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Between Two Burdens: Invisible Disability and the Performance of Masculinity Among Men in India

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Abstract

Men living with invisible disabilities in India navigate a compounded set of pressures: the internal burden of an unacknowledged impairment alongside external demands of a patriarchal social order premised on bodily invulnerability and economic productivity. This qualitative study draws on Reflexive Thematic Analysis (RTA) of in-depth interviews with five cisgender men, aged 25–32, living with invisible disabilities, including neurodevelopmental conditions, autoimmune illness, and musculoskeletal conditions, in urban India. Five themes were identified: (1) The Diagnostic Journey and Medical Interactions; (2) Masculinity and Social Identity; (3) Productivity and Capitalist Expectations; (4) Masking and Adaptations; and (5) Support Systems and Relationships. Findings indicate that medical gaslighting, gendered pain bias, and late misdiagnosis are common experiences, and that masculine norms significantly delay both diagnosis-seeking and help-seeking. Participants also described active, deliberate rejection of hegemonic masculine norms, a process this paper terms counter-hegemonic resistance, as a response to the lived inadequacy of those norms in the face of chronic illness and neurodivergence. Implications for clinical practice, workplace policy, and mental health service design are discussed with reference to the specific Indian socio-cultural context.

Keywords: invisible disability, hegemonic masculinity, neurodivergence, chronic illness, masking, qualitative research

1. Introduction

Invisible disabilities, conditions that are functionally limiting but carry no immediately apparent physical markers, present a distinctive set of challenges for the individuals who live with them. Unlike visible impairments, invisible conditions offer neither the social recognition nor the institutional accommodation that visibility, however grudgingly, sometimes confers. For men in India, this precarity is compounded by culturally dominant constructions of masculinity that equate manhood with physical resilience, stoic endurance, and uninterrupted economic productivity (Connell, 2005; Johri, 2018).

The intersection of these two systems, ableism and patriarchal masculinity, has received limited empirical attention in the Indian context. Studies of disability in India have tended to focus on visible impairment, physical accessibility, and legislative frameworks (Addlakha, 2013; Ghai, 2002). Studies of South Asian masculinity have examined violence, labour, and domesticity but have not systematically engaged with chronic illness or neurodivergence as sites of masculine identity negotiation (Malhotra et al., 2018). The experience of men living at this intersection remains largely undocumented.

This paper addresses that gap. It reports findings from a qualitative study exploring how five urban Indian men living with invisible disabilities, including ADHD, autism, autoimmune illness, and musculoskeletal

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conditions, experienced and negotiated the demands of masculinity in relation to their health. The paper aims to contribute to empirical knowledge at the intersection of disability and gender studies in India, and to generate practically grounded implications for clinical and workplace settings.

The researcher's own positionality is relevant here. As a cisgender man living with obstructive sleep apnea, anxiety, depression, and a probable autism spectrum condition, the researcher occupies a dual position as both investigator and member of the community under study. In line with the reflexive epistemology of this study (Braun & Clarke, 2019), this positionality was actively engaged as an analytical resource: it facilitated rapport and trust in interviews, and informed the interpretive sensitivity brought to data analysis. The ways in which the researcher's own experience shaped thematic interpretations were documented through a reflexive journal maintained throughout the analytic process.

2. Literature Review

2.1. Invisible Disability and Institutional Legitimacy

Invisible disabilities occupy a contradictory position in social life. The absence of visible markers can allow individuals to "pass" in ableist environments, but this passing comes at the cost of access to accommodations, legitimacy, and social support (Goffman, 1963). In the Indian context, Addlakha (2013) argues that disability is a social identity produced through the friction between global human rights frameworks and highly localised cultural understandings of the body. For conditions that are not immediately legible to institutional gatekeepers, the burden of proof falls entirely on the individual; the psychological and practical weight of this is considerable.

Research from comparable Global South contexts has documented the particular difficulties that arise when invisible disabilities interact with healthcare systems that lack awareness of, or protocols for, such conditions. Trani et al. (2016) found that in low- and middle-income countries, individuals with psychosocial and cognitive disabilities face systematic exclusion from health services even when those services are nominally available to them. In India specifically, Kasthuri (2018) has documented significant treatment gaps for neurodevelopmental conditions at both child and adult levels, attributable to a combination of low awareness among general practitioners, stigma among patients and families, and the absence of population-level screening.

2.2. Masculinity and Health in the Indian Context

A body of empirical work has established that hegemonic masculine norms, the culturally dominant expectations of stoicism, self-reliance, and emotional unavailability, are associated with delayed help-seeking, under-reporting of symptoms, and poorer health outcomes among men (Galdas et al., 2005; Möller-Leimkühler, 2002). These effects are documented across cultural contexts, though the specific content of hegemonic masculine norms varies considerably.

In the South Asian context, Awan et al. (2025), in a qualitative study of South Asian men living with long-term conditions in primary care, found that participants experienced chronic frustration managing their conditions under persistent social pressure to appear capable and self-sufficient. Help-seeking was described by several participants as incompatible with the role of the functioning male head of household, a pattern that led to sustained under-treatment and delayed disclosure of psychological distress. Similarly, Chikovore et al. (2014), studying men with tuberculosis symptoms in sub-Saharan Africa, found that hegemonic constructions of masculinity led men to delay care-seeking for months, framing illness acknowledgement as a failure of male

self-control. Whilst the contexts differ, both studies establish a pattern of gendered health behaviour: masculine identity actively structures the clinical encounter in ways that disadvantage men seeking care.

2.3. Neurodivergence, Masculinity, and Late Diagnosis

Research on ADHD and autism has documented a well-established pattern of later and less frequent diagnosis in individuals who were assigned female at birth, attributable partly to gendered presentation differences and partly to diagnostic instruments calibrated primarily on male-presenting symptoms (Allely, 2019; Skefington & Brook, 2021). Paradoxically, however, men with these conditions are not reliably diagnosed early either. Young et al. (2020) found that the majority of adults presenting for ADHD diagnosis in specialist clinics had experienced significant functional impairment for years or decades prior to assessment, often having been misidentified as having conduct disorder, substance use problems, or personality difficulties. In the Indian context, Srinath et al. (2019) found neurodevelopmental conditions to be substantially under-identified in clinical settings, with most cases presenting only when functional impairment becomes severe.

2.4. Men, Chronic Illness, and Identity Negotiation

A separate but related body of work has examined how men negotiate identity under the conditions of chronic illness specifically. Cooper et al. (2025), in a qualitative diary study of men living with lymphoedema in the UK, found that participants organised their adaptive responses around two broad strategies: concealment of symptoms to preserve masculine continuity, and the development of routines that reasserted a sense of competence and control. Both strategies served the same underlying function — managing the threat that chronic illness posed to masculine self-concept — but at considerable psychological cost. The study is notable for its finding that men who moved toward reflection, disclosure, and relational support reported better long-term wellbeing than those who maintained rigid concealment. This trajectory, from concealment to gradual disclosure to reconstructed identity, closely parallels the arc described by several participants in the present study, particularly Siddharth and Ahmed.

Mokhwelepa and Sumbane (2025), in a systematic review of 47 studies on masculinity norms and mental health help-seeking among men, found consistent evidence that restrictive masculine norms created a "double bind" for men with health conditions: seeking help violated masculine self-concept, while not seeking help allowed conditions to worsen. The review identifies this double bind as operating across cultural contexts but with particularly acute effects in settings where masculine norms are tightly enforced through community surveillance — a finding with direct relevance to the caste and community dynamics documented in Theme 2 of the present study.

