ISSN 1998 – 409X

REVIEW ARTICLE

"Just to Survive": Masking as Gendered Performance among Women with ADHD in Chennai

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Abstract

Masking, the suppression or camouflaging of neurodivergent traits to meet neurotypical expectations, is well documented in autism but remains undertheorised in attention-deficit/hyperactivity disorder (ADHD), particularly outside Western contexts. This study examined the lived experience of masking among adult women with ADHD in Chennai, India, and asked how that experience is shaped by gender. Interpretative phenomenological analysis was applied to semi-structured interview material from 10 women aged 23–30, all formally diagnosed with ADHD. The sample was evenly divided between mental-health professionals or advanced trainees (n = 5) and women from non-clinical backgrounds (n = 5), a distinction used analytically. Analysis was conducted through a feminist mental health framework. Three superordinate themes were developed: Masking as gendered socialization, learned in childhood through family correction, school discipline, and culturally specific expectations of feminine composure; the phenomenological cost of sustained masking, in which anxiety functioned as a substitute for executive function and the effort of daily presentation management produced burnout and self-erosion; and the role of masking in defeating clinical recognition, including among clinically literate participants and their own clinicians. Masking in these accounts was not an individual coping choice but a condition imposed by gendered social expectation, shaped by the particular pressures of the Chennai context, including family achievement expectations, conservative gender-role norms, in-law dynamics, and stigma around neurodevelopmental difference, maintained at significant personal cost and invisible enough to defeat clinical detection. The findings carry implications for clinical assessment, for how masking is theorized in ADHD, and for addressing the long-term costs of diagnostic delay in Indian healthcare contexts.

Key words: Attention-deficit/hyperactivity disorder, camouflaging, gender, India, interpretative phenomenological analysis, masking, women

INTRODUCTION

Masking in attention-deficit/ hyperactivity disorder (ADHD)

Masking refers to the suppression of neurodivergent traits and the substitution of socially expected behavior. The construct originates in the autism literature, where camouflaging have been characterised as the effortful management of a neurotypical presentation.[1,2] Its extension into ADHD research has been recent and uneven, but masking is increasingly recognize as central to understand why ADHD is missed disproportionally in women, whose symptom profile are more often inattentive and internalized then overtly hyperactive.[3,4] Where hyperactivity is internalized, the outward sign that prompts referrals is absent, and the labor of appearing unimpaired become invisible for observers, to clinicians, and frequently to the women herself.[5]

Gender and the social production of masking

Masking is not a biological feature of ADHD; it is a response for expectation. The more internalized presentation

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Received: 22-08-2026
Revised: 23-09-2026
Accepted: 30-09-2026

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associated to women is, in significant part, the product of differential socialization: Girls are rewarded for composure and compliance, and the social costs of non-compliance are higher than for boys. A feminist mental health framework reframes masking as the expected female response to a neurotypical social order calibrate around masculine norms.[6] Its costs are structurally produced: Women perform a normality more harder for them to sustain, and they pay in ways that remain unseen.[7] This study takes that reframing as its starting point.

The Indian context and the research gap

Research on masking in South Asian populations is close to absent.[8] In Chennai, gendered ideals of female composure, academic achievement, and domestic competence operate with particular intensity. The South Indian academic environment, with its focus on board examinations, engineering and medical tracks, and competitive postgraduate entry, create a pressure-cooker in which masking is necessary for survival.[9] The patriarchal structures of the extended family impose further demands: Managing domestic routines, remembering festival obligations, perform the role of the "ideal daughter-in-law." Stigma around neurodevelopmental differences remains considerable, and ADHD disclosure carry perceived risks in the matrimonial market.[10] This study ask: How do women with ADHD in Chennai experience masking, and how are that experience shaped by gender?

METHODS

Design

The study uses interpretative phenomenological analysis (IPA)[11] from a constructivist epistemology. IPA's double-hermeneutic stance, in which the researcher makes sense of the participant making sense of her experience, allows analysis to reach for what masking feels like before participants had language for it. Because masking render experience invisible by definition, a method orient to recovering submerged meaning are appropriate.

