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Rejection Sensitive Dysphoria in Autistic People:

A critical, research-informed examination of lived experience, clinical oversight, and practice implications

By Dr Lisa Alcorn

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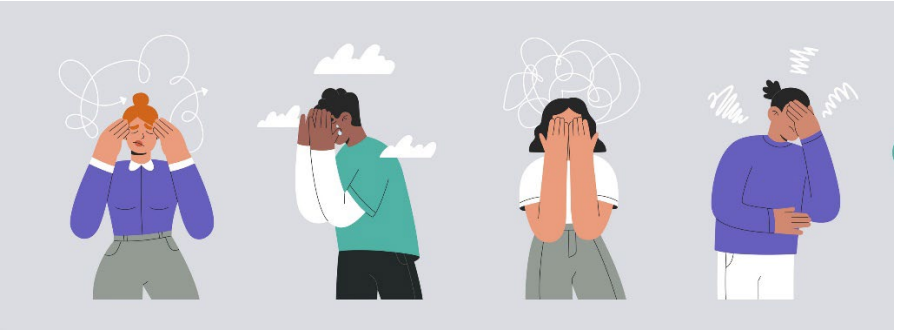

Abstract

Rejection Sensitive Dysphoria (RSD) describes an intense affective response to real or perceived rejection, criticism or failure. Although not formally recognised in diagnostic manuals, RSD is increasingly acknowledged within neurodivergent communities and clinical practice, particularly among autistic and ADHD populations.

This paper synthesises emerging research, lived-experience accounts, and practitioner perspectives to critically examine the construct of RSD, its relevance to autistic experience, and its implications for mental health, including vulnerability to suicidal ideation.

It argues for a shift from individualised deficit-based interpretations toward relational, trauma-informed, and environmentally embedded approaches. Recommendations are offered for practitioners and organisations seeking to identify and support autistic people experiencing RSD. Where RSD-related distress escalates, **Here to Help** can provide immediate emotional support.

Here to Help is a community-based autism and suicide prevention initiative designed to reduce isolation, improve emotional safety, and provide accessible support, guidance, and resources for autistic people, families, professionals, and wider community partners. In alignment with this paper's focus on lived experience, clinical oversight, and practice implications, **Here to Help** can use these findings to strengthen responses to RSD-related distress among autistic people.

By translating emerging research and autistic testimony into practical, accessible guidance, the paper can support staff, families, professionals, and community partners to recognise rejection sensitivity earlier, understand its links with masking, shame, burnout, and suicidal ideation, and respond through relational, trauma-informed, and neurodiversity-affirming approaches. This positions **Here to Help** as an important route for ensuring autistic people experiencing escalating distress are met with compassionate support rather than misunderstanding or judgement.

1. Introduction

Rejection Sensitive Dysphoria has gained prominence as a term used by neurodivergent individuals to articulate a form of emotional pain that is often misunderstood or misdiagnosed. While originally described in ADHD contexts, autistic people frequently report parallel experiences of acute emotional overwhelm, shame, and withdrawal following perceived interpersonal threat.

The absence of formal diagnostic recognition has contributed to inconsistent understanding among practitioners, leading to misinterpretation as personality disorder traits, behavioural issues, or 'overreaction'. This has significant practice implications: without a shared clinical understanding of RSD, autistic people may have their distress invalidated or mislabelled, delaying appropriate support and reinforcing cycles of shame, masking, withdrawal, burnout, and mental health vulnerability.

This paper positions RSD as a socially mediated, neurobiologically influenced phenomenon emerging at the crossroads of autistic cognition, cumulative trauma, and environmental invalidation.

2. Lived Experience: The Emotional Texture of RSD

Many autistic lived-experience accounts describe RSD-like distress as sudden, overwhelming, and difficult to regulate. Rather than being experienced as ordinary disappointment or

sensitivity to feedback, it is often described as a whole-body threat response in which emotional pain, physical arousal, shame, fear, and self-criticism occur almost simultaneously.

Recent lived-experience research similarly describes rejection sensitivity in autistic adults as profoundly exhausting, with responses that may include physical tension, pain, rumination, reliving earlier rejection, and intensified distress when experiences are dismissed or invalidated.

The following illustrative composite accounts reflect themes commonly described in autistic lived-experience narratives. They are not presented as direct research participant quotations unless separately attributed and consented.

