

CAMOUFLAGING TO ADHD: MOTIVATIONAL, NEUROCOGNITIVE, AND CONSTRUCT VALIDITY CONSTRAINTS

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ABSTRACT

The construct of “camouflaging” has rapidly migrated from autism research into discourse surrounding attention-deficit/hyperactivity disorder (ADHD), where it is increasingly invoked to explain concealed symptomatology and delayed diagnosis. This paper critically examines the theoretical, neurocognitive, and construct validity foundations of this transposition. Drawing upon Bayesian frameworks of impression management originally proposed for autism, it evaluates the motivational assumptions, computational demands, and measurement practices underlying claims of “ADHD camouflaging.” Three core incompatibilities are identified. First, motivational incompatibilities arise because the presumed stigma-driven model of concealment fails to account for pre-diagnostic masking and the diffuse, often implicit nature of ADHD stigma. Second, neurocognitive incompatibilities emerge because the executive function deficits characteristic of ADHD—particularly in working memory, inhibitory control, planning, and self-monitoring—contradict the iterative computational processes posited by Bayesian models of social inference. Third, construct validity deficits persist because extant measurement instruments are adapted from autism research, lack ADHD-specific content, and fail to demonstrate discriminant or predictive validity. The paper further analyses how the construct’s institutional uptake exemplifies Derksen’s concept of “human engineering,” wherein moral alignment and testimonial justice secure acceptance ahead of empirical substantiation. It concludes by advocating rigorous ADHD-specific instrument development, longitudinal validation, and ethical clinical practice that recognises compensatory effort without reifying an under-specified construct.

1 INTRODUCTION

The phenomenon of ‘camouflaging’—variously termed masking, compensation, or passing—has emerged as a significant focus within neurodevelopmental research, particularly concerning autism spectrum conditions (1, 2). Camouflaging broadly includes the strategic modification of behaviour whereby individuals minimise the visibility of their differences to navigate predominantly neurotypical social environments (3). Within the autism literature, camouflaging has been conceptualised as including both ‘masking’ strategies—the active suppression or concealment of traits perceived as socially undesirable—and ‘compensatory’ strategies—the deployment of alternative cognitive resources to achieve superficially neurotypical social performances despite underlying processing differences (4, 5).

Recent theoretical advances have positioned autistic camouflaging within established frameworks of impression management (IM), the ubiquitous human tendency to regulate information about the self to influence how one is perceived by others during social interactions (1, 6, 7). Ai and colleagues’ (1) important reconceptualisation of autistic camouflaging as transactional IM represents a significant theoretical integration, synthesising insights from computational neuroscience, social psychology, and neurodevelopmental

research. Their framework positions camouflaging within predictive coding and Bayesian inference principles, proposing that individuals engage in iterative social computations wherein they draw upon internalised social priors—regularities abstracted from previous social experiences—to generate action states predicted to minimise discrepancies between desired and achieved social impressions. This computational account emphasises the dynamic, context-dependent, and inherently transactional nature of IM, highlighting how social alignment emerges through recursive cycles of prediction, error detection, belief updating, and action refinement across interactive moments.

In the same work, Ai and colleagues integrate the dialectical misattunement hypothesis (8), which suggests that autistic social difficulties arise not solely from individual neurological differences but from bidirectional mismatches in cross-neurotype interactions, wherein autistic and neurotypical individuals hold incompatible social priors that complicate mutual understanding and coordination. This transactional perspective represents a departure from deficit-focused models by emphasising how social challenges emerge from the dynamic interplay between neurodivergent cognition and neurotypical-majority social contexts.

Within this background, the concept of camouflaging has travelled rapidly from autism research into discourse surrounding attention-deficit/hyperactivity disorder (ADHD), appearing with increasing frequency in clinical communications, educational materials, and social media although not so much in research publications. Emerging studies document that individuals with ADHD likewise engage in camouflaging strategies to conceal core symptoms of inattention, hyperactivity, and impulsivity (9). The idea is that that ADHD camouflaging includes both masking strategies—suppressing visible ADHD traits such as fidgeting, interrupting, or losing track of conversations—and compensatory strategies—deploying structured routines, extensive cueing systems, rehearsed social scripts, and selective avoidance to achieve socially acceptable behavioural outputs despite underlying executive function difficulties (10, 11). Paralleling the autism literature, ADHD camouflaging has been associated with significant mental health costs, including elevated depression, anxiety, exhaustion, and reduced life satisfaction, particularly among women and individuals experiencing high levels of internalised stigma (9).

However, the rapid acceptance of camouflaging as an established construct in ADHD has outpaced the empirical foundation supporting its validity, measurement properties, and clinical utility. This paper argues that the application of Bayesian computational frameworks developed for autism to ADHD contexts encounters three fundamental classes of problems: (1) motivational incompatibilities, wherein the presumed role of stigma awareness as driver of strategic concealment fails to account for pre-diagnostic masking and the distinct phenomenology of ADHD stigma; (2) neurocognitive incompatibilities, wherein the executive function deficits characteristic of ADHD directly contradict the computational demands specified by Bayesian models of iterative social inference; and (3) construct validity deficits, wherein the measurement instruments, sampling strategies, and theoretical boundaries of "ADHD camouflaging" remain insufficiently specified to support the strong claims increasingly made in clinical and research contexts. We propose that the swift consensus surrounding ADHD camouflaging reflects not robust empirical validation but rather what Derksen (12)) terms "human engineering"—the tactful synthesis of personal testimony, moral rhetoric, and scientific language that secures agreement in the absence of strong evidence. Throughout, we emphasise that acknowledging compensatory efforts and hidden effort in ADHD assessment remains ethically essential, yet this recognition need not entail reifying an under-specified construct or treating autism-derived measurement tools as if they validated an ADHD-specific phenomenon.

Ai and colleagues' (13) Bayesian framework conceptualises impression management as an iterative predictive processing cycle wherein actors draw upon social priors—internalised regularities of social expectations, norms, and contingencies—to generate action states predicted to foster desired impressions upon neurotypical audiences. Within this model, successful social performance requires the actor to sample and evaluate audience feedback through perceptual channels (e.g., facial expressions, vocal prosody, postural shifts), update beliefs about appropriate behaviours based on detected prediction errors, and recursively refine action selection to minimise discrepancies between intended and achieved social impressions. The computational challenge intensifies when actors possess mismatched or "attenuated" priors that are incompatible with dominant social conventions, necessitating increased iterations of belief updating and imposing greater cognitive load (13, 14).

This framework integrates concepts from active inference (14) which posits that organisms minimise prediction error through two complementary routes: (1) updating internal models to better match sensory input (perceptual inference), and (2) acting upon the environment to bring sensory input into alignment with

predictions (active inference). Applied to social contexts, actors can reduce prediction errors either by revising their beliefs about what audiences expect or by modifying their observable behaviours to better match anticipated expectations. The dialectical misattunement hypothesis (8) emphasises that social difficulties arise not solely from individual neurological differences but from transactional mismatches between neurodivergent individuals and neurotypical social contexts, wherein incompatible priors and processing styles generate cumulative communicative failures across repeated interactions.