Participants

Ten women aged 23–30, all connected to Chennai and formally diagnosed with ADHD, takes part. Five were mental-health professionals or advanced trainees; five came from non-clinical backgrounds. This division is best understood not as a clean dichotomy but as a proxy for a spectrum of clinical literacy: Familiarity with neurodivergence concepts acquire through formal training, workplace exposure, or lived diagnosis. One participant (P1) related her entry into a psychology-adjacent field with her diagnostic history; another (P5), non-clinical by profession, acquired clinical vocabulary through work at a mental-health organisation. The analytic question was whether clinical literacy shapes how masking is narrated, or whether the underlying experience transcends it. Participant characteristics are in Table 1.

Data collection

Semi-structured interviews were conducted online, audio-recorded with informed consent. Participants use English, Tamil, or both. The guide covered the diagnostic journey, gendered experiences, and coping strategies. These focus elicited rich phenomenological accounts of masking; relevant material was identified through iterative returns to all ten transcripts.

Analysis

Analysis followed Smith *et al*.: Close reading, line-by-line coding, pattern identification across cases, theme development, and interpretation through the double hermeneutic.[11] The researcher conducted all coding and thematic clustering. Participants are referred to as P1 to P10.

Reflexivity

The researcher shares the diagnostic profile of participants, a resource enabling contextual sensitivity and a risk of confirmatory reading. Several participants arrived with fluent clinical vocabulary, which was treated as a starting point rather than endpoint, with experiential probes used to access the pre-conceptual accounts beneath it.[12]

RESULTS

Three superordinate themes are presented below, each with illustrative extracts. All extracts are lightly edited for readability while preserving meaning. Participants' grouping by clinical literacy [MHP or non-MHP, as summarized in Table 1] is noted where it bears on interpretation.

Theme 1: "Stay in One Spot," masking as gendered socialization

Across these accounts, masking did not begin with diagnosis or with a clinical encounter. It preceded both, by years in some cases, by decades in others, and was learned in childhood and adolescence in response to specifically gendered expectations about how girls should present, behave, and regulate themselves. The mask was assembled long before anyone had a name for what it concealed.

Early suppression of behavior coded as unfeminine

The earliest layer was the suppression of behavior coded as unfeminine or socially disruptive. P1 located the difference

Table 1: Participant characteristics (anonymized)

P	Age	Diagnosis age	Diagnosed by	Occupational background	Group
P1	27	~7–8	Psychiatrist	Self-employed creative (MSc Psychology)	MHP
P2	23	12	Psychiatrist	Early-career psychologist; HR and private practice	MHP
P3	28	25–26	Psychiatrist	Counseling psychologist and therapist	MHP
P4	23	20	Clinical psychologist	Psychology postgraduate (trainee)	MHP
P5	24	~22	Psychiatrist	Engineer; corporate sector	Non-MHP
P6	28	~22	Two psychiatrists	Development-sector professional	Non-MHP
P7	25	~23	Psychiatrist	Medical doctor	Non-MHP
P8	30	3–4	Psychiatrist	Design postgraduate; founder	Non-MHP
P9	23	22	Psychiatrist	Computer science/AI postgraduate; corporate intern	Non-MHP
P10	23	22	Clinical psychologist	Counseling psychologist; freelance and entrepreneur	MHP

MHP means mental-health professional or advanced psychology trainee. All identifying details have been removed or generalize

squarely in childhood conditioning, describing a set of instructions delivered to girls but not to boys: "Even as children, women are expected to be silent, stay in one spot, don't answer back, don't be too loud, and guys just get to do whatever. So that way it does make a huge difference." (P1, MHP).