2.5. Invisible Disability, Work, and Economic Participation

The intersection of invisible disability and work has received increasing empirical attention. Lindsay et al. (2018), in a systematic review of qualitative studies, found that young adults with invisible disabilities consistently reported workplace concealment as a primary coping strategy, driven by fears of discrimination, reduced career opportunities, and stigma. Participants in these studies described the mental and emotional labour of performing normalcy at work as a significant secondary burden, compounding the difficulties already produced by their conditions. In the Indian workplace context, Pandya et al. (2022), in a scoping review of workplace mental health interventions in India, found that existing initiatives overwhelmingly focused on stress and burnout, with almost no coverage of neurodevelopmental conditions or invisible physical disabilities. The review noted that even where employee assistance programmes existed, they were designed for disclosed and recognised conditions; workers whose difficulties were invisible or undiagnosed had no structured route to support.

3. Methodology

3.1. Research Design

This study employed a qualitative design grounded in social constructivism, which holds that both gender and disability are identities constituted through social interaction, institutional practice, and cultural discourse rather than pre-given biological categories (Berger & Luckmann, 1966). Data were analysed using Reflexive Thematic Analysis (RTA) as developed by Braun and Clarke (2019). RTA treats the researcher as an active co-producer of analytic themes whose theoretical commitments and biographical position are intrinsic to, rather than contaminants of, the analytic process. This orientation was well suited to the present study's dual commitment to empirical rigour and reflexive transparency.

The study did not use Interpretive Phenomenological Analysis (IPA) as a primary framework, though IPA-influenced principles of idiographic attention, specifically close and particularistic engagement with individual cases, informed the interview approach and early stages of analysis.

3.2. Participants and Sampling

Participants were recruited through purposive sampling (Patton, 2002), targeting men who met the following inclusion criteria: (a) self-identified as male; (b) aged between 21 and 45 years; (c) resident in India or, in one case, recently relocated abroad but holding Indian nationality and primary socialisation; (d) living with one or more self-identified invisible disabilities, defined as conditions that are not immediately apparent to a casual observer; and (e) able to participate in an interview conducted in English or Hindi.

Recruitment was conducted through online disability advocacy communities, mental health support groups, and social media networks focused on chronic illness and neurodivergence in India. The researcher's own network within these communities facilitated initial contacts. A sample of five participants was recruited, consistent with the analytic aims of RTA, where depth and richness are prioritised over breadth or statistical representativeness (Braun & Clarke, 2019).

All five participants self-identified as cisgender men. One participant (Arjun) identified as pansexual and was navigating a polyamorous relationship structure at the time of interview; the remaining four identified as heterosexual. These identities are noted because Arjun's experience of navigating both a non-normative sexual identity and a neurodevelopmental condition in the Indian workplace adds an additional intersectional dimension to his account of professional concealment.

Table 1 presents full participant profiles, incorporating demographic, diagnostic, occupational, and relational information. Pseudonyms are used throughout.

Table 1. Participant Profiles.

Pseudonym	Age	Condition(s)	Onset / Diagnosis	Education	Occupation	Relationship Status	Therapy	Background
Ahmed	25	Autoimmune hepatitis; Ulcerative Colitis	Symptoms from age 11; UC confirmed 2016; hepatitis 2018	Postgraduate (France)	Recent graduate; employed in France	3-year relationship	Not reported	Urban Muslim man; born Pune; educated Delhi and France
Arjun	31	ADHD (inattentive type)	Diagnosed October 2024	Engineering degree	Customer Success Manager; remote	Pansexual; polyamorous	Yes	Urban North India (Punjabi background)
Dev	32	ADHD; probable	Childhood onset;	BA (Tamil	Freelance content	Dating;	Yes; IFS;	Lower-middle

		Dyslexia or Dyspraxia (unconfirmed)	ADHD confirmed in therapy 2022	Nadu); incomplete postgraduate	writer; published poet	limited relationship history	sober 4 years	class; West Bengal origins; Bengaluru-based
Shyam	31	Autism Spectrum; ADHD; Depression	Diagnosed ~age 12–13	Not specified	Technology sector	Partnered; heterosexual	Yes; significant history	Tamil Brahmin; South India
Siddharth	32	Cervical instability; Hypermobility; GAD; Mild Depression	Symptoms March 2023; diagnosed April 2024; treated June 2025	Not specified	Graphic designer; unemployed during illness	Single; significant community losses	Yes; during illness	Urban upper-caste; Mumbai

3.3. Data Collection

Data were collected through semi-structured, in-depth interviews conducted via video-conferencing platforms between October and December 2025. Interviews were conducted in English, with participants freely shifting to Hindi where preferred; this code-switching was treated as natural and was retained verbatim in transcription.

Each interview was guided by five broad topic areas: (a) the history of diagnosis and medical encounters; (b) the relationship between the participant's disability and his experience of masculine identity; (c) experiences of work and economic participation; (d) coping and adaptive strategies developed over time; and (e) social relationships and support systems. The topic guide functioned as a conversational scaffold; participants were encouraged to expand on areas of particular personal salience and to introduce themes the researcher had not anticipated. The researcher disclosed his own experience of invisible disability at the outset of each interview, which participants consistently identified as facilitating trust and candour.

Interviews ranged from 55 to 95 minutes. All sessions were audio-recorded with written informed consent and transcribed verbatim by the researcher. Transcripts were shared with participants for member-checking; no substantive corrections were requested. Audio recordings were deleted after transcription.

3.4. Ethical Considerations

Ethical approval was obtained from the Departmental Ethics Review Board at the School of Gender and Development Studies, Indira Gandhi National Open University (IGNOU). The researcher submitted the research proposal and the proposed interview schedule to the Departmental Ethics Review Board and obtained approval prior to beginning the study. Since this was a study conducted as part of a Master’s Degree, ethics review was done at the departmental level.

All participants provided written informed consent, with explicit information about the voluntary nature of participation and the right to withdraw at any time. Given the psychological sensitivity of the material, participants were informed at the outset that they could pause or terminate any session without explanation, and were offered access to mental health support resources at the close of each interview.

Two specific ethical adaptations were made to interview practice. First, the researcher's own disclosure of lived experience with invisible disability was offered at the start of each interview, reducing the inherent power differential between researcher and participant. Second, for Siddharth, whose condition had resulted in significant physical limitation and a history of self-harm, the interview was conducted in two separate sessions with a break between them, at the participant's request.

All data were stored in password-protected encrypted files. Pseudonyms were applied at the point of transcription. Identifying information, including specific workplace names, hospital names, and geographical details, was removed or generalised in the analytic write-up.

3.5. Analytic Procedure

Analysis followed Braun and Clarke's (2019) six-phase RTA model. In Phase 1 (familiarisation), all five transcripts were read repeatedly in full, with initial analytic notes documenting both manifest content and latent meaning. Phase 2 (coding) produced 52 initial codes across the five transcripts. Phase 3 (theme generation) involved grouping codes into candidate themes reflecting patterns of shared meaning. Phase 4 (theme review) tested candidate themes against the full data corpus, resulting in the consolidation of two overlapping candidates and the refinement of theme boundaries. Phase 5 (theme definition and naming) produced five superordinate themes, each with two or three sub-codes, defined to capture both empirical content and interpretive significance. Phase 6 (report writing) involved the integration of participant voice and researcher interpretation, with ongoing attention to the evidential relationship between quotes and claims.

A reflexive journal was maintained throughout. Entries documented the researcher's own experiential responses to participant accounts, points of analytical uncertainty, and the ways in which personal familiarity with invisible disability shaped interpretive choices. This reflexive record was reviewed at the close of analysis to identify any systematic distortions and is available to reviewers on request.

4. Results

The analysis produced five superordinate themes. Before presenting them, a brief contextualising account of each participant's disability experience is offered, since the nature of participants' conditions must be legible to the reader for the themes to be meaningfully understood.

Ahmed was diagnosed with ulcerative colitis at age 14 following years of abdominal pain, weight loss, and repeated misdiagnosis. Autoimmune hepatitis was subsequently identified after recurrent jaundice-like symptoms. At the time of interview he was managing both conditions with medication, with markedly better disease control since relocating to France, where he attributed improvement partly to cleaner water and food conditions. He had undergone five colonoscopies, two without anaesthesia.