2 APPLICATION TO ADHD: THEORETICAL EXTENSION AND INITIAL PLAUSIBILITY

Applied to ADHD, this model would suggest that individuals engage in camouflaging when their natural behavioural tendencies—driven by core ADHD features such as impulsivity, distractibility, hyperactivity, difficulty sustaining attention, and challenges with prospective time management—fail to align with social expectations, prompting effortful attempts to suppress visible symptoms and deploy compensatory strategies to approximate neurotypical social performances. The model predicts that ADHD individuals would experience greater computational demands during social interactions due to mismatched priors regarding appropriate attentional focus, conversational timing, activity levels, and organisational displays. Qualitative accounts support this phenomenological reality: adults with ADHD describe elaborate compensatory routines—rigid scheduling, dense environmental cueing, memorised social scripts, and strategic avoidance of situations likely to expose difficulties—that reduce the outward visibility of struggles whilst increasing subjective effort and exhaustion (11, 15).

However, three fundamental problems undermine the sufficiency and specificity of applying Bayesian frameworks to ADHD: motivational incompatibilities concerning the presumed drivers of camouflaging, neurocognitive incompatibilities between ADHD cognitive profiles and the computational requirements of the model, and construct validity deficits in the measurement and theoretical specification of "ADHD camouflaging" as a discriminable phenomenon.

2.1 Critique I: Stigma as Insufficient Motivator in Undiagnosed and Diagnosed ADHD

A fundamental limitation of applying the Bayesian camouflaging framework to ADHD contexts concerns the presumed role of stigma as a primary motivator for impression management. Ai and colleagues (13) position stigma mitigation and social exclusion avoidance as central drivers of camouflaging, asserting that marginalised individuals engage in impression management as a "compelled social modification" necessitated by anticipated discrimination and devalued social positioning. This formulation presupposes that actors possess conscious awareness of their stigmatised identity and engage in strategic performances specifically to conceal this identity from neurotypical audiences (16, 17). Within the computational framework, stigma awareness functions as a high-level prior that shapes the actor's beliefs about audience expectations and the social penalties associated with visible neurodivergence, thereby motivating the allocation of cognitive resources toward impression management computations.

The model's emphasis on stigma-driven motivation maps readily onto autism contexts, wherein many diagnosed autistic individuals possess explicit awareness of societal attitudes toward autism, can articulate stereotypically autistic behaviours that attract negative judgements, and describe strategic efforts to conceal these behaviours to avoid social exclusion or discrimination. However, this motivational structure encounters significant difficulties when extended to ADHD.

First, substantial evidence indicates that many individuals with ADHD suggest they engage in masking behaviours prior to receiving formal diagnosis, often throughout childhood and adolescence without explicit recognition that their struggles stem from a neurodevelopmental condition (10, 18). In the absence of diagnostic awareness, the motivational structure underlying ADHD camouflaging necessarily differs from stigma-driven impression management. Rather than strategically concealing a known stigmatised identity, undiagnosed individuals may instead experience their camouflaging as attempts to meet poorly understood social expectations, manage chronic feelings of inadequacy or "wrongness," or respond to repeated negative

feedback (e.g., being labelled as lazy, disorganised, inconsiderate, or irresponsible) without comprehending the neurocognitive basis of their difficulties.

Grimell and colleagues (10) documented that girls with ADHD described their impression management efforts as responses to feeling "different" or "wrong" rather than as deliberate strategies to hide a diagnosed condition. Participants reported awareness that their natural behavioural inclinations attracted negative responses from peers and teachers, prompting efforts to suppress fidgeting, force sustained attention, or rehearse socially appropriate responses, yet these efforts preceded any conceptual understanding of ADHD as explaining their experiences. This pattern suggests that camouflaging in ADHD may emerge from internalised shame, social confusion, and reactive adaptation to chronic negative feedback rather than from rational assessment of condition-specific stigma.

The Bayesian model presumes that actors can formulate sufficiently articulated beliefs about audience expectations to guide iterative action selection and belief updating. However, if ADHD individuals lack clear mental models of how their condition is perceived, which specific manifestations carry social penalties, or what alternative behaviours would be more acceptable, the computational processes specified by the framework become theoretically incoherent. Without well-defined priors regarding ADHD stigma and its associated behaviours, it remains unclear what prediction errors actors would attempt to minimise, how belief updating would converge toward effective camouflaging strategies, or why particular compensatory behaviours would be preferentially selected over alternatives. The absence of diagnostic clarity and stigma conceptualisation represents a substantial departure from the autism context and challenges the motivational assumptions underlying Bayesian accounts.

Second, even among diagnosed individuals, the salience and conceptualisation of ADHD stigma may differ substantially from autism stigma in ways that complicate direct application of the Bayesian framework. ADHD remains widely misunderstood as a condition primarily affecting hyperactive young boys, with pervasive cultural narratives dismissing ADHD as overdiagnosis, pharmaceutical industry fabrication, lack of discipline, or moral failure rather than as a legitimate neurodevelopmental condition (19, 20). Consequently, individuals with ADHD—particularly women and adults with predominantly inattentive presentations—may struggle to identify relevant social priors regarding how ADHD is perceived in professional, educational, or social contexts and what specific behaviours require concealment versus which might be accommodated or even valued.

Unlike autism, wherein stereotypical features (e.g., repetitive behaviours, atypical eye contact, literal language processing) are relatively well-defined in cultural representations, ADHD symptomatology includes diffuse attentional, organisational, and emotional regulatory difficulties that may be attributed to character flaws, laziness, or lack of effort rather than recognised as disorder-related. This attribution ambiguity means that even diagnosed individuals may lack coherent mental models of "ADHD stigma" that could function as high-level priors guiding computational processes. The Bayesian framework's premise that actors possess sufficiently articulated beliefs about audience expectations becomes strained when the audience itself lacks clear conceptual boundaries between ADHD symptoms and moral failings, and when cultural narratives deny the legitimacy of the diagnosis itself.

These considerations suggest that alternative motivational frameworks may be required to capture ADHD camouflaging experiences—perhaps emphasising internalised shame, social confusion, chronic negative feedback accumulation, perfectionism, anxiety-driven safety behaviours, or identity-level distress rather than strategic stigma mitigation. Individuals may engage in compensatory effort not because they possess clear models of ADHD stigma and consciously calculate optimal concealment strategies, but because they have learned through repeated social failures that their natural inclinations attract punishment, that organisational scaffolding prevents catastrophic outcomes, or that hypervigilant self-monitoring temporarily forestalls negative judgements—all without necessarily conceptualising these efforts as "masking ADHD."

This shift in motivational framing has implications for the computational account. If camouflaging emerges from diffuse anxiety, perfectionism, or reactive adaptation rather than from articulated stigma priors, the iterative belief-updating processes specified by Bayesian models may not adequately describe the underlying mechanisms. Instead, ADHD individuals may rely on rigid heuristics, anxiety-driven behavioural avoidance, or generalised impression management strategies that are not specific to ADHD concealment and that do not involve sophisticated social inference or recursive error minimisation. We return to this point in discussing neurocognitive constraints.