The same gendered asymmetry appeared in P2's account, where it was framed not as a one-off correction but as a standing requirement to alter the self. She contrasted the tolerance extended to hyperactive boys with the pressure on women to remodel their behavior into something acceptable: "It's so normalized for them… it's a little bit more acceptable and accessible for men to live with it than it is for a woman. For us, we are forced to change our ways." (P2, MHP)P2 also described a more subtle maneuver: Rather than only suppressing a trait, she had learned to rebrand it into a permissible feminine form, channeling hyperactive energy into a "chirpy," buoyant persona that society would absorb without alarm, a mask that passed precisely because it flattered a gender script. P9, from a computer science background, encountered the gender bias in a more clinical register: A mental-health organisation in India told her that hyperactivity is "often associated with men," despite her experiencing severe physical and mental hyperactivity, a clinician-endorsed version of the same suppression. P7, a medical doctor, encountered a more explicit articulation of the double standard in her training environment, where a "boys will be boys" permissiveness coexisted with the demand that "girls should do everything right." Her considerable achievements, passing examinations through immense effort, were dismissed as merely what was expected.

P10, a counseling psychologist, added a dimension specific to internal rather than external correction. The gendered expectation of perfection did not merely suppress symptoms; it produced shame about having them: "I feel like we tend to internalize our symptoms more than men… there was a lot of shame growing up about having these symptoms. I were always expected to be that perfect person. So when it came to seek help, I masked it so good because of that." (P10, MHP).

Family, school, and the south Indian academic pressure-cooker

Family and school function as the primary training grounds. For P6, the conditioning arrived as a steady accretion of labels from parents and teachers, lazy, forgetful, talkative, capable of more, that does the work of correction without ever naming a condition: "I grew up hearing my parents say the same thing that were later given as symptoms. You keep forgetting stuff, you never finish what you start… she has more capacity, but she just don't do it, she's lazy." (P6, non-MHP).

In the South Indian academic environment, these labels carry additional weight. P4, who was forced into MBA preparation which she found agonizing, described the psychological friction of having to suppress her lack of interest to meet familial and financial expectations: "Every day I regreted sitting in the coaching classes," while P2 recalled the invalidation of trying and failing to study like a neurotypical student in a family where academic achievement was intensely prioritized. P9's account extend this to the examination hall itself, where she could not sustain attention long enough to write answers and require a peer as an "anchor" to tether her to the task. The pressure-cooker of board examinations and competitive entrance tests functions not only as an academic demand but as a site where masking was forged: The women learned to perform sustained focus they did not possess, because the cost of failing to perform was understood in familial, not merely educational, terms.

P8 traced the mechanism to a broader cultural injunction, the ubiquitous instruction to "adjust," which she experienced as a training program in people-pleasing: "In the average Indian society, you're always told to adjust… the whole idea of adjusting became like a plot for me to be a people-pleaser. I'd think, if I don't dress like this that auntie won't like it, if I

don't speak like this that girl won't like it, the truth being that neither of them care." (P8, non-MHP).

The internalization of the neurotypical standard

The final movement of this theme is the point at which external correction became internal self-monitoring, the moment the neurotypical standard was installed as a personal self-standard. P3, herself a practicing therapist, captured this with unusual precision. Even with clinical training, she had governed herself by rules designed for a brain unlike her own: "Everything that worked for any person should work for me. I should put things on my calendar, I should make a timetable and stick to it… I was treating myself as if I didn't have ADHD." (P3, MHP)P4's account showed the same internalization taking root early, in the form of a "parentified" vigilance, a child who policed her own attention and pulled herself back to task before any adult had to, and who was later praised by assessors for having "learned to manage it." P10's experience was structurally identical: Her internalization was so thorough that she had, in her own phrase, "sorted through it in my head," pre-processed and pre-compensated for every symptom to the point where she no longer knew what the unmasked experience looked like. P3 also described internalized gendered norms about domestic adequacy: "I'm a bad woman, I'm a bad wife, I've not even been able to cook… that pressure was ingrained into me from when I was a child." The expectations of the ideal Indian wife, a woman who cooks, organizes, remembers, and manages without being asked, had been installed so deeply that failing to meet them registered as moral failure, not as a mismatch between neurotype and expectation. What is notable across these accounts is that the neurotypical standard was experienced not as external imposition but as the self: The mask had been worn long enough to be mistaken for the face.