- **"When I feel criticised, it's like my whole body collapses inward. I can't separate the comment from who I am."**
- **"It feels like a physical pain, like being winded. I shut down because I can't bear the idea that I've disappointed someone."**
- **"I replay conversations for days, convinced I've ruined everything, even when nothing actually happened."**

These accounts suggest that RSD is not simply a reaction to a single event, but a rapid process of meaning-making shaped by previous experiences of exclusion, correction, misunderstanding, or social punishment. A neutral facial expression, delayed reply, change in tone, or brief piece of feedback may be interpreted through a history of being judged or rejected. For some autistic people, the perceived rejection therefore confirms an already internalised fear of being 'too much', 'wrong', or fundamentally unacceptable.

The impact can be cognitive as well as emotional. Autistic people may replay conversations repeatedly, search for evidence that they have caused harm, apologise excessively, or withdraw to prevent further perceived damage. This rumination can continue long after the original interaction has ended, increasing anxiety, reducing concentration, disrupting sleep, and contributing to avoidance of relationships, education, employment, or support services. In this way, RSD can narrow a person's world, not because they lack resilience, but because the cost of anticipated rejection becomes too high.

Such accounts challenge reductive interpretations of emotional dysregulation as a lack of resilience. Instead, they highlight the embodied, relational, and cumulative nature of RSD: the distress is felt in the body, shaped by interpersonal meaning, and intensified by repeated experiences of misunderstanding or invalidation. Recognising this texture is essential for practice, because responses that minimise, challenge, or pathologise the person's reaction can compound shame and reinforce withdrawal. A more helpful response begins with validation, curiosity, emotional safety, and attention to the environment in which the distress has arisen.

3. Literature Review: RSD, Autism and Emotional Dysregulation

The literature on RSD remains emergent, fragmented, and heavily influenced by ADHD-centred frameworks. However, several strands of evidence are relevant to autistic experience.

At present, there are no robust autism-specific prevalence figures for RSD itself; therefore, the most clinically useful evidence comes from adjacent areas of research. These include emotional dysregulation in ADHD, suicidality in autistic adults, camouflaging, unmet support needs, and the psychological impact of repeated social exclusion. This distinction is important: RSD should not be presented as a formally established diagnostic category, but as a meaningful lived-experience construct that overlaps with well-evidenced risks affecting autistic and ADHD populations.

3.1 Origins of the construct

RSD was popularised in ADHD clinical commentary, particularly through Dodson's description of 'extreme emotional sensitivity and pain' triggered by perceived rejection (Dodson, 2021). As this source is clinical commentary rather than peer-reviewed autism research, it should be used cautiously. It is helpful for describing how the term is used in practice, but it should not be treated as evidence of prevalence or diagnosis.

3.2 Overlap with rejection sensitivity and emotional dysregulation

RSD converges with established constructs:

- **Rejection sensitivity**: a cognitive–affective bias involving heightened expectation and perception of rejection (Downey & Feldman, 1996).
- **Emotional dysregulation**: now recognised as a core feature of ADHD, affecting 30–70% of adults (Shaw et al., 2014).

Bercovici (2022) argues that RSD represents a specific pattern within broader emotional dysregulation: intense affective responses to rejection, accompanied by shame, avoidance, and people-pleasing.

The ADHD literature is relevant because RSD was first popularised in this context and because autism and ADHD frequently co-occur. Shaw et al. (2014) report that emotional dysregulation affects approximately 30–70% of adults with ADHD, while later meta-analytic evidence indicates that around 70% of adult ADHD patients report emotion dysregulation or emotional lability. Although these figures cannot be directly transferred to autistic populations, they demonstrate that intense affective reactivity is not rare within neurodevelopmental presentations and provides a plausible framework for understanding RSD-like responses in AuDHD groups.

3.3 Emerging links with autism

Although empirical autism-specific research is limited, emerging peer-reviewed work and community sources highlight relevant parallels:

- Accessible community and explanatory sources report that many autistic people describe heightened sensitivity to criticism, social threat, and perceived failure (Simply Psychology, 2023).
- Community discussion suggests that AuDHD populations may be particularly vulnerable, although this requires stronger empirical study (Embrace Autism, 2022).
- Peer-reviewed qualitative research links camouflaging to exhaustion, social connection, and threats to self-perception, providing relevant context for understanding RSD-like distress (Hull et al., 2017).
- A recent scoping review identified 12 relevant studies on rejection-related distress in autistic adults, concluding that the evidence base remains fragmented and that no studies had directly evaluated interventions for RSD (van Asselt, Reekers and Roke, 2026).