2.2 Critique II: ADHD Neurocognitive Profile Fundamentally Conflicts with Computational Demands of Bayesian Camouflaging

A second important limitation concerns the compatibility between ADHD neurocognitive characteristics and the computational demands specified by the Bayesian impression management framework. Ai and colleagues' (13) model delineates camouflaging as requiring sophisticated iterative processing involving belief updating, action state search, precision weighting, and recursive error minimisation across interactive moments. The framework explicitly identifies executive functions—including cognitive flexibility, response inhibition, working memory, planning, and self-monitoring—as "fundamental in supporting social inference and subsequent action searching". Additionally, the model emphasises the need of self-monitoring capacities to track whether impression management attempts are succeeding or failing, self-other processing to distinguish one's internal states from those of the audience, and sustained attention to social feedback to accumulate reliable prediction errors that drive belief updating.

The computational architecture presumes actors can maintain concurrent representations of audience expectations, track ongoing social feedback across multiple modalities, hold multiple candidate action states in working memory for precision weighting and selection, inhibit prepotent but socially undesirable responses, flexibly shift between action strategies when initial attempts fail, plan sequences of compensatory behaviours in anticipation of demanding social contexts, and retrospectively consolidate interaction outcomes into refined social priors that inform future encounters. Furthermore, actors must efficiently evaluate "computation utility"—determining the optimal trade-off between deeper iterative processing to improve action precision versus terminating processing to avoid excessive cognitive load—which itself constitutes a metacognitive regulatory function. However, extensive meta-analytic evidence demonstrates that ADHD is characterised by substantial deficits across precisely these neurocognitive domains.

Pievskey and McGrath's (21) comprehensive review of meta-analyses examining ADHD neurocognition, which synthesised 253 standardised mean differences from 34 meta-analyses, revealed medium-to-large effect sizes for between-groups differences in response inhibition ($d = .52$), working memory ($d = .54$), planning and organisation ($d = .51$), reaction time variability ($d = .66$), vigilance ($d = .48$), and intelligence/achievement ($d = .51$), with consistent evidence of impairments in executive functions generally. These findings converge across diverse measurement paradigms including continuous performance tasks, stop-signal tasks, working memory span tasks, Tower of London planning tasks, and Wisconsin Card Sorting flexibility measures.

In addition, Barkley's (22) influential theoretical model posits that ADHD fundamentally involves deficits in behavioural inhibition that cascade to disrupt working memory, self-regulation, internalisation of speech (which supports verbal mediation and self-instruction), and reconstitution (flexible analysis and synthesis of behavioural sequences)—the very cognitive processes required for effective impression management according to Bayesian frameworks. Subsequent empirical work has largely supported this cascade model, demonstrating that inhibitory control deficits predict difficulties with working memory maintenance, prospective planning, and self-directed behaviour in ADHD populations (23, 24).

The neurocognitive profile of ADHD creates specific computational bottlenecks that undermine the feasibility of the iterative processing cycles central to Ai and colleagues' model. First, working memory limitations would constrain the capacity to maintain concurrent representations of audience expectations, track ongoing social feedback across verbal and nonverbal channels, hold multiple action state candidates in mind for precision weighting, and retain previous interaction outcomes to inform belief updating. The Bayesian framework requires actors to simultaneously represent (1) their own internal states and intentions, (2) inferred audience expectations and reactions, (3) candidate action states under consideration, (4) precision estimates associated with each candidate, and (5) accumulated prediction errors from moment to moment. This computational load would rapidly exceed working memory capacity in individuals with ADHD, particularly during cognitively demanding or affectively arousing social interactions.

Second, response inhibition deficits would impede the suppression of prepotent ADHD-related behaviours (e.g., interrupting others, fidgeting, blurting out tangential comments, losing track of conversational threads) that constitute the "backstage" requiring concealment, whilst simultaneously interfering with the controlled selection and execution of alternative, socially acceptable "frontstage" performances (25). The model presumes actors can consistently inhibit automatic or habitual responses that would reveal ADHD symptoms whilst selecting and executing deliberate alternative behaviours—a dual-task demand that would be particularly taxing for individuals with compromised inhibitory control. Meta-analytic evidence indicates that

ADHD is associated with elevated commission errors on continuous performance tasks, longer stop-signal reaction times, and greater interference effects on Stroop tasks, all indexing difficulties with response inhibition and interference control (21, 25)

Third, planning and organisational difficulties would obstruct the structured deployment of compensatory strategies and the anticipatory preparation of social scripts or rehearsed responses that constitute deeper compensation routes described in the camouflaging literature (5). The Bayesian account assumes actors can prospectively identify high-demand social contexts, develop contingency plans, rehearse specific behavioural sequences, and deploy these plans appropriately when cues indicating their relevance are detected. Yet ADHD is characterised by deficits in prospective memory (remembering to execute planned actions at appropriate future moments), planning ability (generating effective action sequences to achieve goals), and organisation (structuring materials, time, and activities) (21). These deficits would compromise the anticipatory scaffolding that enables sophisticated camouflaging.

Fourth, characteristic reaction time variability and attentional inconsistency in ADHD (26) would disrupt the sustained self-monitoring necessary to track whether impression management attempts are succeeding or failing, thereby preventing the accumulation of reliable prediction errors to drive belief updating. Reaction time variability—moment-to-moment fluctuations in response speed—has emerged as one of the largest and most consistent neurocognitive markers of ADHD, with meta-analytic effect sizes ($d = .66$) exceeding those for most other cognitive domains (21, 26). This variability likely reflects lapses in sustained attention and executive control, meaning that even when individuals with ADHD attempt to monitor social feedback, their attention will periodically disengage, causing them to miss critical audience reactions or lose track of their own performance. Without consistent self-monitoring, actors cannot reliably detect prediction errors or evaluate whether their compensatory strategies are achieving desired effects.

Fifth, whereas Ai and colleagues’ model presumes that actors can efficiently evaluate “computation utility” and regulate depth of iterative processing based on available cognitive resources, individuals with ADHD possess fundamentally compromised executive control systems for implementing such metacognitive regulation. The decision to terminate iterative processing and select an action (versus continuing to search for higher-precision alternatives) itself constitutes an executive control demand. Research on decision-making in ADHD indicates difficulties with optimal stopping, temporal discounting, and balancing exploration versus exploitation trade-offs—all relevant to regulating computational depth ((27). Individuals with ADHD may therefore either persevere in unproductive action searches (unable to terminate processing efficiently) or prematurely select low-precision actions (unable to sustain processing sufficiently), both of which would compromise camouflaging effectiveness.

Moreover, the transactional emphasis within Ai and colleagues’ framework assumes that increased social alignment and successful impression management emerge through iterative optimisation processes that gradually improve over developmental time and across repeated interactions. The model proposes that actors learn effective social priors through recursive belief updating, consolidating episodic social experiences into generalised knowledge structures that enable more efficient future computations. However, ADHD is characterised not only by cross-sectional deficits but by developmental trajectories of persistent executive function difficulties that show limited improvement relative to neurotypical peers (21). The computational account’s premise that actors can learn effective social priors presumes intact learning mechanisms, memory consolidation, and generalisation capacities.