Theme 2: "Running on Anxiety," the phenomenological cost of sustained masking

Masking was not costless concealment. It demand continuous cognitive and emotional labor, and in the absence of acknowledged need, participants had built substitute systems to keep the performance running. The most striking of these, name almost identically by several women, was anxiety: Not anxiety as a symptom of ADHD, but anxiety enlist as the engine of executive function.

Anxiety as Functional Substitute for Executive Function: P1 gave this its clearest articulation. For her, anxiety was not an affliction to be reduced but the precondition of getting anything done at all: "I'm literally running on anxiety. That day, if I don't wake up with anxiety, I know I won't get anything done, and if I don't get anything done, nobody's going to do it for me." (P1, MHP).

She maintained an architecture of checklists, alarms, and nested reminders on top of this, but anxiety was the foundation the architecture rested on. The gendered dimension was explicit: As a married woman, she carried the household cognitive load, remembering schedules, tracking obligations, managing domestic logistics, because, as she put it, "women don't get to cut that slack." P5, from a non-clinical background but with vocabulary acquired through work at a mental-health organisation, described the same mechanism from the inside and named its danger: that a coping strategy had quietly become load-bearing: "Anxiety was discussed as one of the ways I coped with my ADHD symptoms, but it was never presented as something to keep using as an aid for executive dysfunction and memory issues." (P5, non-MHP).

In P4, the hyperactive energy that could not be expressed outwardly turned inward and became indistinguishable from anxiety, overthinking, spiraling, and panic. P9's account confirmed the same trajectory from a non-clinical vantage: Unaware and unmedicated, she had been "extremely dysregulated," her anxiety uncontainable, and she had turned to binge eating as a numbing mechanism, a bodily cost of sustained emotional masking that resulted in significant weight gain. The internalization described in Theme 1 thus reappears here as a physiological cost: The disallowed external symptom does not vanish but is metabolized into a more socially acceptable, and more punishing, internal one.

The emotional labor of daily presentation management

Alongside anxiety ran the daily emotional labor of managing a neurotypical presentation. P5 described being read as an extrovert while privately rationing her energy and managing overstimulation, the sociability itself a performance. P10 named the same disjunction with precision: "It seemed like I was very regulated on the outside, when in reality my brain was running a hundred miles an hour." P8 reached for two images to convey the gap: The "swan," serene above the water and frantic beneath it, and the "clown with a hundred hands" others believed her to be, when in reality she was "just another human being with two hands and one brain." Her high efficiency, far from protecting her, invited escalating demands: "When they realize it's my ADHD powering me through my deadlines, people get greedy. Oh, you can do a lot, just do even more." (P8, non-MHP).

In the domestic sphere, P3's mother-in-law refused to acknowledge ADHD and expected traditional domestic performance across festival obligations and extended-family duties. P3 had to deliberately and repeatedly "drop the ball" to train her environment: "I had to constantly keep letting down everyone on purpose, just so they understood the message that just because my husband is now married to me doesn't mean I take over every responsibility… I've let down enough expectations that people call him instead of calling me." (P3, MHP).

The masking, in other words, had created a false baseline that others then enforced, and unmasking required a deliberate, sustained campaign of disappointing people.

Exhaustion, burnout, and the moment of collapse

The cost accumulated invisibly until something gave. P6 articulated the felt quality of high-functioning collapse, the gap between the competent exterior and the interior, and questioned the very resilience she was praised for: "I'll be breaking apart inside, but then I get my job done, the stress involved in getting it done is quite high… I consider myself strong, but I don't think I should have to be strong this way. It should come with support." (P6, non-MHP).

P3 described an older relative who had never received diagnosis and had "pretty much lost her own personality" through lifelong masking, a culturally specific image of generational cost.At the extreme, P7 sustained her academic record through what she termed "torturing myself," the outward success financed by numbing, isolation, and passive ideation. (This material touches on self-directed distress; it is presented as analytically necessary.) P8 drew the cost into the body, linking internalized emotion to autoimmune illness: "women endure, because we tolerate while internalizing every single emotion." P4 chose retreat into isolation, the only space where unmasking was safe.

