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Guest Editorial

Camouflaging in ADHD: the need for construct validation before clinical adoption

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Summary

This editorial argues that camouflaging, as developed in autism research, does not transfer coherently to attention-deficit hyperactivity disorder (ADHD). The executive functions required for sustained symptom concealment are precisely those impaired in ADHD. Current measures lack ADHD-specific validity, and compensatory behaviours should not be reclassified as camouflaging without dedicated theory, operational definitions and validated measurement.

Keywords

Camouflaging; masking ADHD; executive dysfunction; construct validity; compensatory strategies.

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The concept of social camouflaging has gained prominence in autism research,[1] and recently appears with increasing frequency in discussions of attention-deficit hyperactivity disorder (ADHD). Operationally defined, camouflaging refers to strategic modification of behaviours intended to reduce the visibility of neurodevelopmental differences. Whereas ongoing debates exist regarding diagnostic boundaries and phenotypic heterogeneity in ADHD, the analysis here examines camouflaging discourse within current clinical frameworks rather than adjudicating diagnostic validity. One can speculate that social camouflaging has transferred from autism to ADHD because these conditions are positioned as closely related neurodevelopmental diagnoses with substantial overlap. Their shared framing as dimensional, lifelong traits without clear boundaries between typical and disordered presentation encourages explanations and assumptions of similar lived experience. This has enabled constructs such as camouflaging to migrate from autism to ADHD, despite limited ADHD-specific empirical evidence.

In ADHD, these behaviours are said to consist of effortful acts designed to hide core symptoms or the condition's presence, including suppressing hyperactivity, restraining impulsivity or employing perfectionistic strategies to appear competent and controlled.

Within camouflaging frameworks, the driver of such motivation has been attributed to reducing stigma. From this perspective, people recognising themselves as belonging to a stigmatised group may engage in a form of deliberate impression management to avoid negative social comments or consequences. Recent literature has placed autistic camouflaging within established frameworks of impression management.[2] According to these, through Bayesian models of social prediction, people adjust their behaviour through iterative cycles of prediction, observation and refinement as they form expectations about others' responses, evaluate feedback and modify their future behaviour to fit with anticipated social norms.

However, we argue that the rapid acceptance of camouflaging as a construct in ADHD has outpaced the empirical foundation supporting its validity, or its measurement properties, and clinical utility. This editorial argues that transposing the concept from autism to ADHD brings with it three classes of problem: first, motivational incompatibilities, wherein the presumed role of stigma awareness as a driver of strategic hiding of symptoms does not adequately account for the distinct phenomenology of ADHD-related stigma; second, neurocognitive incompatibilities, wherein the executive function deficits characteristic of ADHD directly contradict the computational demands as described by Bayesian models of impression management; and third, construct validity deficits, wherein the measurement instruments used, sampling strategies that underpin them and theoretical boundaries of 'ADHD camouflaging' remain insufficiently defined to support the strength of claims increasingly made in clinical and even research contexts.

Motivational incompatibilities: stigma without strategic concealment

It is not contested that stigma in ADHD is pervasive and socially consequential, evident through public, self and structural mechanisms. Public stigma reflects enduring misconceptions construing ADHD as laziness or irresponsibility rather than as a legitimate neurodevelopmental disorder. Self-stigma arises when negative feedback from others is internalised, producing shame and anxiety. Quantitative research demonstrates that approximately one in four adults with ADHD report high levels of internalised stigma, and nearly 90% anticipate discrimination in daily life. Structural stigma operates at institutional levels through lack of recognition of the diagnosis, professional scepticism about it and systemic barriers to recognition and treatment.

The core point is that, although stigma around ADHD is well recognised, its psychological role is not the same as the deliberate, consciously computed concealment assumed in Bayesian accounts of camouflaging. Public and internalised stigma may intensify efforts to modify behaviour, but these actions arise as automatic responses to persistent negative feedback rather than as intentional attempts to hide a known diagnostic identity. A person cannot strategically mask a condition of which they have no awareness, and their behavioural changes reflect unconscious adjustment rather than purposeful concealment grounded in a precise self-representation. This distinction matters, because Bayesian models rely on an element of conscious intentionality for such behavioural computations to occur.