Yet substantial evidence documents that ADHD involves difficulties with reward-based learning, temporal credit assignment, and the integration of feedback across temporally extended sequences (27). These learning constraints would impede the formation of refined social priors even when individuals with ADHD receive clear social feedback. If working memory limitations prevent individuals from maintaining representations of social outcomes long enough to consolidate them into memory, if attentional variability causes them to miss feedback signals, and if temporal credit assignment difficulties prevent them from accurately linking their actions to subsequent audience reactions, then repeated social experiences may fail to crystallise into the kind of generalisable social knowledge that supports efficient camouflaging. This limitation is compounded by the context-dependent nature of ADHD symptom expression; variability in executive function performance across situations and internal states (e.g., interest, arousal, fatigue) would produce inconsistent capacity for engaging impression management computations, undermining the formation of stable, generalisable camouflaging strategies.

In summary, the Bayesian impression management framework specifies computational demands—concurrent

working memory maintenance, sustained inhibitory control, prospective planning, consistent self-monitoring, flexible belief updating, and metacognitive regulation—that are precisely the neurocognitive capacities most compromised in ADHD. This creates a fundamental tension: the individuals hypothesised to engage most intensively in camouflaging (due to heightened social-communication challenges and stigma) possess the cognitive architecture least suited to support the sophisticated iterative computations that the framework specifies as necessary for effective camouflaging. This tension suggests either that (1) the Bayesian model inadequately captures ADHD camouflaging mechanisms, or (2) ADHD individuals rely on qualitatively different, less computationally demanding strategies that fall outside the scope of the model.

2.3 Critique III: Construct Validity Deficits in ADHD Camouflaging Measurement and Theory

Beyond motivational and neurocognitive incompatibilities, the application of camouflaging frameworks to ADHD encounters fundamental construct validity problems. The construct of "masking" or "camouflaging" in adult ADHD has achieved rapid prominence, yet the evidence base supporting it remains fragile even in autism (3, 28). Diagnostic criteria for ADHD require more than the presence of symptoms: onset in childhood, pervasiveness across settings, and demonstrable functional impairment must be established, and alternative explanations must be excluded ((29). These criteria already anticipate that behaviours wax and wane across contexts and over time. The question, therefore, is not whether adults with ADHD ever hide symptoms or deploy compensatory strategies—the qualitative literature clearly documents that they do (15). The question is whether "masking" or "camouflaging" in ADHD constitutes a valid, measurable, and discriminable construct that adds something substantive to careful assessment beyond well-recognised phenomena such as compensation, impression management, anxiety-driven safety behaviours, perfectionistic overcompensation, or ordinary social self-presentation.

The present corpus on ADHD camouflaging relies overwhelmingly on instruments developed within autism research, most prominently the Camouflaging Autistic Traits Questionnaire (CAT-Q). By design, CAT-Q items operationalise three domains—Compensation, Masking, and Assimilation—derived from autistic adults' descriptions of managing social-communication demands (30). Items include statements such as "I monitor my body language or facial expressions so that I appear interested by the person I am interacting with," "I practice my facial expressions and body language to make sure they look natural," and "I have developed techniques to help me appear interested in a conversation". When this instrument is applied to adults with ADHD, it captures self-reported social effort and impression management, but its content validity remains anchored to autistic social-communication phenomena (e.g., managing eye contact, interpreting nonverbal cues, understanding implicit social rules) rather than ADHD-specific attentional control, time-management, organisational scaffolding, and impulsivity suppression.

Even within autism, systematic reviews and comparative method papers emphasise definitional dispersion across studies, modest concordance between measurement approaches, and reliance on cross-sectional designs, advising restraint in strong construct claims until a shared measurement model is established (3). Cook and colleagues' (2021) systematic review identified substantial heterogeneity in operationalisations of camouflaging across 29 included studies, with wide variation in how camouflaging was defined, measured, and related to outcomes. Hannon and colleagues' direct comparison of measurement approaches found that self-report instruments (like CAT-Q) and "discrepancy" methods (which index camouflaging as a residual gap between internal traits and external behaviour) only moderately correlate (r .30–.40) and appear to track partially distinct constructs. The authors caution against treating these methods as interchangeable and recommend restraint in cross-diagnostic inference until measurement theory matures.

When autism-anchored tools are nonetheless applied to ADHD samples, the pattern is consistent but cautionary. In a pre-registered comparative study, van der Putten and colleagues (31) examined adults with autism, adults with ADHD, and non-clinical controls on an autism-derived camouflaging metric. ADHD participants scored higher than non-clinical controls but lower than autistic participants; critically, autism-trait measures out-predicted ADHD-trait measures as determinants of camouflaging scores. This finding is compatible with real compensatory effort in ADHD whilst simultaneously demonstrating that variance captured by an autism-specific instrument is driven predominantly by autistic characteristics rather than by ADHD symptoms or traits. The result is informative but not confirmatory of an ADHD-specific masking construct; it reflects instrument behaviour and construct overlap rather than discriminant validation. As van

der Putten and colleagues note, elevated CAT-Q scores in ADHD samples may index generic social effort, anxiety-driven self-monitoring, or overlapping autistic traits rather than ADHD-specific camouflaging.

Several recurrent methodological limitations across the ADHD camouflaging literature constrain the strength of conclusions that can be drawn. First, sampling frequently draws on online convenience samples or advocacy-adjacent communities, which are likely to over-represent individuals already primed by neurodiversity discourse to recognise themselves in camouflaging narratives (9). Self-selection biases mean that prevalence estimates and associations observed in these samples may not generalise to broader ADHD populations, particularly those unaware of camouflaging concepts or unengaged with neurodiversity communities.

Second, having or not an established ADHD diagnosis is often mixed, combining self-report and clinical confirmation, with variable attention to comorbidity. Anxiety disorders, social anxiety, depression, and perfectionistic personality features are common in ADHD samples and are themselves strongly associated with impression management, self-monitoring, and behavioural suppression (. Yet these comorbidities are rarely modelled as potential confounds in analyses examining associations between camouflaging and outcomes. Without explicit statistical control or stratification by comorbidity status, observed associations between camouflaging and distress may reflect third-variable confounding rather than specific effects of ADHD-related concealment.

Third, designs are predominantly cross-sectional, precluding temporal inference about whether camouflaging precedes internalising morbidity, whether mood and anxiety symptoms drive both endorsement of camouflaging items and negative affectivity on outcome measures, or whether camouflaging emerges as a downstream response to chronic strain (3). The study by Wicherkiewicz and Gambin which reported that higher self-reported social camouflaging was associated with lower life satisfaction and higher depressive symptoms among Polish women with ADHD, exemplifies both the strengths and limitations of the current literature. The study’s focus on an under-recognised population and its alignment with qualitative narratives of exhaustion and identity strain are valuable, yet cross-sectional design, self-selection via online recruitment, self-report for both predictors and outcomes (introducing common-method variance and negative affectivity confounds), and use of instruments not validated for ADHD all limit causal interpretation.