P8 drew the cost into the body itself, linking a lifetime of internalized emotion to autoimmune illness: "women have been told to tolerate things so much… men tolerate, but women endure, because we tolerate while internalizing every single emotion. And that causes us autoimmune diseases." Whether or not the causal claim holds medically, its analytic significance is that she experienced masking as somatic, written into her health, not merely her mood. P4 offered a different form of coping with the cost: Retreat into isolation, the only space where unmasking was safe, "I preferred to do it privately because with myself I'm able to give myself the space and time… it gets exhausting what I'm trying to do, it only adds on to my stress."

Theme 3: "They're Not Able to Understand," masking and the limits of clinical recognition

Masking did more than delay self-recognition; it actively defeated clinical detection. Several participants had been missed, dismissed, or redirected by clinicians, in some cases by their own, precisely because the compensatory systems described in Theme 2 had concealed the impairment the assessment was designed to find.

Masking defeating clinical and self-assessment

That masking defeats standard assessment was stated most sharply by P1, who, despite a childhood diagnosis, recognised that a present-day questionnaire would likely screen her out, because the instrument measures surface function, and her surface had been engineered to pass: "Even if I do the normal questionnaire now, it'll probably say I don't have it, because you cope with the anxiety. They're not able to understand that if I just removed anxiety from my life… you cope with your own strategy." (P1, MHP).

P10's account offered the most striking demonstration of this phenomenon. During formal assessment, she found herself uncertain whether to answer questions as she functioned now, with years of compensatory systems in place, or as she would function without them: "It was shocking to me that I had internalized the coping mechanisms so much that people had thought I didn't have ADHD at all… I remember asking him, am I supposed to answer this as pre-coping mechanism or post-coping mechanism? And it was only then that he realized I'd internalized it so much that I'd sorted through it in my head earlier." (P10, MHP).

P6 located the failure not in the instrument but in clinical attention itself, encountering doctors who underrated an internalized presentation and met her difficulty with an invitation to try harder, the same correction she had received as a child, now in a consulting room: "Doctors themselves don't give a lot of importance to ADHD, because it manifests differently; it's more internal than external, except when it's hyperactivity. The first doctor did make me think, oh, why don't you try a bit harder." (P6, non-MHP).

P9 was given the wrong diagnosis entirely: Seeking ADHD medication in Chennai, she was diagnosed with generalised anxiety disorder, the compensatory anxiety read as a primary condition. Clinical dismissal was compounded by cultural secrecy: P6's parents were unaware of her diagnosis because disclosure would, she believed, threaten her standing in the matrimonial market.

Clinical literacy and the experience of diagnostic invisibility

Clinical literacy did not protect. P3, a therapist, was not diagnosed until her mid-twenties; her psychiatrist declined the term ADHD, and a later therapist dismissed it as a "crutch." P10's own therapist initially told her she did not have ADHD: "that is how well I had mastered it." That the clinician with the most sustained exposure was unable to see past the mask underscores how thoroughly the concealment operated. Through the more literate members, literateness advanced self-understanding while debatably excavating camouflage, since a well-informed mask is an additional convincing one.

The comparison reveals a difference of register rather than experience. Clinically literate participants narrate invisibility in diagnostic language (executive function, coping mechanism, psychoeducation); participants without training use moral language (lazy, try harder, adjust). The experience

of being unseen was common to both; the vocabulary diverge. P5, non-clinical by profession but literate through workplace exposure, narrate in the same register as the trained group. P1's entry into a psychology-adjacent field following her diagnosis raises the possibility that lived neurodivergence and clinical literacy are mutually reinforcing, a suggestion these data raise but cannot establish.

A revealing counterpoint emerges from P10's friendships. While her therapist and assessor were initially deceived, her close friends were not surprised at all: "I thought I had masked it so well that even I don't realize I had ADHD, but everyone was like, what are you talking about? It was so clear." The mask, it appears, operates selectively: Convincing formal clinical systems while remaining transparent for those with sustained, informal proximity. This distinction has implications for how we understand masking's targets: It may be calibrated, consciously or not, for the environments where social costs are highest.