In autism, on the other hand, camouflaging arises from clearly conceptualised awareness of difference. Autistic people recognise specific features (reduced eye contact, monotone speech repetitive gestures) for which negative external feedback had been given, and can then consciously modulate their behaviour in anticipation to that negative social feedback. This process does fit with Bayesian models wherein stigma awareness operates as a high-level prior (meaning already having an overarching belief or expectation that

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shapes how new information is interpreted), therefore guiding predictive modelling and iterative refinement of self-presentation.[2]

However, in ADHD, changes to behaviour do not have this metacognitive structure and inferential sophistication. They originate not from explicit prediction of others' judgements in real time but from affective conditioning shaped by chronic criticism. For example, people repeatedly characterised as careless or unreliable develop enduring anxiety regarding competence and control. The compensatory behaviours that can be developed as a result – for example, over-preparation, overcompensation and hypervigilant self-monitoring – are instead reactive attempts to prevent disorganisation or reproach, not strategic acts of hiding symptoms. In short, their patterns of adaptation reflect emotional response to social threat (are more unconscious) rather than rational impression management (computational and strategic).

The contrast in adaptive behaviours between the two conditions can be sharpened by examining the level of predictive detail that guides behavioural change. In autism, camouflaging is driven by previous knowledge about which specific and observable behaviours evoke negative responses, which allows intentional and finely tuned adjustments of social presentation. In ADHD, the signalling environment is far less precise: stigma is delivered through diffuse and inconsistently reinforced feedback that is framed in moral terms rather than tied to identifiable behaviours. People with ADHD often struggle to consistently link specific actions to consequences. Their adaptive behaviours are therefore a lot more inconsistent, individualised and thus rely on broad behavioural rules such as working harder, checking repeatedly or avoiding lateness. These responses may reduce the likelihood of failure, but they do not involve the stepwise prediction error correction that Bayesian models require, nor do they reflect a systematic process of modelling specific social contingencies.

In summary, stigma in ADHD generates non-strategic, affectively driven adaptations shaped by diffuse criticism whereas autistic camouflaging relies on intentional, belief-guided adjustment rooted in precise awareness of specific social cues. This divergence means that applying autism-derived camouflaging terminology to ADHD lacks conceptual validity, because the motivational architecture of ADHD does not support the deliberate, belief-updating processes central to genuine camouflaging. The evidence shows that ADHD responses reflect unconscious global effort rather than strategic impression management, and that the autism model presupposes metacognitive precision that ADHD stigma does not produce. Using autism-based terminology therefore obscures these mechanistic differences and risks mischaracterising the lived experience associated with ADHD.

Neurocognitive incompatibilities: the executive dysfunction paradox

The proposition that people with ADHD can effectively camouflage the disorder's core symptom domains – for example, sustained inattention, impulsivity and hyperactivity – is incompatible with the accepted neurocognitive architecture of the condition. ADHD affects the functional domains required for self-regulation, goal maintenance and real-time behavioural adaptation, and therefore the cognitive mechanisms needed for camouflaging are structurally and functionally impaired.

Meta-analytic evidence confirms medium to large deficits across executive domains relevant to behavioural control. Pievsky and McGrath[3] synthesised 253 standardised mean differences from 34 meta-analyses and identified significant impairments in response inhibition ($d = 0.52$), working memory ($d = 0.54$), planning and organisation ($d = 0.51$), vigilance ($d = 0.48$) and variability in reaction time ($d = 0.66$). These findings demonstrate that ADHD is characterised by instability in the cognitive control system responsible for sustaining attention and regulating action over time.

Barkley's[4] seminal model of executive dysfunction identifies deficient behavioural inhibition as the central deficit from which secondary impairments develop, including dysfunctions in working memory, self-regulation of affect and motivation, and reconstitution. Together, these deficits undermine the metacognitive processes required for intentional or real-time self-control. Without consistent inhibition and working-memory updating, people with ADHD cannot retain representations of social expectations in real time, suppress automatic behaviours or flexibly adapt their actions in light of feedback to avoid stigma, all necessary preconditions for deliberate camouflaging.