Fourth, measurement invariance—whether instruments function equivalently across sex, age, cultural context, comorbidity profiles, and diagnostic groups—is rarely examined. Even within autism, attempts to transport the CAT-Q across languages and cultures have warned against between-group comparisons without explicit tests of configural, metric, and scalar invariance (28) These constraints are magnified when crossing diagnostic categories. Without evidence that CAT-Q items hold equivalent meaning, factor structures, thresholds, and relations to external criteria in ADHD versus autism samples, elevated scores in ADHD participants should not be interpreted as confirming an ADHD-specific construct.

A central threat to construct validity concerns discriminant validity: the extent to which camouflaging can be distinguished from conceptually related but distinct phenomena. Social anxiety, generalised anxiety, trauma-related hypervigilance, and trait perfectionism can each increase self-monitoring, suppression of behaviours perceived as socially undesirable, and effortful self-presentation (7). Without explicit tests against these alternatives, endorsements on camouflaging items cannot be uniquely attributed to an ADHD-specific process. Current measures do not include validity scales or subscales designed to differentiate ADHD-specific concealment (e.g., suppressing fidgeting, forcing sustained attention) from general impression management (e.g., appearing agreeable, competent, or likeable) or anxiety-driven behavioural avoidance.

Furthermore, the distinction between “camouflaging” and “compensation” remains theoretically underdeveloped in the ADHD literature. Compensation broadly refers to the deployment of alternative strategies, environmental structuring, or external supports to achieve functional outcomes despite underlying impairments. Livingston and Happé (5) distinguish “shallow” compensation—superficial, inflexible strategies such as rote scripts or simple imitation that may succeed in structured contexts but break down under novelty—from “deep” compensation—recruitment of alternative cognitive resources (e.g., using strong verbal abilities to scaffold weak implicit social understanding) that enables more flexible adaptation. Many behaviours described in ADHD qualitative studies (e.g., rigid scheduling, dense environmental cueing, reliance on timers and reminders) plausibly reflect compensation rather than concealment per se. Yet current instruments conflate these phenomena, leaving it unclear whether elevated “camouflaging” scores reflect strategic hiding of symptoms, adaptive use of compensatory scaffolds, or both.

Ambiguity in definition further undermines construct validity. In current usage, “masking” variously denotes concealment of symptoms, compensatory routines that maintain role performance, impression man-

agement in socially evaluative settings, anxiety-driven safety behaviours, and perfectionistic over-preparation. Without operational boundaries distinguishing these phenomena from ordinary self-regulation and adaptive coping, the term becomes a container for heterogeneous practices, encouraging category creep rather than conceptual clarity. This vagueness intersects problematically with ADHD diagnostic requirements. Formal frameworks stipulate that ADHD diagnosis requires more than symptoms: onset in childhood, pervasiveness across settings, and demonstrable interference with functioning must be established, alongside exclusion of alternative explanations (29). Invoking "masking" to justify a diagnosis when observable impairment is limited risks circular reasoning: the concept is used to explain away precisely the evidential gaps that diagnostic standards are designed to detect, functioning as a post hoc rationalisation that lowers the threshold of corroboration.

A particularly important example of this circularity concerns the claim that masking explains failures to detect ADHD during clinical assessment. From a logical and neurophysiological standpoint, attributing a missed ADHD diagnosis to sustained masking throughout a prolonged clinical assessment is unsound. The argument presupposes that an individual can maintain simultaneous suppression of inattentiveness, hyperactivity, and impulsivity across an entire structured examination—potentially lasting 60–90 minutes or more—without observable signs of effort, lapses, or degradation in performance. Yet this claim contradicts established models of attention, inhibition, and executive control. Sustained attention in ADHD is unstable rather than absent, relying on limited executive resources that deteriorate under continuous demand (32). Behavioural inhibition—the mechanism required to suppress hyperactive or impulsive behaviour—is similarly resource-dependent and vulnerable to fatigue (33). Empirical research demonstrates that performance variability, attentional lapses, and subtle behavioural "leakage" typically emerge within minutes when such systems are taxed (26).

To maintain an appearance of neurotypical functioning across an entire assessment would require continuous top-down regulation over multiple domains—attentional, motor, and behavioural—without degradation. This would necessitate sustained executive control that neurocognitive evidence shows to be physiologically implausible in ADHD. Observable signs of compensatory strain, such as subtle restlessness, motor overflow, delayed or effortful responses, fatigue, or post-assessment exhaustion, generally betray such efforts. The idea that masking could fully conceal core symptoms over lengthy, demanding clinical interactions commits a logical fallacy of absolute generalisation: inferring from brief, situational self-regulation (which is possible) to sustained, global suppression capacity (which contradicts the neurophysiology of ADHD). What may occur is situational modulation—a temporary increase in control under structured observation—which can produce transiently composed presentations without implying diagnostic inaccuracy. Attributing missed diagnoses to masking therefore misrepresents the phenomenology and neurocognitive constraints of ADHD, whilst simultaneously functioning as an unfalsifiable explanation that insulates diagnostic practices from scrutiny.

Perhaps most critically, there currently exists no ADHD-specific construct of masking with established measurement theory, discriminant validity, and longitudinal predictive value. For an ADHD-specific construct to be persuasive, item content would need to originate in ADHD phenomenology, covering attentional control in socially salient situations, prospective time-management under scrutiny, suppression of hyperactive or impulsive behaviours, deployment of organisational scaffolds, and context-dependent self-presentation that is not reducible to social anxiety or general impression management. Structural validity would require stable factor solutions across diverse samples, with evidence of configural, metric, and scalar invariance. Discriminant validity would require separation from executive compensation, trait perfectionism, social anxiety, and general impression management. Predictive validity would require longitudinal demonstrations that camouflaging scores predict clinically meaningful outcomes—time-to-diagnosis, help-seeking patterns, treatment response, or later morbidity—over and above established predictors such as ADHD severity, mood, and anxiety.

No study to date satisfies these requirements. The corpus provides phenomenological descriptions of compensatory labour and cross-sectional associations between camouflaging scores (derived from autism instruments) and wellbeing outcomes, but it does not demonstrate that a valid ADHD-specific construct has been measured or that this construct adds incremental predictive value beyond well-characterised variables. Until such demonstrations are provided, "masking in ADHD" remains, from an evidential standpoint, an under-specified construct superimposed upon a well-documented landscape of compensation and adaptive coping.

Given the conceptual ambiguities, measurement limitations, and construct validity deficits outlined above, an important question arises: How did "masking" or "camouflaging" in ADHD achieve rapid acceptance across clinical, research, and advocacy contexts, outpacing the development of its empirical foundation? The answer lies not in robust validation but in what Derksen (12) terms "human engineering"—the tactful synthesis of personal testimony, moral rhetoric, and scientific language that secures agreement in the absence of strong evidence.

