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ADULT ADHD IN WOMEN MISDIAGNOSED AS DEPRESSION: DIAGNOSTIC CHALLENGES, CLINICAL CONSEQUENCES AND IMPLICATIONS FOR HEALTHCARE EDUCATION – A NARRATIVE REVIEW

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ABSTRACT

Background. Attention-deficit/hyperactivity disorder (ADHD) in adult women remains substantially underdiagnosed and frequently misinterpreted as depressive disorders. This diagnostic inaccuracy is associated with gender-specific symptom presentation, internalization of difficulties, and compensatory masking strategies.

Aim. The aim of this narrative review is to examine the mechanisms underlying the misdiagnosis of ADHD as depression in adult women, identify key diagnostic challenges, evaluate clinical consequences, and discuss implications for healthcare education.

Material and methods. A narrative review of 30 peer-reviewed articles published between 2009 and 2026 was conducted. Databases including PubMed and Google Scholar were searched using keywords related to adult ADHD, women, depression, and misdiagnosis.

Results. Evidence indicates that adult women with ADHD are frequently misdiagnosed with depressive disorders due to overlapping symptoms such as fatigue, impaired concentration, and emotional dysregulation. Gender-specific factors, including social expectations and masking behaviors, significantly delay diagnosis. Misdiagnosis results in inappropriate pharmacological treatment, chronic functional impairment, and increased psychiatric comorbidity.

Conclusions. ADHD in women requires a gender-sensitive diagnostic approach. Increased clinician awareness and improved training in differential diagnosis are essential to reduce misdiagnosis and improve patient outcomes.

KEYWORDS

Adult ADHD, Women, Misdiagnosis, Depression, Diagnostic Delay, Masking, Differential Diagnosis

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1. Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition traditionally associated with childhood and predominantly diagnosed in males. Classical diagnostic frameworks have emphasized symptoms such as hyperactivity, impulsivity, and externalizing behavioral disturbances. However, over the past two decades, a paradigm shift has emerged, recognizing ADHD as a lifespan disorder that persists into adulthood in approximately 60% of cases (Thapar & Cooper, 2015). Current epidemiological data estimate the prevalence of adult ADHD at approximately 2.5–4%, although this figure is likely underestimated due to substantial rates of underdiagnosis (Kooij et al., 2019).

A particularly critical gap in the literature and clinical practice concerns the identification of ADHD in women. Historically, ADHD has been underrecognized in females, largely due to gender differences in symptom presentation, coping strategies, and sociocultural expectations (Young et al., 2020; Martin, 2024). While boys are more likely to exhibit disruptive, hyperactive behaviors that prompt early clinical referral, girls and women tend to present with predominantly inattentive symptoms, emotional dysregulation, and internalized distress, which are less likely to be identified as manifestations of ADHD (Quinn & Madhoo, 2014).

One of the most significant clinical consequences of this gender disparity is the frequent misdiagnosis of ADHD in adult women as depressive disorders. Depression is among the most commonly diagnosed psychiatric conditions in women, and its symptomatology—including low mood, fatigue, impaired concentration, sleep disturbances, and reduced motivation—overlaps extensively with ADHD (Bron et al., 2016; Fu et al., 2025). As a result, clinicians may attribute cognitive and emotional symptoms solely to mood disorders, overlooking the possibility of an underlying neurodevelopmental condition.

The issue of misdiagnosis is further complicated by high rates of psychiatric comorbidity. Individuals with ADHD are at significantly increased risk of developing mood and anxiety disorders across the lifespan (Powell et al., 2021). In many cases, depression may develop secondary to chronic functional impairments,

academic or occupational difficulties, interpersonal problems, and persistent feelings of inadequacy associated with undiagnosed ADHD. This bidirectional relationship creates a complex clinical picture in which primary and secondary conditions are difficult to disentangle.

Another important factor contributing to diagnostic challenges is the phenomenon of masking or camouflaging, which refers to the conscious or unconscious suppression of ADHD symptoms through compensatory behaviors. Women with ADHD often develop strategies such as excessive organization attempts, overpreparation, perfectionism, and heightened social conformity in order to meet external expectations (Lynch & Davison, 2022; Mylett et al., 2026). While these strategies may temporarily reduce visible impairments, they frequently lead to increased psychological burden, burnout, and emotional exhaustion over time.