Arjun was diagnosed with ADHD in his early thirties, though the condition had shaped his trajectory through multiple jobs, relationship difficulties, and substance use across the preceding decade. His diagnosis arrived only when he began living alone and the functional consequences of his ADHD, including leaving his stove on overnight and an inability to sustain attention at work, became impossible to attribute to personality or circumstance.

Dev had been misidentified in childhood as having social anxiety disorder, a diagnosis that was later understood in therapy as a probable misreading of ADHD and a co-occurring learning difference (likely dyslexia or dyspraxia, not yet formally confirmed). His condition was not recognised or accommodated in childhood; he compensated through solitary creative work, while assuming significant financial responsibility for his family from the age of fifteen. He has been sober for four years.

Shyam was one of the earlier-diagnosed participants, having received his autism and ADHD diagnosis in early adolescence. Despite early diagnosis, institutional support in educational and workplace settings was limited.

His account focuses significantly on the tension between his Tamil Brahmin cultural background and his neurodivergent social presentation.

Siddharth had the most recent and acutely traumatic illness trajectory of the five participants. His cervical instability resulted from a self-harm incident during a period of severe psychological distress and was not diagnosed for over a year, during which he saw more than thirty clinicians without a definitive answer. His illness rendered him housebound for an extended period, cost him most of his friendships, and required him to fundraise publicly for treatment costing over fifteen lakh rupees. At the time of interview he had received stem cell treatment in the United States four months prior and was reporting approximately 25 percent improvement in symptoms.

Table 2. Thematic Framework

Theme	Sub-code	Definition
1. Diagnostic Journey	Medical gaslighting	Sustained dismissal of symptoms as psychological or fabricated
	Gendered pain bias	Clinical presumption of elevated male pain tolerance
	Late / misdiagnosis	Formal diagnosis reaching adulthood after years of mislabelling
2. Masculinity & Social Identity	'Weird kid' stigma	Childhood exclusion and identity injury from unrecognised conditions
	Counter-hegemonic resistance	Active, deliberate rejection of hegemonic masculine norms
	Caste and community pressure	Culturally specific masculine performance expectations
3. Productivity & Capitalist Expectations	Economic disposability	Conflation of productive capacity with personal worth
	Breadwinner burden	Expectation of primary financial provision despite health limitations
	Professional concealment	Workplace masking of diagnosis due to stigma
4. Masking & Adaptations	Self-developed compensatory frameworks	Autodidactic systems for executive or social functioning deficits
	Substance use as self-regulation	Alcohol, cannabis, caffeine to manage distress and overstimulation
	Remote work as accommodation	Preference for remote employment as informal adjustment
5. Support Systems & Relationships	Emotional labour gap in male friendship	Male friendship networks failing to provide emotional support
	Partner as primary support anchor	Concentration of support in romantic relationship

	Community attrition following disclosure	Social losses following public or interpersonal disclosure

4.1. Theme 1: The Diagnostic Journey and Medical Interactions

For all five participants, encounters with medical institutions were sites of institutional power as much as clinical care, and frequently of institutional failure. This theme documents three distinct patterns: the dismissal of symptoms as psychological or invented (medical gaslighting), the denial of adequate pain management on the basis of gender (gendered pain bias), and the delayed or incorrect identification of neurodevelopmental conditions (late/misdiagnosis).

Medical Gaslighting. Across the sample, participants described sustained periods during which their symptoms were attributed to anxiety, hypochondria, or fabrication by clinicians, family members, and friends, often simultaneously. For Siddharth, this experience lasted over a year, during which he saw more than thirty clinicians:

"I went to several doctors. I consulted with an audiologist... a cardiologist... a neurologist... a urologist. I was on Reddit, trying to rule out every possible disease. My parents were confused. They were like, 'It's all in your head because you have anxiety.' And my friends; my guy friends; were like, 'No bro, nothing is wrong with you, I think you should just go to a therapist.' It got to a point where I thought, maybe there's nothing physically wrong with me." (Siddharth)

Siddharth later reflected on what it cost him to begin doubting his own body:

"I just felt like I was in a void, I felt like I was in a vacuum. The world outside my little bedroom did not exist. It was really bad. Like right now I'm speaking to you and it's just traumatic to talk about it." (Siddharth)

The gendered dimension of this invalidation is significant: it was Siddharth's male friends in particular who redirected his distress towards psychological explanation and away from medical investigation. This pattern maps onto a well-documented tendency, noted by Griffiths et al. (2018), for men with chronic illness to encounter scepticism about the authenticity of their suffering from within their own social networks.

Ahmed's experience of gaslighting took the form of diagnostic errors compounded over time: treated for a urinary tract infection he did not have, then classified repeatedly as experiencing "growing pains," then told that his symptoms were the consequence of a cholesterol problem, all before his ulcerative colitis was identified at age fourteen:

"The doctors were confused... a lot of the doctors we were visiting were from public hospitals... they did take a very long time to really realise that what I'm going through isn't just growing pains, as they would often say... it took my mom a very long time to convince [the doctors] that I'm not just making things up."

The phrase "not just making things up" shows how far Ahmed had internalised the possibility that his suffering was illegitimate. This internalisation, the colonisation of self-perception by the medical gaze, is one of the more psychologically damaging consequences of sustained diagnostic failure documented in the literature on invisible disability (Nettleton, 2006).

Gendered Pain Bias. The clearest example in this sub-code is the explicit denial of anaesthesia during colonoscopies on the basis of Ahmed's gender. This happened on two separate occasions, with two different clinical justifications: one economic, one ideological.

"The doctor purely did it [colonoscopy without anaesthesia] again... he kept telling me and my dad that he's pretty disappointed to see two grown men crying over something that's so small. The first one was purely just

out of the doctor's understanding that if I am a boy, if I'm of growing age, if I'm a teenager, there's no reason for me to get anaesthesia."

Ahmed's father was present during the second procedure; his father wept. The doctor's expressed disappointment at the sight of "two grown men crying" crystallises the intersection of clinical ableism and patriarchal masculinity: the withholding of pain management was a normative decision, premised on the assumption that male bodies do not require, and male persons should not need, relief from pain. This is consistent with empirical findings on gendered pain treatment disparities: Samulowitz et al. (2018) found in a systematic review that men's pain is more often attributed to physical causes and yet paradoxically less often treated with adequate analgesia, partly because male stoicism is presumed rather than assessed.

Late and Misdiagnosis. For Arjun, Dev, and Shyam, invisible disability took the form of neurodevelopmental conditions that went unidentified for years or decades. Shyam's experience illustrates a different but equally significant dimension of diagnostic instability: he received an early diagnosis, but that diagnosis was itself partially wrong. Speaking about the initial assessment he received around class seven, he noted:

"I was diagnosed with Autism, ADHD, and some parts of BPD as well. Those high characters — that was dicey. Since then I've just gone back and done my own research and evaluated my own body. I don't really have an official diagnosis as such now, but symptoms largely aligned to the same thing." (Shyam)

The BPD components of his childhood diagnosis have since been questioned; he now understands his presentation primarily through autism and ADHD. Early diagnosis did not provide clarity so much as a partially accurate map that he has spent years revising. For Dev, a childhood diagnosis of social anxiety disorder was retrospectively understood in therapy as a probable misidentification of ADHD and a co-occurring learning difference:

"I do think I was misdiagnosed. And I know this now. I have been in therapy since 2022… and what I know now is that I always had ADHD… I couldn't tell time until I was 13. I was not able to tie my shoelaces until I was 17 or 18." (Dev)

The practical consequences of this misidentification were severe. Without a diagnostic framework within which to understand his executive functioning differences, Dev was labelled as careless, selfish, and inattentive by teachers, family members, and employers throughout his twenties. The absence of early diagnosis did not protect him from the social consequences of his condition; it denied him the explanatory framework that would have allowed him to understand and respond to those consequences effectively.