Derksen's (12) historical analyses demonstrate that influence in psychological and social scientific contexts does not depend solely on experimental evidence or logical arguments. Rather, it depends on tact—a situated social intelligence that anticipates objections, aligns messages with prevailing moral sensibilities, and allows audiences to experience new norms as self-directed rather than imposed. In the case of ADHD, communication that foregrounds testimony about unseen effort, exhaustion, and the relief of recognition meets widely shared professional commitments to harm reduction, inclusivity, and testimonial justice (34). It reduces friction by framing acceptance of masking as continuous with ethical practice, rather than as an epistemic concession requiring strong evidence.

Cernei and Derksen (35) demonstrate how, in autism discourse, organisational websites operationalise such tact by weaving identity-first language, lived narratives, and scientific idioms into coherent communicative artefacts that position assent as the reasonable and humane response. The same rhetorical pattern now surrounds ADHD, where lived-experience accounts from late-diagnosed adults—particularly women—are amplified through advocacy channels, social media, and educational materials in ways that highlight the costs of "passing" and the validation afforded by recognition. These narratives are compelling and ethically important; they also create social pressure wherein questioning the construct's validity risks being interpreted as indifference to lived experience or complicity in testimonial injustice.

De Certeau's (36) distinction between tactics and strategies clarifies how dispersed individual behaviours cross the threshold into institutional language. Tactics are opportunistic manoeuvres deployed by individuals without control over the rules of the game; strategies belong to institutions that can define spaces, categories, and protocols. Adults with ADHD describe tactics—rigid scheduling, social scripting, careful staging of interactions, avoidance of unstructured settings—to navigate normative environments. Through human engineering, those tactics are gathered, named as "masking," and embedded in institutional strategies: clinical checklists, training modules, service guidelines, and research frameworks. Once institutionalised, the concept shapes expectations for both practitioners and patients, supplying users with a ready-made narrative frame and services with a label that appears to explain challenging presentations.

Foucault's concept of governmentality adds an additional dimension: institutions govern most effectively when individuals govern themselves along preferred lines (37). Naming and normalising "masking" functions as a soft technology of conduct, encouraging self-disclosure in the name of authenticity whilst simultaneously recruiting individuals to align their stories with institutional interpretive frames. Patients learn to articulate experiences in the language of masking; clinicians learn to ask targeted questions; researchers design studies to measure the named phenomenon. Information accumulates that appears to validate the classification, even when measurement specificity remains unsettled.

Hacking's ((38)analysis of "looping effects" completes the picture. Human classifications do not passively reflect fixed human kinds; once they circulate, they alter the conduct and self-understanding of the people classified, which in turn alters the classification itself. With "masking," clinicians begin to ask targeted questions; patients learn to notice and articulate experiences in the new terms; researchers select instruments that register those experiences. Data accumulates that appears to validate the classification, creating a feedback loop wherein the construct becomes increasingly "real" through its social circulation, independent of whether it possesses discriminant validity or predictive utility.

This loop is visible in the comparative findings of van der Putten and colleagues, wherein adults with ADHD endorsed autism-anchored camouflaging items at intermediate levels, yet autism-trait measures predicted those scores more strongly than ADHD traits. The looping effect does not imply fabrication or inauthenticity; it indicates that the instrument is tuned to a different construct lineage and that endorsement reflects the salience of a named practice circulating in discourse rather than a validated ADHD-specific entity. As Hacking notes, such loops can be both generative—opening new possibilities for self-understanding and collective mobilisation—and constraining, reifying categories that may lack strong empirical support.

Studies of terminology preferences in neurodiversity contexts demonstrate that linguistic choices signal moral alignment and cultivate trust (35, 39). Choosing identity-first language (e.g., "autistic person") versus

person-first language (e.g., "person with autism") functions as a cue for the values a speaker holds. When masking discourse is presented alongside this linguistic economy—often in materials that forefront identity-first terminology, critique medical models, and centre lived experience—endorsement of the construct begins to mark ethical competence. To question validity becomes culturally uncomfortable before evidence has consolidated. Tact succeeds when dissent risks social sanction (32)

Two concrete mechanisms illustrate how engineering, tactics, and looping translate into institutional practice. First, measurement follows vocabulary rather than leading it. In the absence of ADHD-specific instruments, autism-derived metrics are used as proxies; their outputs are then treated as confirmatory information about ADHD. Reviews from autism caution that camouflaging has heterogeneous measurement traditions with modest agreement between methods; nevertheless, the presence of numeric scores supplies an aura of objectivity that encourages clinical and policy uptake. Numbers confer authority, even when their construct validity remains uncertain.

Secondly, formats of professional education increasingly integrate service-user narratives through co-production models. This integration is ethically appropriate and should continue, yet it also means that the conceptual frames within which narratives are solicited and presented can prime both clinicians and participants toward stories that fit emergent categories. Over time, such stories populate guidelines, patient information materials, and training curricula, creating infrastructures of expectation wherein both providers and patients learn to recognise and report masking. Jasanoff's (40) concept of co-production highlights that facts and social orders are made together: an accepted vocabulary opens some lines of inquiry whilst foreclosing others. Latour's (41) analysis of scientific stabilisation similarly traces how claims gain durability by being enrolled in networks of texts, metrics, and institutions that mutually reinforce them, independent of empirical robustness.

In summary, the rapid consolidation of masking in adult ADHD discourse exemplifies a broader pattern wherein belief can be responsibly engineered under evidential constraint. Communication aligns the concept with widely shared moral commitments; ready-made instruments from autism provide immediate (if imperfect) measurement tools; looping effects give the concept experiential density; and institutional incorporation stabilises it. None of this renders the concept illegitimate, nor does it imply that compensatory labour in ADHD is unreal or unimportant. It does, however, oblige candour about the current evidence base. The present justification for using the term is ethical and pragmatic as it helps clinicians notice hidden effort, validates patient experiences, and motivates harm-reducing practices. The evidential warrant though remains provisional because measurement in ADHD lacks specificity, discriminant validity, and demonstrated predictive utility beyond established variables.

3 FUTURE DIRECTIONS

The critiques articulated above do not negate the phenomenological reality that individuals with ADHD engage in effortful attempts to modify behaviour in social contexts, nor do they dismiss the psychological costs associated with such efforts. Rather, these arguments challenge the sufficiency of computational frameworks derived from autism research for capturing the distinct aetiological and mechanistic features of ADHD camouflaging. The absence of clear diagnostic awareness and articulated stigma consciousness in many individuals who engage in compensatory labour suggests that alternative motivational frameworks may be required—emphasising internalised shame, social confusion, chronic negative feedback accumulation, perfectionism, anxiety-driven behavioural avoidance, or identity-level distress rather than strategic stigma mitigation.