In addition, diagnostic systems such as the DSM-5 (American Psychiatric Association, 2013) have historically been based on research conducted predominantly in male populations. This has resulted in diagnostic criteria that may not fully capture the female phenotype of ADHD, particularly in adulthood. Subtle manifestations such as chronic disorganization, mental restlessness, emotional lability, and difficulties in sustaining attention in non-stimulating environments may be misinterpreted as personality traits or mood-related symptoms rather than indicators of ADHD (Nussbaum, 2012).

The consequences of delayed or incorrect diagnosis are substantial. Studies show that women with undiagnosed ADHD often experience prolonged psychological distress, reduced self-esteem, impaired occupational functioning, and difficulties in interpersonal relationships (Attoe & Climie, 2023; Holden & Kobayashi-Wood, 2025). Many receive multiple psychiatric diagnoses over time—most commonly depression and anxiety—before ADHD is eventually recognized, often in adulthood or even later life (Henry & Jones, 2011). This diagnostic delay can span decades and is associated with inappropriate or insufficient treatment.

Pharmacological and psychological treatment strategies differ significantly between ADHD and depression, making accurate diagnosis essential. While antidepressants may alleviate mood symptoms, they do not address core ADHD deficits such as executive dysfunction, attentional impairment, and impulsivity (McIntosh et al., 2009). Consequently, patients may experience only partial improvement, leading to treatment resistance, frustration, and repeated cycles of ineffective interventions.

Cognitive research further highlights the complexity of differentiating ADHD from depression. Both conditions are associated with impairments in executive functioning, working memory, and attentional control, although the underlying mechanisms may differ (Paucke et al., 2021). ADHD is typically characterized by persistent, trait-like cognitive deficits, whereas cognitive impairments in depression may fluctuate with mood state. Nevertheless, in clinical settings, these distinctions are often difficult to assess without targeted evaluation tools.

Given the growing recognition of ADHD in adult women and the significant consequences of misdiagnosis, there is an urgent need for improved awareness, more nuanced diagnostic frameworks, and enhanced education among healthcare professionals. Addressing gender bias in diagnosis and incorporating a lifespan perspective are essential steps toward improving clinical outcomes.

Research Objective.

The objective of this narrative review is to comprehensively examine the misdiagnosis of ADHD as depression in adult women, with a focus on identifying underlying mechanisms, diagnostic challenges, and implications for clinical practice and healthcare education.

2. Research materials and methods

2.1. Study design

This study was conducted as a narrative review aiming to synthesize and critically analyze existing literature on the misdiagnosis of ADHD in adult women as depressive disorders. This methodology was selected due to the multidimensional nature of the topic, encompassing clinical, psychological, and sociocultural aspects of ADHD diagnosis in women.

2.2. Literature search strategy

A comprehensive literature search was conducted using major electronic databases, including PubMed, Scopus, and Web of Science, to identify relevant studies published between 2009 and 2026. Additional references were identified through manual screening of the bibliographies of selected articles.

The search strategy combined keywords and Medical Subject Headings (MeSH) related to ADHD, gender differences, depression, and diagnostic challenges. Search terms included combinations of the following expressions: “adult ADHD”, “women”, “female”, “misdiagnosis”, “depression”, “diagnostic delay”, “masking”, “camouflaging”, “comorbidity”, and “differential diagnosis”. Boolean operators (AND, OR) were applied to optimize the sensitivity and specificity of the search process.

2.3. Inclusion and exclusion criteria

To ensure the relevance and quality of the analyzed material, only peer-reviewed articles published in English and focusing on adult populations (≥ 18 years) were included in the review. Eligible studies addressed ADHD in women, gender differences in ADHD presentation, comorbidity with depression, or diagnostic challenges related to differential diagnosis. Original research articles, systematic reviews, and meta-analyses with accessible full texts were considered eligible for inclusion.

Studies focusing exclusively on pediatric populations, articles unrelated to gender differences or diagnostic issues, case reports with limited generalizability, and non-scientific publications lacking empirical basis were excluded from the review. Additionally, studies without sufficient methodological transparency were not included in the final analysis.