Post-diagnosis: Relief, grief, and the retrospective reckoning

Diagnosis, when it finally came, was rarely simple relief. P6 captured its doubleness, vindication braided with grief: "It was both sad and relieving. Relieving because I knew, okay, my brain is wired differently, and sad, because my parents don't know about this." (P6, non-MHP).

For P4, the diagnosis licensed a long-deferred self-forgiveness: "I was able to forgive myself and change my behavior… it was more of talking to myself that, hey, you didn't do it on purpose." P5 described the slow work of healing the guilt and shame of "not doing enough" and "unused potential" that had been laid down in her early years. P9 described the moment of diagnosis differently again: Neither relief nor grief but numbness, a blankness that made sense against the backdrop of multiple comorbidities and clinical exhaustion, the ADHD diagnosis arriving as one more thing to absorb in an already overwhelming clinical picture. P7, similarly, met diagnosis with apathy, ADHD arriving as an unwanted complication beneath more acute crises, and her response a continued, deliberate denial: She "acted like it was not there" to keep functioning. Denial, here, was simply the mask turned inward, the final concealment being from oneself.

P8's reckoning took the longest to arrive and was the most deliberate in its unmasking. After years of people-pleasing, she described sitting with her thoughts and asking, "Is this really what I want to be? Why am I putting the weight of everyone's expectations on me and letting it suffocate me?" Her answer was a conscious program of reclamation: "I don't ask permission to exist, unlike when I used to before." The retrospective reckoning, where it occurred, was less a discovery of a condition than a recognition of how much of life had been spent in performance.

DISCUSSION

Masking as structural, not individual

These accounts resist the framing of masking as individual coping. In every case, the mask was assembled in childhood, in response to gendered expectation, before any clinical encounter. The findings extend existing camouflaging literature[1,2] by grounding it in a context where gendered expectations operate with particular intensity. The feminist reframing offered by Ussher (2011) fits closely: Masking is the expected female response to a neurotypical social order, its cost structurally produced.[5] The substitution of anxiety for executive function, reported across the literacy spectrum, is best read not as comorbidity but as the physiological signature of that demanded performance.

The clinical invisibility problem

That masking constitutes a diagnostic barrier is established in Western literature.[4,8] These findings extend it to urban India with two dimensions: Clinical literacy did not prevent being missed (a participant's own therapist failed to detect the condition), and masking actively produced misdiagnosis (P9 was diagnosed with GAD when she sought ADHD medication).[12] Assessment should probes compensatory effort, what it cost to appear unimpaired, rather than the symptoms presence alone.[13]

Context specificity

The pressures here (the academic pressure-cooker, in-law expectations, the injunction to "adjust," matrimonial-market stigma) give masking a specially local form. P9's account provides a direct demonstration: Encountering two systems with the same brain, her Singaporean pathway was efficient while in Chennai she was misdiagnosed.[14] Holding the person constant while varying the system isolates the difference as systemic.[15] We read these as situated findings; research across India's regional, linguistic, and socioeconomic diversity is needed before broader claims can be supported.[16]

Limitations

Four limitations should be noted. Accounts are retrospective, filtered through post-diagnostic understanding. All participants reached diagnosis; women whose masking never broke down are absent. The sample is educated, urban, and largely English-comfortable. The clinical-literacy contrast is drawn from a small sample; the suggestion that lived neurodivergence may draw women toward clinically literate fields is an inference these data raise but cannot establish.

CONCLUSION

Masking in these ten accounts was not a chosen strategy. It was imposed by gendered social expectation, learned before it could be named, maintained at significant cost, and invisible enough to defeat clinical recognition among clinically trained women themselves. For assessment: Probe compensatory effort, since the most thoroughly masked women are those most likely to screen as unimpaired. For theory: Masking is better understood as gendered performance than neutral adaptation, its costs structurally produced. For Indian healthcare: The long-term costs of diagnostic delay deserve to be addressed rather than retrospectively admired as resilience.

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Source of Support: Nil. **Conflicts of Interest:** None declared.