The neurocognitive limitations characteristic of ADHD require us to reconceptualise impression management not as sophisticated Bayesian inference involving iterative belief updating and recursive error minimisation, but potentially as reliance on more rigid, heuristic-driven strategies that demand minimal working memory and executive control. Livingston and Happé's distinction between "shallow" and "deep" compensation provides a useful framework. Shallow compensation involves simple, inflexible strategies—rote scripts, surface-level imitation, rehearsed phrases—that may suffice in structured, predictable contexts but break down rapidly when confronted with novelty, ambiguity, or high cognitive load. Deep compensation involves recruitment of alternative cognitive resources (e.g., using strong verbal reasoning to compensate for weak implicit social understanding) and permits more flexible, context-sensitive adaptation.

Given ADHD neurocognitive constraints, individuals may predominantly rely on shallow compensation strategies: memorising standard conversational openers, avoiding unstructured social situations, deploying environmental scaffolds (timers, reminders, lists) that reduce organisational demands, or adopting rigid behavioural routines that forestall the need for flexible real-time decision-making. These strategies align with the heuristics-driven route depicted in Ai and colleagues’ wherein incompatible priors and prolonged unsuccessful error optimisation lead actors to reinstate low-resolution, “fail-safe” behavioural scripts that maximise positive feedback and portray superficial adjustment, even if they do not achieve genuine social alignment. Critically, this heuristics-driven route bypasses the sophisticated iterative inference processes that the Bayesian model emphasises, instead relying on learned behavioural routines that minimise computational demands.

3.1 Research:

This reconceptualisation has implications for how camouflaging-like phenomena in ADHD should be understood and researched. Rather than treating ADHD individuals as engaging in the same computational processes as autistic individuals (but perhaps less effectively), researchers might productively investigate whether ADHD compensatory strategies constitute qualitatively different mechanisms—less reliant on social inference and belief updating, more dependent on rigid environmental structuring, external cueing, and anxiety-driven avoidance. Such strategies may be “compensatory” in enabling functional outcomes whilst simultaneously being effortful, fragile, and psychologically costly, without necessarily constituting “camouflaging” in the Bayesian-computational sense.

Progress will depend on building ADHD-specific instruments with clear construct boundaries and rigorous psychometric validation. Instruments should be developed with lived-experience input through co-production methodologies, but must then be tested against ordinary psychometric standards: internal consistency reliability, test-retest stability, structural validity (stable factor structures across samples), measurement invariance (equivalent functioning across sex, age, culture, and comorbidity profiles), convergent validity (appropriate correlations with theoretically related constructs), and discriminant validity (separation from social anxiety, perfectionism, general impression management, and anxiety-driven safety behaviours) .

Critically, item content must be grounded in ADHD phenomenology rather than imported from autism. Items should address ADHD-specific compensatory behaviours: forcing sustained attention during conversations, suppressing fidgeting or restlessness in formal settings, deploying extensive organisational scaffolds to meet deadlines, rehearsing time-management strategies, avoiding situations requiring prolonged focus, and monitoring oneself for signs of losing conversational threads. Items should distinguish concealment of ADHD symptoms from general impression management or social anxiety. Cognitive interviewing and think-aloud protocols during instrument development would help ensure items capture intended constructs and hold equivalent meaning across demographic subgroups.

Longitudinal designs are essential for testing whether ADHD-specific camouflaging predicts meaningful outcomes over time. Does elevated camouflaging at baseline predict delayed help-seeking, later internalising morbidity, poorer treatment response, relationship difficulties, occupational impairment, or burnout, after accounting for baseline ADHD severity, comorbid anxiety and depression, and demographic characteristics? Such demonstrations would establish incremental predictive validity and justify treating camouflaging as a clinically relevant phenomenon beyond a repackaging of known predictors. Additionally, experience-sampling or ecological momentary assessment studies could examine moment-to-moment fluctuations in compensatory effort, tracking within-person variability in camouflaging across contexts and its associations with acute distress or fatigue.

Comparative studies directly contrasting ADHD-specific instruments with autism-derived measures would clarify whether the constructs are empirically separable and whether ADHD individuals’ endorsement of autism instruments reflects construct overlap, generic impression management, or measurement artefact. Such studies should include autistic individuals, individuals with ADHD, individuals with co-occurring autism and ADHD, and neurotypical controls, permitting examination of whether camouflaging constructs show discriminant validity across diagnostic groups (van der Putten et al., 2024). Finally, intervention studies examining whether reductions in putative camouflaging (through cognitive-behavioural interventions targeting perfectionistic self-presentation, psychoeducation normalising ADHD behaviours, or environmental accommodations reducing compensatory demands) improve wellbeing would provide causal evidence of

clinical relevance.

3.2 Clinical Practice

Clinical practice can and should acknowledge compensatory and hidden effort without presuming that these phenomena constitute a validated ADHD-specific construct or that autism-derived instruments measure ADHD camouflaging. The immediate task is to enhance the completeness and transparency of adult ADHD assessment rather than replacing established diagnostic requirements with explanations for limited observable impairment that risk circularity. Thorough assessment should foreground developmental course, cross-situational pervasiveness, and functional interference, actively seeking collateral information and alternative explanations, in line with guidance such as NICE NG87 (42).

Within this framework, clinicians can elicit, document, and monitor sustained compensatory effort as an ethically important dimension of lived experience whilst maintaining conceptual separation from unvalidated "masking" scores. History-taking benefits from explicit, concrete questions about effort, scaffolding, and recovery: How much planning and self-monitoring are required to complete ordinary tasks? Which external aids (calendars, timers, reminders, written instructions) are essential? What level of fatigue, irritability, or mood change follows socially or occupationally demanding days? How much time is spent preparing for interactions, organising materials, or anticipating potential difficulties? Qualitative accounts indicate that adults meeting clinical thresholds often describe rigid scheduling, rehearsed scripts, and strategic avoidance as tiring and only partly effective (. Incorporating this granularity into routine history-taking allows reports of effort to inform, but not dictate, diagnostic judgement.

Collaboration with informants remains essential. Because ADHD diagnosis requires evidence of pervasiveness and functional interference, services should prioritise collateral information across settings rather than inferring "masking" to explain limited observable impairment. School reports, workplace performance records, attendance data, and accounts from partners or close colleagues help distinguish sustained compensation from setting-specific accommodation or normal variability. This approach aligns with established guidance and resists circular reasoning wherein unobserved impairment is attributed to masking rather than investigated through multi-source information.

Neuropsychological testing should be interpreted in light of compensatory histories. Case-series evidence suggests that age, education, and developed compensatory routines may obscure deficits on selected tasks (43). Where performance appears adequate despite extensive scaffolding, reports should explicitly state how practice effects, routines, and structuring may have supported performance, avoiding reification of apparently intact scores as definitive proof of absence of impairment. This transparency guards against both over-pathologising and unwarranted reassurance.

Monitoring effort as a patient-centred outcome can improve care without reifying constructs. Clinicians can document perceived effort alongside symptom ratings, particularly when treatment reduces compensatory workload without dramatic score changes. Lived-experience accounts describe meaningful relief when constant self-control demands ease, even if performance indices move modestly (Palmini, 2008). Recording effort qualitatively (e.g., "reports less post-interaction exhaustion; estimates two fewer hours of evening recovery after work compared with baseline") signals valued outcomes without over-interpreting numeric change.

