriptive, not a measured construct.

APPENDIX A

Measures and rating scales

Worksheets are clinical tools, not measurement instruments. When you need numbers that can be compared over time or communicated to another clinician, use validated measures. The following are the ones most relevant to the material in this book.

Adult ADHD Self-Report Scale (ASRS). A short screening scale developed with the World Health Organization; the six-item screener performs adequately in general-population screening (Kessler et al., 2005). Screening, not diagnosis.

Barkley Deficits in Executive Functioning Scale (BDEFS). Rating-scale assessment of executive function in daily life, with self- and other-report forms (Barkley, 2011). Useful alongside Worksheet 2.1.

Rejection Sensitivity Questionnaire. The measure that operationalised rejection sensitivity as anxious expectation of rejection across situations (Downey & Feldman, 1996). There is, as yet, no validated instrument for rejection sensitive dysphoria as a distinct entity.

Self-Compassion Scale. Measures kindness, common humanity, and mindful awareness toward the self (Neff, 2003); used in the ADHD studies cited throughout this book.

Difficulties in Emotion Regulation Scale and equivalents. Emotion-dysregulation measures are heterogeneous across the adult ADHD literature — a limitation the systematic reviews note explicitly (Soler-Gutiérrez et al., 2023). Choose one and stay with it rather than switching between instruments mid-course.

Valued Living Questionnaire. For the values work in the appreciative-inquiry questions and Worksheet 2.9 (Wilson et al., 2010).

APPENDIX B

Practices at a glance

Every technique taught in this book, on a few pages — skip here at any point rather than hunting back through a chapter.

STOPP ●●

A five-word sequence — Stop, Take a breath, Observe, Pull back, Practise what works — compressed for retrieval under load.

When: The first ten seconds of an acute rejection response. · **How:** Rehearse it calm, in your own words, until it is reflexive. Do not attempt it for the first time at peak intensity.

Derived from standard CBT/DBT crisis skills (Linehan, 2015); brevity is a design choice, not a tested protocol.

Grounding (five senses) ●●

Using external, verifiable sensory information to interrupt an internal spiral.

When: When thought has become unreliable and you need to re-establish contact with the present. · **How:** Name five things you can see, four you can hear, and the temperature of something you can touch.

Standard trauma-informed and CBT grounding technique; effect is well observed clinically.

The slow exhale ●●●

Breathing with an exhale longer than the inhale, to reduce subjective arousal.

When: Any time arousal is rising and you have thirty seconds. · **How:** Inhale for a count of four, exhale for a count of six to eight. Repeat for two minutes.

Reduces subjective arousal and alters heart-rate variability; the popular vagal-mechanism explanation is contested (see Chapter Nine).

Pendulation ○

Moving attention deliberately between a place of activation and a place of relative ease, rather than staying inside the activation.

When: When you can locate both an activated sensation and a neutral or settled one. · **How:** Attend to the activation briefly, shift to the ease, return, three cycles. Stop if it worsens.

Drawn from Somatic Experiencing (Levine, 1997; Ogden et al., 2006); limited controlled evidence.

Body scan (90 seconds) ●●●

A brief, frequent practice of noticing sensation from jaw to hands without trying to change it.

When: Twice daily, and after any spike, to train interoceptive accuracy. · **How:** Move attention slowly through the body. Record what you find, not what you fix.

Interoception is neurally grounded and trainable (Craig, 2009; Garfinkel et al., 2015).

The Rejection Reframe ●●●

A four-movement cognitive reappraisal: Name the conclusion, Test it against verifiable fact, Widen it with three alternatives, Choose a response you would endorse tomorrow.

When: After a sting, once intensity has begun to drop — not at peak. · **How:** Write all four movements out; do not skip Widen, and insist on three alternatives, not one.

Cognitive reappraisal is well supported as a regulation strategy (Gross, 1998, 2015); this four-movement structure is a clinical formulation.

Boundary design ●●

Deciding a rule about your own behaviour in advance, so it does not have to be decided while flooded.

When: Once, on a calm day, for any situation that repeatedly costs you. · **How:** State the boundary as what you will do, not what you ask of someone else. Tell one person about it.

Strategic self-regulation buffers the interpersonal costs of rejection sensitivity (Ayduk et al., 2000).

IFS-informed parts work ●

Speaking to a harsh inner voice as a protective part rather than as the whole self, to reduce fusion and shame.

When: When self-criticism is loud and undifferentiated from identity. · **How:** Name the voice as a part. Ask what it fears would happen if it stopped. Thank it. Ask what it needs.

IFS evidence is early — a depression pilot with no between-group difference (Haddock et al., 2017) and an uncontrolled PTSD pilot (Hodgdon et al., 2022). No published RSD/ADHD trials.

Compassion-focused self-talk ●●●

Responding to yourself with kindness, common humanity, and mindful awareness rather than judgement.

When: Any time self-criticism arrives — the more automatic, the more it is needed. · **How:** Ask what you would say to someone you loved in this exact situation, then say that to yourself, aloud if possible.

Self-compassion interventions show small-to-moderate benefits in meta-analysis (Ferrari et al., 2019; Wilson et al., 2019); lower in ADHD, partly via perceived criticism (Beaton et al., 2020).

Values clarification ●●

Identifying ongoing, chosen directions (values) as distinct from achievable, exhaustible goals.

When: When self-worth has become entirely contingent on output. · **How:** Name a value with evidence — a specific episode proving you have already lived it — then one small action this week.