The wider autism literature also shows why perceived rejection, criticism, or invalidation may carry significant clinical risk. Cassidy et al. (2018) found that 72% of autistic adults in their sample scored above the recommended psychiatric cut-off for suicide risk, compared with 33% of general population adults. Within the autistic group, camouflaging, non-suicidal self-injury, and number of unmet support needs significantly predicted suicidality. These findings do not prove a direct causal relationship between RSD and suicidality, but they indicate that RSD-like experiences may interact with established risk markers such as masking, isolation, shame, unmet support, and mental health vulnerability.

Camouflaging evidence further supports this interpretation. Hull et al. (2017), in a qualitative study of 92 autistic adults, found that camouflaging was commonly used to fit in and increase social connection, but was associated with exhaustion, threats to self-perception, and reduced authenticity. In the context of RSD, this suggests that repeated efforts to avoid criticism or rejection may become psychologically costly over time, reinforcing people-pleasing, perfectionism, withdrawal, and burnout.

3.4 Neurobiological considerations

Neuroimaging studies of rejection sensitivity show increased activation in the dorsal anterior cingulate cortex, associated with social pain and threat detection (Eisenberger et al., 2003). While not autism-specific, these findings align with autistic patterns of heightened threat perception and emotional reactivity.

3.5 Conceptual critique

Researchers caution that RSD may risk becoming a catch-all label for distress arising from hostile environments (Kahn, 2021). The construct overlaps with trauma responses, attachment-related threat, and autistic burnout. However, its value lies in its explanatory power and resonance within neurodivergent communities.

4. Manifestations of RSD in Autistic People

Autistic presentations of RSD often include:

Emotional

- Intense shame, sadness, or anger
- Sudden shutdowns or meltdowns
- Somatic responses such as nausea or breathlessness

Cognitive

- Catastrophic thinking
- Persistent rumination
- Hypervigilance to tone, facial expression, or silence

Behavioural

- People-pleasing and masking
- Avoidance of tasks or relationships
- Withdrawal after perceived conflict
- Perfectionism leading to burnout

These patterns are frequently misinterpreted as manipulative or disproportionate, reflecting a lack of practitioner understanding.

5. Impact on Mental Health and Functioning

RSD can significantly affect:

- **Education:** avoidance of feedback, fear of failure
- **Employment:** quitting roles after perceived criticism
- **Relationships:** withdrawal, conflict avoidance
- **Self-esteem:** internalised shame, self-criticism
- **Wellbeing:** chronic anxiety, exhaustion, burnout

These functional impacts are clinically important because they sit within wider evidence of inequality and vulnerability for autistic people.

In the UK, only around 3 in 10 autistic people of working age are in employment, compared with around 5 in 10 disabled people overall and 8 in 10 non-disabled people, highlighting the cumulative effect of social threat, misunderstanding, and inaccessible environments on participation. Research also shows elevated rates of anxiety, depression, burnout, camouflaging, and suicidality among autistic adults. These figures do not evidence RSD directly, but they show why RSD-like responses to perceived rejection, criticism, or failure should be understood as clinically significant rather than minor interpersonal sensitivity.

RSD and suicidal ideation

While direct autism-specific data are limited, ADHD clinical commentary notes that intense rejection-related episodes may be associated with severe mood-like distress, including

suicidal ideation (Dodson, 2021). Given elevated rates of suicidality in autistic populations (Cassidy et al., 2018), it may be clinically appropriate to consider whether RSD-like distress increases vulnerability through:

- intense emotional pain
- social isolation
- catastrophic self-appraisal
- autistic burnout

Where such distress emerges, **Here to Help** can provide immediate emotional support, guidance, and signposting. Where there is immediate risk of harm, crisis support, emergency services, or local safeguarding pathways should be accessed without delay.

6. Identifying RSD in Practice

Practitioners should consider RSD when autistic individuals:

- experience disproportionate distress after minor criticism
- avoid tasks due to fear of failure
- show perfectionism or over-preparation
- withdraw after perceived conflict
- report intense shame or self-blame
- describe masking or people-pleasing as survival strategies

A relational, trauma-informed lens is essential. RSD is a **threat response**, not a behavioural problem.

7. Embedding Supportive Interventions in Environments

Interventions must address environmental contributors, not only individual coping.

7.1 Emotionally safe communication

- Provide clear, predictable feedback
- Avoid ambiguous criticism
- Frame feedback collaboratively

7.2 Reducing social threat

- Offer advance notice before performance discussions
- Normalise mistakes
- Use strengths-based language

7.3 Supporting emotional regulation

- **CBT for catastrophic thinking:** Cognitive Behavioural Therapy can help autistic people notice and gently test thoughts such as ‘I have ruined everything’ or ‘they must hate me’. When adapted for autism, CBT should be concrete, visual, paced, and linked to

real-life examples, supporting the person to separate perceived rejection from evidence of actual harm.