Comorbidity assessment requires particular care. Anxiety disorders, social anxiety, trauma-related hypervigilance, and perfectionistic personality features all increase impression management and behavioural suppression. Clinicians should screen systematically for mood and anxiety disorders and relevant personality features, formulating how these conditions interact with ADHD rather than attributing all concealment to an ADHD-specific process. Importantly, services should avoid using autism-derived camouflaging questionnaires as stand-alone indicators of ADHD severity or as post hoc warrants for diagnosis lacking corroboration across settings.

Communication with patients should make the evidential situation explicit. Clinicians can acknowledge that services take reports of compensation strategies seriously and will inquire about sustained effort, supports, and exhaustion, whilst explaining that secure ADHD diagnosis requires evidence of early onset, cross-situational interference, and exclusion of alternatives. Presenting assessment in this manner balances testimonial justice with diagnostic discipline, reduces miscommunication, and avoids implying that endorsement of "masking" terminology substitutes for rigorous and quality assessment.

At organisational levels, templates for documentation can include narrative fields inviting description of compensatory effort and recovery, standardising attention to lived experience whilst keeping emphasis on developmental course and cross-situational impairment. Staff training can emphasise eliciting detailed accounts of routines and scaffolds, avoiding circular reasoning, and discussing uncertainty without diminishing patient reports. Services can adopt transparent policies: autism-derived camouflaging instruments will not confirm ADHD diagnosis, but service users may describe costs of sustained organised performance in their own terms. Where research programmes exist, co-production with individuals reporting high compensatory effort can guide ADHD-specific tool development that is then psychometrically tested rather than assumed valid by analogy.

3.3 Reconceptualisation

Future theoretical development might productively integrate insights from the dialectical misattunement hypothesis, which emphasises bidirectional, transactional processes in cross-neurotype interactions, whilst adapting models to accommodate the specific profile of executive dysfunction, attentional variability, and motivational differences characterising ADHD. The dialectical misattunement hypothesis proposes that social difficulties emerge not solely from individual neurocognitive differences but from reciprocal failures in mutual adjustment between neurodivergent and neurotypical interactors, accumulating over developmental time as both parties struggle to predict and respond to one another’s behaviours (Bolis et al., in press).

This framework aligns well with ADHD phenomenology: neurotypical peers and authority figures may struggle to predict ADHD individuals’ lapses in attention, impulsive remarks, organisational failures, or inconsistent follow-through, leading to frustrated or punitive responses; ADHD individuals, in turn, struggle to predict the social consequences of their behaviours due to executive function and learning constraints, leading to repeated social failures and accumulated negative self-perceptions. Over time, these reciprocal prediction failures create a “dialectical misattunement” wherein ADHD individuals develop rigid compensatory strategies (not sophisticated Bayesian inferences) in attempts to forestall negative responses, whilst neurotypical interactors develop lowered expectations or avoidant stances. Importantly, this transactional framing avoids locating pathology exclusively within ADHD individuals and instead highlights how social environments often fail to accommodate ADHD communication and organisational styles, exacerbating difficulties.

Critically, the dialectical misattunement hypothesis does not require that actors engage in sophisticated computational processes involving recursive belief updating and iterative action search. Instead, it emphasises that repeated failures in mutual prediction and coordination create cumulative social strain that both parties experience as effortful and unrewarding. ADHD individuals may respond to this strain through heuristic-driven compensatory strategies, anxiety avoidance, or rigid behavioural scripts—none of which necessitate intact executive functions or Bayesian inference capacities. This modified framework better accommodates ADHD neurocognitive constraints whilst preserving the transactional, context-dependent emphasis that distinguishes contemporary approaches from earlier deficit models.

4 CONCLUSION

This paper has argued that the application of Bayesian computational frameworks developed for autism to ADHD contexts encounters three fundamental classes of problems. First, motivational incompatibilities: the presumed role of stigma awareness as driver of strategic concealment fails to account for widespread pre-diagnostic masking and the distinct, often poorly articulated nature of ADHD stigma. Second, neurocognitive incompatibilities: the executive function deficits characteristic of ADHD directly contradict the computational demands—working memory maintenance, sustained inhibitory control, consistent self-monitoring, flexible belief updating, and metacognitive regulation—specified by Bayesian models of iterative social inference. Third, construct validity deficits: the measurement instruments, sampling strategies, theoretical boundaries, and predictive validity of “ADHD camouflaging” remain insufficiently specified to support strong claims in clinical and research contexts.

The swift consensus surrounding ADHD camouflaging reflects not robust empirical validation but “human engineering”: the tactful synthesis of personal testimony, moral rhetoric, and scientific language that secures agreement in the absence of strong evidence. This process involves looping effects wherein classifications reshape the experiences they purportedly describe, institutional embedding of vernacular tactics as formal

strategies, and moral-political framings wherein questioning construct validity risks social sanction. These mechanisms are not unique to ADHD camouflaging; they characterise many instances wherein concepts achieve rapid uptake across clinical, research, and public spheres despite fragile evidential bases.

Importantly, acknowledging these dynamics does not entail dismissing compensatory labour or hidden effort as unimportant, fabricated, or clinically irrelevant. The phenomenological accounts documenting elaborate scaffolds, sustained self-monitoring, chronic exhaustion, and the relief experienced when compensatory demands ease are valuable and deserve serious clinical attention. What is at stake is not whether ADHD individuals engage in effortful self-regulation—they clearly do—but whether current theoretical frameworks, measurement instruments, and construct specifications adequately capture these phenomena in ways that advance understanding, improve outcomes, and avoid conceptual drift.

The field stands at a crossroads. One path involves reifying “masking” as an established ADHD construct despite unresolved measurement and validity questions, risking diagnostic confusion, circular reasoning, and misplaced research priorities. The other path involves transparent acknowledgement of current evidential limitations, investment in rigorous ADHD-specific instrument development and longitudinal validation, and clinical practices that honour compensatory labour without presuming its measurement through autism-derived tools constitutes evidence of a validated ADHD-specific phenomenon. Clinicians should resist treating camouflaging scores as diagnostic indicators in ADHD, avoid invoking masking to explain away diagnostic uncertainties, and prioritise multi-informant developmental histories that directly assess pervasiveness and impairment. Researchers should develop ADHD-specific instruments grounded in phenomenology, test discriminant validity against adjacent constructs, demonstrate measurement invariance, and establish incremental predictive utility through longitudinal designs.

Until such work matures, the most defensible stance is to treat compensatory effort and impression management in ADHD as important dimensions of assessment and care—warranting careful inquiry, documentation, and response—whilst recognising that “camouflaging” or “masking” in ADHD remains an underspecified construct whose current acceptance outpaces its empirical foundation. This stance balances testimonial justice and harm reduction with intellectual honesty about what is currently known, unknown, and methodologically achievable. It acknowledges the ethical weight of lived experience whilst insisting that measurement in ADHD meet ordinary scientific standards before being treated as authoritative. In so doing, it honours both the experiences of ADHD individuals and the evidential standards that safeguard against premature reification of constructs whose validity remains contested.

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