Arjun's late diagnosis similarly arrived only when functional consequences had accumulated to a point of crisis:

"I got diagnosed with ADHD last year… I think I don't know if this is something I've always had or it's something that's come up more recently, but there are certain patterns in my career that are easier to understand now." (Arjun)

This account is representative of the adult ADHD presentation documented by Young et al. (2020), in which individuals manage significant impairment across education, work, and relationships for years before receiving a diagnosis that reframes much of their life history. For Arjun, the diagnosis did not resolve the difficulties but provided an interpretive shift: "These quick successions happened and all of it was a lot of crash and burn… I hadn't really thought about what kind of career trajectory it would take me. Now certain patterns are easier to understand." The relief of explanation was real, but the preceding decade of misattributed failure had already extracted its costs.

4.2. Theme 2: Masculinity and Social Identity

This theme explores how participants' invisible disabilities shaped, and were shaped by, their experience of masculine identity, from childhood exclusion to deliberate adult resistance of patriarchal norms.

'Weird Kid' Stigma. For participants whose conditions were present from childhood, school environments were consistently described as sites of exclusion and identity injury. In the absence of diagnostic recognition, divergent behaviour was interpreted as character deficiency:

"Everyone told me I was weird. I kept thinking that I was indeed weird… I never thought of myself as anything nice. I thought of myself as… I had horrible self-esteem." (Shyam)

"I was bullied heavily and… I was constantly called mad when I was a kid, crazy, eccentric, selfish, because of my forgetful nature. Even now, I call myself selfish and it's become very common for everybody to call me selfish." (Dev)

Dev's appropriation of "selfish" as a self-descriptor is a sophisticated response to this accumulated labelling: by pre-emptively applying the stigmatised term to himself, he reclaims some degree of interpretive agency over how others understand him. Yet the strategy also reveals the extent to which his sense of self was shaped by others' misreadings of his condition. Shyam elaborated on what this prolonged misrecognition produced in terms of self-concept:

"I was not a productive member of society. I don't think I was even considered as a desirable one. People kept saying, 'You're just being lazy, you're just not taking effort, you should apply yourself.'" (Shyam)

What is striking is that this negative self-image did not dissolve with diagnosis or with career success. Shyam was explicit that it persists:

"I still have a strong sense of negative self-image that I'm working on with therapy — I look horrible, I'm a horrible person, I'm not deserving of love, I'm not deserving of affection." (Shyam)

The persistence of internalised inadequacy beyond the conditions that produced it is documented in the literature on late or complex neurodevelopmental presentations: Canu et al. (2021) found that adults with late ADHD diagnoses continued to carry shame attributable to decades of social mislabelling even after their understanding of themselves had been revised.

This is consistent with research on the long-term effects of unidentified ADHD and learning differences: Canu et al. (2021) found that adults who received late diagnoses reported significantly lower self-esteem and higher rates of internalised shame compared with those diagnosed in childhood, attributable partly to decades of adverse attributions from others.

Counter-Hegemonic Resistance. Several participants described deliberately and consciously rejecting the foundational premises of hegemonic masculinity. This differs from the "de-masculinisation" described by Shuttleworth et al. (2012), in which disabled men are passively stripped of masculine status. Here, participants were active agents:

"I'm not that kind of a man… it's a conscious choice to make sure that I remain sensitive, that I keep speaking about my feelings, that I cry if I feel overwhelmed… I have all the reasons to be [a bitter, cynical man]. But that is not an excuse." (Siddharth)

"I believe that gender is a social construct, as are the so-called gender roles. I see it as functional roles — there's a role for someone who is the emotional comfort-giver, someone who is the financial provider,

someone who is strategic. These roles don't have to conform to a certain gender. And whenever someone tries to enforce it in my life, I push back or I associate distance, depending on the situation." (Shyam)

"I've been able to identify toxic masculinity from a very far away angle." (Ahmed)

Ahmed traced this critical distance back to an intergenerational pattern in his family — and to his conditions' role in making the dominant script legible as a script:

"I think it's a system that does think that men shouldn't really feel this. My grandfather... if you have a condition, just suck it up. It's not going to do anything. My dad has moved past that kind of mindset. But my grandfather — he'd just be like, you're young, you'll get past it." (Ahmed)

All three of these statements were made in explicit reference to the speaker's disability experience. Siddharth directly linked his choice to remain emotionally open to the fact that his illness had given him reasons to turn bitter, a decision he described as conscious. Shyam connected his rejection of gendered roles to his neurodivergent experience of social expectations as arbitrary and structurally constructed. Ahmed connected his distance from hegemonic masculinity partly to the physical restrictions his conditions had placed on conventional masculine activities.

This pattern — where disability experience becomes the generative ground for an identity critique — is consistent with findings from Morris (2001) and Shuttleworth (2004), who note that some disabled men articulate explicitly politicised relationships to masculinity, though this literature has developed predominantly in Western contexts. The present findings suggest this process also occurs in the Indian context, inflected by the specific patriarchal formations that participants were navigating.

Arjun described a quieter but equally significant shift — not a dramatic rejection of masculine norms but a gradual, exhaustion-driven revision of what he expected from himself at work:

"Till a few years ago, it was always, oh, you want to be the best, because that's what we're naturally taught. Now I've let go of that. Now I just want to exist. Now my expectation is to keep my job, basically. But that's changed over the years." (Arjun)

That this is framed as an achievement — as something that required work to arrive at — is itself revealing. The baseline expectation, internalised from early socialisation, was perpetual competitive growth. Settling for stability had to be chosen against the grain of that script.

Caste and Community Pressure. The masculine norms participants were negotiating were not generic but culturally and community-specifically prescribed. Shyam's Tamil Brahmin background generated particularly detailed and exacting expectations:

"My Tamil Brahmin cultural background enforces strong patriarchal values emphasising productivity, leadership, and social dominance... My society or my family [is] super patriarchal. The expectation of being social, leading events, is hard for me... being the dominant one in the relationship." (Shyam)

He also articulated the specific relational expectation that sits at the intersection of neurodivergence and masculine convention — the expectation that men initiate and sustain social contact:

"There is a disproportionate expectation on the man to initiate conversation, plan outings, initiate romantic encounters and so on. In male-female interactions, there's an expectation more often than not that the man initiates and maintains — especially if that relationship is romantic in nature." (Shyam)

For an autistic man for whom social initiation is effortful and often exhausting, this expectation represents a particularly direct collision between neurodivergent functioning and masculine convention. The norm does not merely inconvenience; it positions Shyam's neurological reality as a gendered failure.

Dev's experience of masculinity was shaped by the material conditions of his class background as much as by cultural norms:

"Everybody was like, haan, you're the man, you're supposed to do this, you are expected to do this... taking up emotional responsibilities for my maternal aunts, for my mother. And later, taking up financial responsibilities for the whole family."

Ahmed, reflecting on how his father managed his illness, described a domestic emotional division of labour that left financial and existential worry on the male side while outsourcing emotional processing to his mother:

"My dad assumes that a lot of the emotional aspect of it will be taken care of by my mom. So then he can just focus on the more economic and financial aspects of it. He's just so perturbed by the sheer nature of everything — every time I have a consult, he asks: what are the odds I won't be able to work?" (Ahmed)

Dev assumed primary financial responsibility for his family from the age of fifteen, following his father's injury-induced early retirement. This chronology — a teenage boy with undiagnosed ADHD and a probable learning difference, simultaneously managing the financial survival of his family and concealing the cognitive difficulties that made that management significantly harder — illustrates the compounding nature of the double burden with particular clarity. The demands of masculinity did not relax in recognition of his condition; they intensified.