From a computational perspective, sustained symptom concealment in ADHD would demand four sequential executive operations in real time: conscious recognition of one's behaviour as socially undesirable; maintenance of that representation in working memory while monitoring ongoing performance; inhibition of the prepotent response; and adjustment of behaviour in response to feedback. Each operation, according to the evidence base, is impaired in ADHD. Working-memory impairments reduce the ability to maintain self-representations across time, inhibitory deficits impair suppression of impulsive responses, attentional inconsistency fragments self-monitoring and planning deficits impede anticipatory structuring of behavioural strategies.

The argument is, therefore, that a person with ADHD can hide their core symptoms in real time is self-refuting: the mechanisms required to hide ADHD are the same mechanisms the disorder disables. What may appear as camouflaging is in fact short-lived, effortful modulation of general behaviours rather than genuine suppression of core symptoms. Consequently, when ADHD symptoms are present at diagnostic threshold, they will inevitably manifest during a competent clinical assessment and cannot be claimed to have been hidden.

Construct validity deficits: measurement without validation

Beyond motivational and neurocognitive challenges, applying camouflaging frameworks to ADHD presents fundamental construct validity problems. The question is not whether adults with ADHD deploy compensatory strategies, but whether 'camouflaging' as currently described in ADHD constitutes a valid, measurable and discriminable construct that adds to understanding beyond well-recognised compensatory behaviours.

Current literature on ADHD camouflaging relies overwhelmingly on instruments developed within autism research, most prominently the Camouflaging Autistic Traits Questionnaire (CAT-Q).[5] By design, CAT-Q items operationalise domains derived from autistic adults' descriptions of managing social communication demands. When applied to adults with ADHD it captures self-reported social effort, but its content validity remains anchored to autistic phenomenology rather than to ADHD-specific behavioural patterns.

Even within autism, systematic reviews highlight that the concept of camouflaging itself is heterogeneous, with modest concordance between measurement approaches and reliance on cross-sectional designs.[1] When autism-derived tools are applied to ADHD, interpretation requires even greater caution. Van der Putten and colleagues[6] compared adults with autism, ADHD and neurotypical controls using an autism-based camouflaging measure. Participants with ADHD showed greater camouflaging than controls but less than those with autism, and autism traits were stronger predictors of

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camouflaging scores than ADHD traits. This demonstrates that variance captured by autism-specific instruments is driven predominantly by autistic characteristics rather than by ADHD symptoms.

Several methodological limitations constrain conclusions in the very few studies that refer to ADHD camouflaging. Sampling frequently draws on online convenience samples likely to overrepresent people already primed by neurodiversity discourse. These participants may both retrospectively reinterpret adaptive behaviours through a camouflaging lens and represent a subset of individuals more invested in neurodevelopmental identity, limiting generalisability.

Another concern involves discriminant validity: the extent to which camouflaging can be distinguished from other conditions. Social anxiety, generalised anxiety, trauma-related hypervigilance and trait perfectionism each increase self-monitoring and effortful self-presentation. Without explicit tests against these alternatives, attributing changes in behaviour to ADHD camouflaging cannot be supported.

Furthermore, ambiguity in definition undermines construct validity. In current usage, camouflaging variously denotes concealment of symptoms, compensatory routines, impression management, anxiety-driven safety behaviours and perfectionistic over-preparation. Without operational boundaries, the term becomes a container for heterogeneous presentations, encouraging category expansion rather than conceptual clarity. Most importantly, there currently exists no ADHD-specific construct of camouflaging with established measurement theory, discriminant validity and longitudinal predictive value.

Taken together, these gaps indicate that camouflaging cannot be regarded as a valid construct within ADHD research until it is defined with clear operational boundaries, measured with ADHD-specific instruments that demonstrate content, discriminant and predictive validity and is shown to explain behaviour in ways not already accounted for by established compensatory mechanisms or comorbid conditions.

Human engineering: belief ahead of evidence

Considering the clear lines of enquiry discussed above showing that the concept of masking in ADHD is clearly problematic, one would like to theorise why the concept achieved such swift acceptance despite its limited empirical base. As part of such sociological enquiry, Derksen's[7] concept of 'human engineering' provides such a means of engagement because, precisely, the concept describes the deliberate integration of personal testimony, moral rhetoric and scientific language to generate consensus in the absence of decisive evidence. Within this framework, ideas gain traction not primarily because they withstand empirical scrutiny but because they resonate with shared ethical and professional norms.