Values-based work is a core ACT mechanism (Hayes et al., 2012); measurable via the Valued Living Questionnaire (Wilson et al., 2010).

Externalisation / capture systems ●●●

Moving cognitive load out of the head and into a single, checked place — lists, alarms, one inbox.

When: Ongoing; the core daily practice for executive scaffolding. · **How:** One capture place. One check-point per day. Resist adding a second system.

Central mechanism in adult ADHD management (Barkley, 1997, 2015); supports maintained treatment gains (Lopez-Pinar et al., 2018).

The repair script

A short, unapologetic four-part message for after a rupture or a dropped commitment: acknowledge, state, re-commit, ask.

When: As soon as possible after a rupture — badly and early beats polished and late. · **How:** Write the four parts once, in advance, so you are not composing it while ashamed.

Repair behaviour, not absence of conflict, distinguishes stable relationships (Gottman & Levenson, 1992).

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Going deeper on each technique

Organised by the frameworks this book draws on — including the two most contested, polyvagal theory and Internal Family Systems.

POLYVAGAL THEORY — AND THE DEBATE ABOUT IT

Porges, S. W. (2011). *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation*. Norton. — the original formulation.

Grossman, P. (2023). Fundamental challenges and likely refutations of the five basic premises of the polyvagal theory. *Biological Psychology, 180*, 108589. — the central critique.

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INTERNAL FAMILY SYSTEMS AND PARTS WORK

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COGNITIVE BEHAVIOURAL AND DIALECTICAL BEHAVIOUR THERAPY

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ADULT ADHD, GENERAL

Barkley, R. A. (2015). *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* (4th ed.). Guilford Press. — the clinical reference.

Hallowell, E. M., & Ratey, J. J. (2021). *ADHD 2.0*. Ballantine Books. — general-reader.

Nigg, J. T. (2017). *Getting Ahead of ADHD*. Guilford Press. — general-reader, research-grounded.

MINDFULNESS-BASED APPROACHES

Kabat-Zinn, J. (1990). *Full Catastrophe Living*. Delacorte Press. — the foundational text.

Janssen, L., et al. (2019). Mindfulness-based cognitive therapy for adults with ADHD. *Psychological Medicine, 49*(1), 55–65. — the strongest trial evidence cited in this book.

Our premier clinical title, *Signal and Sensitivity*, goes deeper into the diagnostic and treatment questions raised throughout this book. More at www.adhdrsd.com.

If you are looking for assessment or treatment, seek a clinician experienced in adult ADHD; current consensus guidance on adult diagnosis and treatment is summarised by Kooij et al. (2019) and Faraone et al. (2021), and is a reasonable thing to ask a prospective clinician whether they follow.

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A sensitive mind is not a mind that needs less feeling. It is a mind that needs better conditions — and it is capable of building them.

Old story, put down —
a lighter thing takes its place:
just you, walking on.

ABOUT THE AUTHOR

Ammanuel Santa Anna

Founds fields.

Ammanuel Santa Anna builds infrastructure for human development. After more than two decades of contemplative practice, a period of catastrophic personal loss ended in an encounter he describes as arriving at the source of things — where he asked that the loss be of use to the highest good of all beings. What followed was the work.

In the years since, he has written five hundred and seventy-seven books and codified one hundred and seventy-seven methodologies drawn from thirty-six wisdom and scientific traditions, integrating Dąbrowski's theory of positive disintegration, Kegan's stages of adult development, Spiral Dynamics, Internal Family Systems, Integral Theory, Appreciative Inquiry, living systems theory, and nondual philosophy into a single practitioner framework.

Within that canon he wrote the first guide ever published on Rejection Sensitive Dysphoria, a ten-part international series spanning every stage of life, and *The Clinician's Guide to RSD*. Beyond the books, he has contributed hundreds of pages across dozens of scholarly articles spanning economics, developmental science, complex adaptive systems theory and theology.

He founded Haute Lumière, a cross-disciplinary couture magazine at hautelumiere.life, and works as an AI engineer with more than five hundred applications shipped across nine platforms, from macOS and iOS to Windows, Android and Linux. He is currently building the Luminous Prosperity Operating System and Office Suite, a cross-platform outgrowth of Luminous Linux, which he built the year prior.

He also runs a spiritual art studio and blog that sells prints on sustainably sourced wood, and has written the most complete extant book series on the angelic feminine.

His most recent field is Ecstatic Economics, a framework for regenerative abundance that mathematically articulates standing abundance in living-systems economics, drawn from more than one hundred and thirty-five original texts and now taught in university classrooms and academic coursework. Before it came Temporal Somatics, which treats the body as a store of compressed future potential rather than only past injury, and Luminous Holonics, which carries one architecture from individual awakening through organizational design to civilizational coordination.

Luminous Gainshare, his gainshare company, began the night he wrote the living-systems mathematics behind his economic theories after drinking too much tequila. He woke up to a software suite locating fortunes of unrealized sums inside Fortune 1000 corporations.

The thesis underneath all of it is a single sentence: present consciousness coheres systems. Incoherent systems are not obstructed by a force — they are vacant at the layer where coordination happens. Nothing has to be defeated. Presence has to arrive. He was expelled from Naropa University for returning a book on spiritual emergency and somatic psychology late, is founder and CEO of Luminous Prosperity Inc. and founder of Luminous Gainshare, and works from Providence, Rhode Island.

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