- **ACT for self-compassion:** Acceptance and Commitment Therapy can support people to make space for painful feelings without becoming defined by them. It can help autistic people reconnect with values, reduce shame, and develop a kinder internal response when rejection sensitivity is triggered.

- **DBT for distress tolerance:** Dialectical Behaviour Therapy skills can be useful where RSD leads to intense emotional escalation, shutdown, impulsive communication, or crisis. Skills such as grounding, paced breathing, sensory regulation, and crisis planning can help the person stay safe while the emotional intensity reduces.

7.4 Addressing masking and people-pleasing

- **Validate emotional experiences:** Practitioners should acknowledge that the person's distress is real, even where the trigger appears minor to others. Validation does not mean agreeing with every interpretation of events; it means recognising the intensity of the emotional and physical response, reducing shame, and creating enough safety for the person to reflect, regulate, and consider alternative meanings.

- **Encourage authentic communication:** Autistic people may mask disagreement, distress, confusion, or overwhelm to avoid being seen as difficult or disappointing. Support should actively invite clear, direct, and accessible communication, including written options, processing time, agreed phrases for distress, and permission to ask for clarification without fear of judgement.

- **Support boundary-setting:** People-pleasing can become a survival strategy when rejection feels unsafe. Support should help the person identify their limits, practise saying no, request adjustments, and distinguish between genuine responsibility and excessive self-blame. This can reduce burnout and strengthen a sense of agency.

7.5 Organisational and environmental design

- **Predictable routines:** Consistency reduces uncertainty and helps autistic people anticipate expectations, transitions, and feedback. Where change is unavoidable, advance notice, clear explanation, and time to process can reduce threat responses and prevent avoidable escalation.

- **Clear communication channels:** Organisations should avoid relying on implied expectations, vague feedback, or informal social interpretation. Clear written guidance, agreed routes for questions, structured supervision, and transparent decision-making reduce ambiguity and make it easier for autistic people to seek clarification without fear of being judged.

- **Trauma-informed leadership:** Leaders and practitioners should recognise that strong reactions to perceived criticism may reflect cumulative experiences of exclusion, invalidation, or social punishment. A trauma-informed response prioritises safety,

choice, collaboration, trust, and empowerment rather than blame, confrontation, or punitive escalation.

- **Sensory-considerate environments:** Sensory overload can reduce emotional capacity and make rejection sensitivity harder to manage. Quiet spaces, flexible communication formats, predictable meeting environments, lighting adjustments, reduced noise, and permission to step away can support regulation before distress escalates.

- **Policies recognising neurodivergent emotional experience:** Organisational policies should recognise that emotional distress, shutdown, withdrawal, or difficulty responding immediately may be part of neurodivergent experience rather than misconduct or disengagement. Policies on supervision, complaints, feedback, performance, safeguarding, and reasonable adjustments should therefore include routes for accessible communication, reflective repair, and early support.

8. Conclusion

Rejection Sensitive Dysphoria represents a significant yet under-recognised emotional experience for autistic people, sitting at the juncture of neurodivergent emotional processing, cumulative social threat, masking, shame, burnout, and mental health vulnerability. Although the construct requires further empirical scrutiny and should not be presented as a formal diagnosis, its explanatory value and resonance within neurodivergent communities are clear. The evidence and lived-experience accounts discussed throughout this paper show that RSD is not simply an overreaction to feedback or rejection, but a whole-body threat response shaped by repeated experiences of misunderstanding, invalidation, exclusion, and unmet support. For autistic people, this can affect education, employment, relationships, self-esteem, wellbeing, and access to help, particularly where distress is mislabelled as behaviour, personality difficulty, or lack of resilience.

The implications are therefore both clinical and organisational. Practitioners, services, families, and communities need to move away from deficit-based interpretations and instead respond through relational, trauma-informed, neurodiversity-affirming approaches that prioritise emotional safety, validation, predictable communication, sensory regulation, boundary-setting, and accessible routes into support.

In this context, **Here to Help** provides an important practical bridge between the paper's findings and real-world community support. As an autism and suicide prevention initiative, it can use this evidence to raise awareness of RSD-related distress, support earlier recognition, reduce isolation, guide compassionate responses, and ensure autistic people experiencing overwhelming distress or suicidal thoughts are met with timely, non-judgemental, and emotionally safe support.

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