It can be proposed that the accounts of people describing effort to develop adaptive behaviours, exhaustion and pursuit of social acceptance speak directly to clinicians' moral sensibilities. They evoke empathy and fit with contemporary imperatives of inclusivity. The discourse of camouflaging therefore expands through moral sentiment rather than empirical rigour, because it feels compassionate and congruent with professional virtue.

Hacking's[8] analysis of looping effects clarifies how this dynamic unfolds once a morally appealing but empirically uncertain construct enters clinical circulation. Human classifications do not simply describe stable, unchanging types but actively shape how people interpret their own behaviour, respond to the label and consequently modify the very phenomenon that the classification was meant to capture. Once clinicians, patients and researchers adopt these definitions, they reshape behaviour, self-understanding and even data production for research. Clinicians begin asking questions framed by the new construct; patients internalise this framework and articulate experiences through its vocabulary; and researchers design instruments calibrated to detect these newly articulated experiences. The resulting data appear to confirm the construct, not because it demonstrates discriminant validity but because the classification has already shaped what is noticed, expressed and measured. It would appear that such a journey has already started in relation to the concept of camouflaging in ADHD.

Clinical and research implications

Whereas the discussion above has placed the concept of ADHD camouflaging on an evidence-based basis, there are some implications in relation to clinical practice that need to be discussed. One important implication is that effort in adaptive behaviours in ADHD should be recognised as real, but should not be reinterpreted as evidence for an ADHD-specific camouflaging construct. Such behaviours should be understood as compensatory approaches that developed over many years and are there to provide support, not to hide core ADHD symptoms. Diagnostic assessments must remain centred on developmental history, the presence of symptoms across situations, functional impairment and the exclusion of alternative causes following the structure of diagnostic criteria.

When people state that they camouflage ADHD symptoms, they are usually describing the internal experience of strain, shame or overcompensation, not deliberate suppression of core symptoms. These reports indicate burden and threat sensitivity rather than concealed diagnostic-level impairment. They should inform formulation by identifying pressure points and emotional cost, but should not be treated as evidence that ADHD symptoms exist but are intentionally hidden.

At the service level, autism-derived camouflaging tools should not be used to draw inferences about ADHD. Measures such as CAT-Q lack content validity for ADHD. Their use risks interpretive error, especially in individuals with anxiety, trauma-related vigilance or perfectionistic tendencies.

For research, the field cannot proceed by importing constructs from autism without theoretical rationale. Any future model of ADHD camouflaging must be consistent with the disorder's neurocognitive profile, which includes instability in working memory, inhibition, vigilance and self-monitoring. A viable construct requires a clear account of how behavioural concealment could occur within such limitations, and must demonstrate that the construct is empirically distinguishable from impression management, social anxiety, trauma-related hypervigilance and perfectionism.

The discussion here has argued that applying camouflaging frameworks to ADHD is not supported at the psychological, cognitive or construct validity levels. Psychologically, behaviours described as camouflaging in ADHD do not arise from real-time deliberate concealment informed by stigma awareness. They emerge from patterns of criticism, affective conditioning and attempts to avert failure over many years, lacking the intentional structure assumed in camouflaging models of autism. Cognitively, the executive function profile of ADHD is incompatible with the sustained, strategic behavioural modulation that camouflaging requires. At the level of construct validity, existing formulations rely on autism-derived instruments, conflate heterogeneous behaviours and do not demonstrate discriminant validity from anxiety-related hypervigilance, perfectionistic striving or general impression management.

Recognition of adaptive behaviours remains clinically and ethically important, but this does not justify treating autism-derived tools or concepts as validating ADHD-specific behaviours.

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Clinicians should recognise adaptive behaviours as an indicator of chronic emotional strain, but reports of camouflaging should not be interpreted as evidence that diagnostic-level symptoms are being suppressed. For research, the task is to determine whether an ADHD-specific construct of camouflaging is theoretically coherent and empirically separable. Until these requirements are met, the construct remains insufficiently defined for clinical use. The field should acknowledge and explore compensatory effort while maintaining conceptual clarity and evidential discipline.

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