4.3. Theme 3: Productivity and Capitalist Expectations

Economic Disposability and the Breadwinner Burden. Participants articulated a painful and destabilising equation of productive capacity with personal worth. When illness or impairment disrupted the capacity to work, participants experienced this as a threat to self-concept, not merely a practical problem:

"Since I'm disabled, I am not a contributing member to capitalism... if I cannot move, then I'm disposable." (Siddharth)

"I felt like if I'm not earning, then I'm not even deserving of getting this treatment." (Siddharth)

Siddharth's second statement warrants attention. His sense of being undeserving of healthcare was felt acutely: he had raised over fifteen lakh rupees through public fundraising for a medical treatment, and yet the very act of needing that treatment — of not being able to fund it from his own earnings because illness had made earning impossible — produced a sense of moral unworthiness. The logic here is circular and punitive: disability prevents work; inability to work means one does not deserve care; without care, the disability continues. This is the ableist-capitalist nexus that disability scholars have described theoretically (Oliver, 1990; Campbell, 2009) instantiated in one man's reported emotional experience.

For Dev, the breadwinner burden had been operative since adolescence and had never been suspended in response to his difficulties:

"I was providing for the family by the time I was 15. I was paying my own school fees. I was doing tuition in different households, I was an activity teacher, I was doing odd jobs... and I was constantly bullied at school because I was skinny and wore clothes that were twice my size." (Dev)

Ahmed offered a pointed comparison between how disability and healthcare intersect with masculinity in India versus his experience in France, grounding the abstract rights-versus-charity distinction in the material:

"If I were to go to India and say I need help, it is going to be seen as a bad thing, or people brushing it off — 'he needs help, he's an invalid.' Here [France] it is the opposite. If you have a certain medical condition, you legally cannot be fired from your job. They provide you with a vehicle, a personal aid. My medicine here — one month costs €600, more than my rent. If I had to pay for it I would have to choose between medicine and a roof." (Ahmed)

He also noted the long lag in his own treatment: a private consultant had told him that the medication he was finally prescribed in 2023 should have been the first course of action a decade earlier. The systemic failure was not merely clinical; it was economic and institutional — and its costs had been absorbed entirely by him and his family.

The image of a fifteen-year-old with undiagnosed ADHD working multiple jobs, managing familial finances, and enduring school bullying — with none of these pressures acknowledged by those around him as being in any tension with each other — captures something specific about the intersection of class, masculinity, and invisible disability that neither theoretical framework alone would be sufficient to produce.

Shyam, having achieved career stability and outward professional performance, had also developed a more expansive definition of productivity that ran alongside the capitalist one:

"Productivity — there is the capitalistic lens, and there is the emotional lens. I find myself productive if I'm able to make the people's lives around me better — making them laugh, providing comfort. Someone is having a panic attack; I was able to calm them down. So that for me is productive." (Shyam)

This dual-lens formulation — holding capitalist and relational productivity simultaneously rather than replacing one with the other — represents a more pragmatic form of identity negotiation than outright rejection. Shyam was not dismissing the capitalist lens but supplementing it with a register in which he could consistently meet the standard. This is consistent with what Wilton and Fudge Schormans (2025) describe as "reimagined masculinity" — not the rejection of masculine values but their creative reordering to accommodate disability experience.

Professional Concealment. All five participants described maintaining careful concealment of their conditions in professional environments. The decision not to disclose was consistently framed as a calculated response to a perceived absence of safety rather than a preference for privacy:

"I've not been able to share [my ADHD] at all [at work]… I don't think Indian workplaces have the space for [ADHD and queer identities]… the way [male colleagues] talk about women… people who are not them… you realise it would be a hard time for them to accept anyone outside their comfort zone." (Arjun)

Arjun's career trajectory before diagnosis was shaped by what he now understands as unrecognised ADHD: a pattern of rapid ascent, disengagement, lateral moves, and periodic collapse that looked, from the outside, like restlessness or ambition:

"There was one specific instance where I literally worked through the night, talked to some random person because I needed that dopamine rush, cheated on my girlfriend — which in no way is correct — but that was the point where I realised, okay, it's affecting me more than it should. Within six months I had quit the job. I just walked in and said, I don't want to do this, give me this and this and I will leave today." (Arjun)

The account connects three domains usually treated as separate — professional conduct, intimate relationships, and neurological dysregulation — in a single, honest account of what undiagnosed ADHD looked like in practice.

Arjun's account connects professional concealment of his neurodevelopmental condition directly to his experience of workplace culture as broadly intolerant of non-normative identities. For him, ADHD disclosure and queer identity disclosure carried similar risks, and his decision not to disclose either was based on the same environmental read. This connecting of neurodivergence and queer identity within a shared logic of concealment is a finding with direct relevance to intersectional approaches to workplace inclusion.

Arjun had made a concrete attempt to create a structural support for his attentional difficulties — not through institutional accommodation, which was unavailable, but through a personal arrangement:

"I tried hiring a friend to just sit with me and get things done. She would work as a PA — make sure I got stuff done. That worked for about a month and a half, then it went to shit. It was also complicated because she was my ex." (Arjun)

The pragmatism here is notable: body doubling — having another person present while working — is a well-documented self-management technique in adult ADHD (Kessler et al., 2006). Arjun had arrived at it independently. The attempt also illustrates the specific social and relational entanglements that arise when informal support structures substitute for formal ones: the friend, the accountability partner, and the ex-partner were the same person.

Shyam offered what is perhaps the sharpest single-sentence analysis of how ableism operates in professional contexts across the whole sample:

"The stigma was because I was not a productive member of society. It was because of the effects of the symptoms rather than the underlying cause." (Shyam)

This distinction — between stigma directed at the condition and stigma directed at its functional consequences — is analytically significant. Shyam was not stigmatised for being autistic; he was stigmatised for failing to produce. The invisible disability remained invisible, but its effects were entirely legible and entirely penalised. He elaborated on the conditional nature of acceptance that followed once he became productive:

"Fundamentally, people don't give a damn about you. People care about what you have to offer them. And somewhere, if you're in a position to offer things to people, all of these other things just go away." (Shyam)

This account echoes Baker et al. (2024), who found among disabled men in their sample that perceived burdensomeness — the felt sense of being a net drain on social resources — was a primary driver of identity crisis, and that this burden was lifted almost entirely by demonstrations of economic or social utility. Shyam's account documents the same conditional logic from the inside.

Shyam described the active performance of normalcy as a skilled but exhausting practice: "I've learned how to masquerade as a productive employee." This characterisation is consistent with the accounts compiled by Lindsay et al. (2018), in which workers with invisible disabilities described performing a version of productivity that was distinct from, and significantly more costly than, the actual work they were doing.

4.4. Theme 4: Masking and Adaptations

Self-Developed Compensatory Frameworks. A recurring finding across the sample was the development of elaborate, self-directed coping frameworks in the absence of formal diagnosis or institutional support. These

were not therapeutic interventions but autodidactic systems devised through trial, error, and resourcefulness:

"If you probably saw me on the street or in a social setting, you'd probably think I'm super extroverted and super social. But in reality that is a very draining mask that I put on. And that's something I've trained over a long period of time." (Shyam)

The gap between presentation and experience was made vivid by feedback Shyam received from relatives after a family gathering:

"The feedback they gave to my partner was: hey, this guy socialises a lot then suddenly shuts off. And that sudden shut-off point is probably when I got too exhausted from masking." (Shyam)

The social mask had become convincing enough that even its collapse was misread — perceived as a personality shift rather than depletion. This is precisely the condition that Lindsay et al. (2018) describe as the core burden of invisible disability in social contexts: the performance succeeds so well that even its failure is invisible. In terms of compensatory work strategies, Shyam had arrived at a similar task-management insight to his self-developed frameworks for social interaction:

"I religiously followed the framework from How to Win Friends and Influence People. I would prepare extensively before social gatherings, researching topics, rehearsing questions." (Shyam)

"I now say, 'Hey, I'm a selfish person. I forget birthdays, I forget this and that. Don't expect too many things from me.'" (Dev)

"I can't do a three-hour exam. So I asked the person sitting behind me to pinch me every five minutes to make sure I was still concentrating." (Dev)

The resourcefulness of these strategies is notable; their limitations are equally apparent. They represent the work of individuals who had received no formal support developing workarounds for structural inadequacies. Dev's examination strategy, arranging for a peer to physically pinch him at intervals, is both ingenious and a damning indictment of an educational system that provides no accommodation for students with attentional difficulties. Shyam described an equivalent breakthrough in his work approach, reached entirely through self-experiment:

"My first approach was to go sequentially. And that almost never worked — it felt very claustrophobic, very constraining. I'd get bored. So I gave myself the freedom to jump around and that kind of unlocked things." (Shyam)

Both strategies — Dev's external interruption and Shyam's internal permission to context-switch — represent the same underlying discovery: that the linear, focused working mode assumed by most institutional structures is precisely what neurodivergent cognition finds most costly, and that circumventing it, once permitted, releases rather than undermines productivity. As Nettleton (2006) observes of chronic illness management more broadly, the expertise that patients develop about their own conditions is rarely recognised or systematised by the institutions that might benefit from it.

Ahmed's account adds an important dimension: the costs of an invisible condition can include the gradual, private loss of capacities that others take for granted, without any external marker that might invite recognition or accommodation:

"I used to do track at state level. But I can't really run like that anymore. The reason I stopped in the first place was because the moment I ran for two minutes I would get a crippling headache because of my anaemia. A lot of it is atrophy now because I just don't do it — but the atrophy started because I couldn't." (Ahmed)

The distinction is significant: the body's current limitations are visible as lifestyle choices, not as disability consequences. The illness has retreated invisibly into the history of how those choices were made.

Dev also described how the autodidactic route eventually became generative rather than merely compensatory — finding a way to learn through what his brain was drawn to rather than what he was told he should do:

"I learned counting because I learned how to play cricket. I still think in tables of sixes because one over is six balls. So if somebody is bowling 90 overs, they're delivering 540 balls. I just did multiplication in my head. I did that because I started playing cricket — and that is exactly why I know how to count." (Dev)

This account illustrates what could be described as neurodivergent autodidacticism: the development of domain-specific competencies through intrinsically motivated routes that bypass conventional pedagogical structures.

Substance Use as Self-Regulation. A concerning pattern of substance use as an undirected self-regulatory strategy emerged across the sample. Arjun described a multi-year cycle of caffeine, cannabis, and sugar use deliberately employed to manage stimulation levels:

"I've been using caffeine, sugar and pot to sort of control my moods and figure things out… by 2018, 2019, I reached a very vicious cycle where the minute work ended, I'd smoke up because I couldn't sleep without it, and in the morning I'd still be somewhat hungover, so I'd drink a lot of coffee." (Arjun)

Dev described escalating to three packets of cigarettes a day and significant alcohol use from the age of nineteen, in a context where alcohol was freely available through his part-time employment, his family's financial constraints had removed most other forms of relief, and the distress produced by his undiagnosed condition had no other outlet:

"I got into addictions. I got into alcohol; I got into cigarettes… It was an escape for me. Those things were an escape for me… By the time I was 20, I was smoking three packets a day." (Dev)

For Arjun, the cycle of self-regulation through substances was not experienced as addiction so much as a pragmatic — if ultimately damaging — attempt to manage a neurological system he did not yet have a name for. His subsequent ambivalence about formal medication for ADHD is illuminating:

"There's a little bit of stigma, there's a little bit of just apprehension, because you don't know what it will do to your morning. There's also a little bit of a known thing where I know that any meds I try will be a trial and it will be a process — and I know that's going to be an excruciatingly long process." (Arjun)

The reluctance to medicate, often read in clinical settings as non-compliance or denial, is here a reasoned response to prior experience of protracted, poorly-supported trial-and-error processes. Dev has been sober for four years. His sobriety was achieved through therapy and a reconnection with creative work, without formal addiction treatment. The trajectory — undiagnosed ADHD, accumulating life stressors, substance use as self-medication, eventual therapeutic engagement, and sustained recovery — closely resembles pathways documented by Kessler et al. (2006) in studies of ADHD and comorbid substance use disorder in adult populations.

Remote Work as Structural Accommodation. The post-pandemic normalisation of remote work had created an informal but significant structural accommodation for neurodivergent participants. The ability to manage one's own sensory environment, pace one's own work, and task-switch without scrutiny was reported as substantially reducing the daily cost of masking:

"I find it very easy to function in a remote setup because I am jumping between projects... I'm able to jump from here and there; it's very nice." (Arjun)

"Because I work remotely, it's easier to mask these things on most days." (Shyam)

Shyam's account is ambivalent: remote work is experienced as accommodation, but the accommodation is framed as making masking easier rather than making masking unnecessary. This reflects a broader finding in the disability and work literature: structural changes that reduce the daily cost of concealment do not substitute for cultural changes that make disclosure safe (Lindsay et al., 2018).

4.5. Theme 5: Support Systems and Relationships

Emotional Labour Gap in Male Friendship. All five participants described male friendship networks as inadequate, and in several cases actively unhelpful, as sources of emotional support. Participants attributed this inadequacy to the relational norms of male friendship rather than individual failing:

"I did not know if I could be emotionally vulnerable with them [male friends]. I even got some very cold responses from a couple of them; like, 'why don't you just get the surgery done and get on with it?'" (Siddharth)

"He [closest male friend] spoke about how why couldn't he; why couldn't I call him when I was going through something harrowing? We came to a point where we said, these are patriarchal constructs. We need to be more open, we need to be uncomfortable with each other in terms of emotional support." (Siddharth)

The second quote merits closer attention: it documents not just the failure of male friendship to provide support but a conversation in which both parties explicitly named patriarchal norms as the structural cause of that failure. Siddharth and his friend had reached a theoretical analysis of their own relational limitations, consistent with the extensive empirical literature on male emotional stoicism and friendship quality (Bank & Hansford, 2000; Migliaccio, 2009), and had chosen to work actively against those norms. The exchange illustrates counter-hegemonic resistance at the relational level.

The hollowness of male friendship became concrete in the first message Siddharth received from a childhood friend after he had returned from treatment in the United States:

"He texted me asking, 'Oh, abhi tu bahar nikal sakta hai kya?' — can you step out now — for lunch. You have not asked me how I'm doing. You did not check in on me. And now you want to come for lunch." (Siddharth)

The question was social reintegration — whether Siddharth was mobile enough to be a normal friend again — not an inquiry into what the preceding two years had cost him. The instrumental logic of male friendship, in which contact is organised around activity rather than emotional availability, could hardly be more plainly illustrated.

Siddharth also noted the gender and sexuality profile of the supportive community he had eventually found:

"The majority of the people [providing online support] are women. Or queer people. There were only maybe a couple of men who were receptive and reciprocative."

This finding is consistent with research on online support communities for chronic illness and disability: Barker (2008) found that women were significantly more active than men in constructing and sustaining online peer support networks, and that men who did engage with these spaces often reported doing so with some ambivalence about the gender composition of the group.

Shyam's account of support contains the single most stark data point in the entire study: the degree to which the absence of adequate support — and the eventual availability of therapy — determined whether he survived:

"I was extremely suicidal in 2022. Therapy got me out of it. If you know the 10-point suicidal scale — I was at 10. Then I came down to 8, then 5. Now I'm probably 2-3." (Shyam)

This trajectory makes concrete what the rest of the data describes in less acute terms: the compounding of invisible disability, masculine norms that discourage help-seeking, and social networks that provide inadequate emotional support does not produce merely reduced quality of life. For some men, it produces crisis. The therapeutic relationship — which Shyam had accessed, unlike many men in comparable situations — was the primary factor that changed the trajectory. Galdas et al. (2005) note that men's under-utilisation of mental health services is well documented; what Shyam's account adds is the specific cost of that under-utilisation when the underlying conditions are invisible, misunderstood, and compounded by masculine norms around self-sufficiency.

Despite this, Shyam's engagement with his ADHD peer support community was characterised by a significant irony: he was more present in it as a helper than as someone who consumed support for himself:

"[The ADHD peer group] mostly helps in giving slight joy and being there for others. I have not consumed it as much for my own sake — I use it more to help others." (Shyam)

This pattern — the neurodivergent man who can extend support to others but struggles to receive it — runs through the support theme more broadly.

Partner as Primary Support Anchor. For partnered participants, the romantic relationship had assumed a primary support function that extended well beyond emotional companionship into practical health management:

"My partner is very understanding of my issues. She knows what I have and she understands... when it's getting late for me to have my medicine, she just tells me, 'Please have your dinner because I know you have to have your meds.'" (Ahmed)

Arjun described a related but more constrained version of partnership support — not the practical medication-monitoring Ahmed described but the more basic problem of having the cognitive bandwidth to be present in a relationship at all:

"There are a lot of times you're just too overwhelmed to really communicate with someone. I'm now trying to be at a point where at least I tell them: listen, I need to communicate with you but I don't have the bandwidth for it right now." (Arjun)

The phrase "bandwidth" is borrowed from professional language but describes something deeply personal: the felt experience of ADHD as a limited cognitive resource that relationships compete for alongside work, regulation, and self-management. Arjun's previous relationships had, by his own account, suffered from this: the undiagnosed ADHD that drove his workplace pattern also drove a relational pattern he could now name but was still learning to navigate.

Shyam's description of what his partner provided was less about practical management and more about emotional calibration:

"In terms of being a vent, being someone who can listen to me, who can try to understand — even if not give a solution, at least empathize and tell me that what I'm going through is not so bad. She's someone who also has a lot of anxiety. When I see that, it kind of calms me down — it helps me reassure that I'm not alone." (Shyam)

The mutual anxiety within the relationship is significant: Shyam finds comfort partly in recognising that his partner shares a form of his distress, which reduces the felt distance between his experience and others'. This is a different form of partner support than Ahmed's practical medication-prompting — it is fundamentally about co-regulation and the abolition of isolation.

This dynamic — in which a partner monitors medication, manages health routines, and provides emotional regulation — is characteristic of what Kessler et al. (2006) identify as the 'adaptive partner' pattern in ADHD relationships. While the practical benefits are clear, the arrangement also raises questions about the distribution of relational labour and the degree to which the partner's own needs and wellbeing are sustained within it. The present data do not permit analysis of the partner's perspective, but this would be a productive area for future research.

Community Attrition Following Disclosure. For Siddharth in particular, the decision to speak publicly about his condition — motivated by the need to fundraise and the absence of adequate private support — had produced active social loss rather than the connection he sought:

"I have definitely experienced a huge loss of community. I felt quite disposable as a friend... simultaneously [I'm] losing a lot of friends, a lot of people are ghosting me, a lot of people are unfollowing me, because I'm talking about, I'm being vulnerable online." (Siddharth)

He also noted the particular shape the community's response took when a man was the one being vulnerable:

"I'm getting quite a lot of support because I'm a man. So it's like, oh, I'm a man and I've been so vulnerable. So people are congratulating me or saying 'kudos to you for being so strong'. But also simultaneously losing people because I'm talking about this." (Siddharth)

This doubling — receiving praise for male emotional openness whilst simultaneously losing social connection for it — reveals the ambivalent relationship Indian masculine culture has with male vulnerability. Disclosure is applauded as exceptional precisely because it violates the norm; and the social cost arrives alongside the applause.

Shyam's relationship to social isolation itself was notably different from Siddharth's: where Siddharth experienced community attrition as a wound, Shyam described a chosen and largely comfortable solitude. When asked whether his withdrawal from social interaction got isolating, he replied:

"It does get isolating but I like it." (Shyam)

This brief statement carries significant analytic weight. It points to a dimension of autistic experience that the disability-masculinity literature has not fully engaged: the possibility that social withdrawal is not always a loss to be compensated or a symptom to be treated but sometimes a genuine preference that conflicts with the masculine expectation of sociability and social leadership. Shyam was not absent from community because illness had stripped it from him; he was choosing degrees of solitude that felt appropriate to him, and the difficulty was others' interpretation of that choice.

The irony of this dynamic, that vulnerability produces isolation, is consistent with research on stigma and disclosure in chronic illness. Earnshaw and Quinn (2012) found that anticipatory stigma (concern about how others will respond to disclosure) was associated with reduced disclosure, reduced social support, and poorer mental health outcomes in individuals with chronic conditions. The present data contribute a specific mechanism: in the context of Indian masculine norms, male vulnerability is experienced as a social category violation, a breach of the implicit contract of masculine stoicism, that licenses disengagement or abandonment.

5. Discussion

The five themes outlined above, taken together, describe a coherent experiential pattern: men in urban India living with invisible disabilities face compounded pressures from medical institutions that do not take their conditions seriously, labour markets that equate worth with productivity, social networks structured around emotional unavailability, and cultural scripts that define masculine identity in terms that their conditions cannot consistently support. These pressures interact and reinforce each other in ways that the existing theoretical literature has described but that this study documents empirically, from the inside.

Diagnostic Failure and Gendered Healthcare: The pattern of late diagnosis, symptom dismissal, and gendered pain management documented here is consistent with existing empirical literature. Awan et al. (2025), in a qualitative study of South Asian men with long-term conditions, found that masculine identity actively structured how participants presented to, and interacted with, healthcare services: men consistently framed delayed care-seeking as an obligation to appear self-sufficient and functional. Chikovore et al. (2014), studying men with TB symptoms in Malawi, found a closely parallel pattern, with masculine norms framing illness acknowledgement as a failure of male self-control. In both studies, the clinical encounter became a site where masculine norms were reproduced rather than challenged. The present study adds a further dimension: symptom dismissal and withheld pain relief were not only individual clinical failures but expressions of institutional assumptions about male bodies and endurance.

The finding regarding colonoscopies performed without anaesthesia on the explicit grounds of the patient's gender illustrates this concretely. Samulowitz et al. (2018) identified in a systematic review that male patients' pain reports were more frequently met with dismissal than female patients' reports, and that male stoicism was frequently assumed rather than assessed. In Ahmed's account, the clinician expressed disappointment at two men crying during a painful procedure: the withholding of anaesthesia was a normative enforcement, not a clinical assessment. This is a particularly stark example of what the literature on gendered healthcare documents as a structural pattern rather than an individual failure.

Masculinity, Disability, and Identity Work: The counter-hegemonic resistance documented in Theme 2 extends existing knowledge in two directions. First, it confirms for the Indian context a pattern noted in Western disability studies: that some disabled men respond to the inadequacy of hegemonic masculine norms not by seeking compensatory routes to masculine status (Gerschick & Miller, 1994) but by questioning the value of those norms altogether (Morris, 2001; Shuttleworth, 2004). Second, it documents more clearly than prior studies the specific mechanism by which disability experience generates this critique: participants could articulate the precise points at which their disability had made the hegemonic ideal impossible to sustain, and it was at those points that the ideal's arbitrary and constructed character became visible to them.

The finding has implications for understanding disability and masculine identity more broadly. The existing literature has tended to frame the relationship between disability and masculinity in terms of threat, loss, and adjustment (Gerschick & Miller, 1994; Shuttleworth et al., 2012). Wilton and Fudge Schormans (2025), in a

comparative qualitative study of three men living with chronic physical illness, intellectual disability, and psychiatric disability respectively, found that disability experience generated complex, non-linear renegotiations of masculine identity in which breadwinning, domesticity, and relational norms were all sites of active reconstruction rather than passive surrender. The present data extend this finding into the Indian context and add a dimension the Western literature has not fully addressed: the role of caste and community-specific masculine formations in shaping what must be resisted and what is available as an alternative. The men in this study were not simply negotiating against a generic hegemonic masculinity but against Tamil Brahmin productivity ideals, Muslim intergenerational stoicism, and lower-middle-class breadwinner obligations — each with its own texture and its own specific form of incompatibility with invisible disability.

Work, Productivity, and the Ableist-Capitalist Nexus: The equation of productive capacity with personal worth documented in Theme 3 is consistent with disability studies accounts of the capitalist body (Oliver, 1990; Campbell, 2009), and with empirical findings from workplace studies. Pandya et al. (2022), in their scoping review of workplace mental health interventions in India, found that existing programmes provided almost no coverage of neurodevelopmental or invisible physical disabilities, leaving workers whose difficulties were not immediately visible without structured support or disclosure routes. Poddar and Chhajer (2024), in a qualitative study of workplace mental health disclosure conducted with employees, HR professionals, and counsellors at Indian organisations, found that employees consistently cited fear of managerial reattribution — the concern that disclosed difficulties would be reframed as excuses for underperformance — as the primary barrier to disclosure. One participant in their study noted: having adult ADHD, they did not mention it to their manager for several months, fearing they would be stopped from meeting clients. The present study finds an identical pattern, with the additional dimension that for Arjun, ADHD disclosure and queer identity disclosure carried the same risk, amplifying the incentive for concealment. Arjun's account of scanning his workplace culture for signs of tolerance before deciding it was unsafe to disclose — not just his ADHD but his queer identity simultaneously — shows how the absence of formal protection translates into deliberate self-concealment. The additional Indian cultural dimension here is significant: the breadwinner ideal, grounded in the karta construction of masculine responsibility, means that the stakes of productive failure are economic and existential; a threat to one's identity as a man and as a family member.

Illness Vulnerability, Resilience, and the Disclosure Paradox: Before addressing support deficits, it is worth noting a specific paradox that several participants experienced: that the act of publicly disclosing illness vulnerability — which might be expected to attract support — frequently produced the opposite. Siddharth's account documents simultaneous praise and abandonment for the same act of online vulnerability. Oliffe (2023), in a secondary analysis of men's illness case studies, identifies what he terms the "illness testimonial paradox": men who disclose vulnerability in public contexts often find that their disclosure is received as a prop for masculine identity reconstruction rather than as a genuine request for support, generating applause rather than sustained engagement. The present data confirm this paradox in the specific Indian context: male vulnerability is treated as exceptional and praiseworthy precisely because it violates the norm, but the social infrastructure required to actually sustain a vulnerable man — consistent relational engagement, practical help, emotional presence — remains largely absent.

Support Deficits and Relational Consequences: The inadequacy of male friendship networks as sources of emotional support documented in Theme 5 is consistent with a substantial body of international research. Bank and Hansford (2000) found significant gender differences in the emotional depth and mutual vulnerability of friendship relationships, with male friendships characterised by shared activities rather than emotional disclosure. Migliaccio (2009) found that men consistently reported lower perceived emotional

support from male friends than women reported from female friends, and attributed this partly to masculine norms that render emotional need-expression in friendship contexts normatively problematic.

The present data document the dynamic consequence of this deficit in the context of invisible disability: when men attempt to disclose their conditions or seek support from male peers, they frequently encounter active discouragement, framed in the language of masculine self-reliance. The result, as Siddharth's account makes clear, is that the act of seeking support produces a further deterioration of the social environment in which support might be found.

6. Conclusion

This study set out to document how five urban Indian men living with invisible disabilities experienced the demands of hegemonic masculinity in relation to their health, and to contribute empirical knowledge to an intersection that has been theorised but not substantially evidenced in the Indian context.

The findings indicate that these men navigated compounded pressures from healthcare institutions that minimised their conditions, labour contexts that equated their worth with productive capacity, and social networks structured around emotional unavailability. Medical encounters were frequently characterised by symptom dismissal and, in at least two cases, by explicit gendered denial of pain management. Workplace environments were experienced as unsafe for disclosure, producing sustained professional concealment at significant psychological cost. Male friendship networks consistently failed to provide the emotional support participants needed, leading them to rely primarily on romantic partners, women, and queer community members.

Against this backdrop, several participants had developed an articulate and deliberate critique of the masculine norms they were unable to sustain; a process this study calls counter-hegemonic resistance. The finding carries both theoretical and practical significance. Theoretically, it suggests that the relationship between disability and masculine identity in the Indian context is one of loss and adjustment, but also of critical insight and deliberate reconstruction. Practically, it suggests that some men with invisible disabilities have already done the identity work that clinical and community interventions often attempt to facilitate, and interventions can build on this work rather than beginning from scratch.

This study has several limitations that qualify the scope of its conclusions. The sample is small and demographically homogeneous in ways that matter. All five participants were urban, educated, and digitally networked men who had already sought therapeutic support and were connected to disability and mental health communities. This reflects both the sampling method (online recruitment) and a degree of self-selection: men who are already engaged with disability discourse and therapeutic frameworks are more likely both to volunteer for a study of this kind and to articulate their experiences in the terms this study employs. The experiences of men without these resources: men in rural contexts, men without access to mental health services, men from communities with more rigid masculine norms. are likely to include significantly more acute and less supported versions of the pressures documented here. Future research should explicitly aim to reach these populations.

The range of conditions represented in the sample is heterogeneous: autoimmune illness, musculoskeletal conditions, and neurodevelopmental conditions present differently and carry different social meanings. While the common thread of invisibility is genuine and analytically productive, this study is not able to make differentiated claims about the specific experience of each condition type. Future work could usefully focus on more condition-specific samples.

The absence of longitudinal data means the study cannot address how the experiences documented here change over time: whether counter-hegemonic resistance is sustained, whether community attrition is eventually reversed, or whether late-diagnosed participants' self-concept continues to shift as they live with their diagnoses longer.

Finally, the researcher's own membership of the participant community, while an analytic resource, also represents a potential source of interpretive bias. The reflexive journal and member-checking procedures described in the methods section were designed to mitigate this, but they cannot eliminate it.

In terms of the future implications of the study, the pattern of gendered pain bias and symptom dismissal documented here suggests a need for training for medical practitioners in recognising and counteracting the assumption of masculine stoicism in clinical encounters. Specifically, protocols for pain assessment and anaesthesia provision should not be calibrated on implicit assumptions about male tolerance. For neurodevelopmental conditions, there is a need for adult ADHD and autism assessment pathways that do not assume childhood diagnosis as the normative route. General practitioners in India who encounter men presenting with unexplained fatigue, attentional difficulties, or substance use difficulties should be equipped to consider neurodevelopmental explanations.

Gender-sensitive clinical protocols for men with invisible disabilities might include routine screening for depression and anxiety (which are under-reported in men due to masculine norms around emotional expression), explicit normalisation of help-seeking during consultation, and awareness training for clinical staff regarding the specific ways in which hegemonic masculine norms shape symptom presentation and clinical behaviour. These are not novel propositions in the global literature (Galdas et al., 2005), but their application in the Indian context requires specific attention to caste, class, and cultural frameworks of masculine identity.

The findings regarding professional concealment and remote work as informal accommodation suggest that Indian organisations have a significant opportunity to improve the experience of employees with invisible disabilities; structural changes such as remote work provision are insufficient without accompanying cultural change. Organisations should consider providing clear, actively communicated channels for disability disclosure that are decoupled from performance management processes, investing in manager training that addresses both visible and invisible disability, and developing accommodation frameworks that do not require formal disclosure as a precondition for support.

The documented relationship between late-diagnosed or undiagnosed neurodivergence and substance use has direct implications for clinical practice. Counselling psychologists and psychiatrists working with Indian men presenting with substance use difficulties should consider neurodevelopmental assessment as part of their standard evaluation, particularly where the substance use pattern is characterised by self-regulatory rather than social functions. The therapeutic relationship may need to specifically address the shame and self-blame produced by decades of adverse social labelling prior to diagnosis.

Lastly, the community attrition experienced by participants following disclosure also has clinical implications. For men navigating the decision of whether and how to disclose their invisible disability; in personal relationships, online, or at work; therapeutic support may need to engage explicitly with the realistic risks of disclosure, rather than simply encouraging openness.

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Conflict of Interest

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