2.4. Study selection and data extraction

Relevant articles were screened in two stages. In the first stage, titles and abstracts were reviewed to assess preliminary eligibility, while in the second stage full-text articles were evaluated against predefined inclusion and exclusion criteria. Data extraction was focused on key domains relevant to the research objectives, including the prevalence of ADHD in adult women, patterns of misdiagnosis and diagnostic delay, symptom overlap between ADHD and depression, as well as cognitive and clinical characteristics. Attention was also given to the impact of masking behaviours and sociocultural factors, the consequences of delayed diagnosis, and implications for clinical practice. Ultimately, 30 sources were selected and included in the final analysis in accordance with the predefined scope of the review.

2.5. Data synthesis

Given the narrative nature of the review, a qualitative synthesis approach was employed. Findings from individual studies were organized thematically into several key areas, including gender-specific presentations of ADHD, symptom overlap with depression, diagnostic challenges and errors, psychosocial consequences of misdiagnosis, as well as implications for clinical practice and healthcare education. This thematic structure facilitated the identification of recurring patterns across the literature, highlighted existing inconsistencies, and helped to define gaps that warrant further investigation.

2.6. Statistical Software

Due to the narrative design of this study, no primary statistical analyses were conducted. However, findings from included studies were interpreted in the context of reported statistical outcomes, including effect sizes, confidence intervals, and significance levels where available.

3. Research results

3.1. Gender-specific presentation of ADHD in adult women

The clinical presentation of attention-deficit/hyperactivity disorder (ADHD) differs considerably between men and women, contributing to frequent underdiagnosis in adult female populations. Historically, ADHD diagnostic models were based primarily on male clinical samples, emphasizing externalizing symptoms such as hyperactivity and impulsivity. In contrast, women more often present with internalized symptoms and less overt behavioral disturbances, which may obscure the disorder during clinical evaluation (Young et al., 2020; Martin, 2024).

In adult women, ADHD is predominantly associated with inattentive symptoms, including distractibility, chronic disorganization, forgetfulness, impaired time management, and procrastination. Because these symptoms are less disruptive than hyperactive behaviors, they are frequently interpreted as personality characteristics, stress-related difficulties, or depressive manifestations rather than signs of a neurodevelopmental disorder (Quinn & Madhoo, 2014).

Emotional dysregulation is another important clinical feature. Women with ADHD commonly report irritability, mood instability, low frustration tolerance, and increased emotional sensitivity. Although emotional dysregulation is not formally included among core DSM-5 criteria, growing evidence suggests that it represents a significant aspect of adult ADHD symptomatology (Nussbaum, 2012). These emotional difficulties often resemble affective disorders, complicating differential diagnosis.

Women with ADHD also demonstrate higher rates of internalizing psychopathology, particularly anxiety and depression, compared with men. Consequently, mood-related symptoms frequently become the primary focus of psychiatric treatment, while underlying attentional deficits remain undetected (Fu et al., 2025; Yavuzlar Civan & Berkol, 2025).

An important contributor to delayed diagnosis is masking, also referred to as social camouflaging. Women often develop compensatory strategies designed to minimize the visibility of ADHD symptoms in academic, occupational, and interpersonal settings. These strategies may involve perfectionism, excessive preparation, rigid organizational routines, or heightened self-monitoring (Lynch & Davison, 2022; Mylett et al., 2026). Although such mechanisms may preserve external functioning, they are psychologically demanding and frequently associated with chronic stress and emotional exhaustion.

Gender expectations additionally influence symptom expression. Girls are often socialized to appear organized, emotionally controlled, and compliant. As a result, ADHD-related difficulties are more likely to be internalized rather than expressed through disruptive behavior. Many women therefore develop low self-esteem, perfectionistic tendencies, and chronic self-criticism instead of exhibiting the hyperactive behaviors traditionally associated with ADHD (Holthe & Langvik, 2017).

The burden of symptoms frequently intensifies during adolescence and adulthood, particularly when environmental demands increase. Academic responsibilities, employment, caregiving roles, and independent living may exceed previously effective coping capacities (Krebs & Donnellan-Fernandez, 2025). Hormonal fluctuations may also influence symptom severity, although this area remains insufficiently explored.

Many women diagnosed later in life retrospectively reinterpret years of functional difficulties that had previously been attributed to laziness, emotional instability, or lack of discipline (Morgan, 2024). Consequently, receiving a diagnosis in adulthood is often experienced as both validating and emotionally challenging.

Overall, the evidence indicates that ADHD in women presents with a less visible and more internalized clinical profile than the traditional male-centered ADHD phenotype, emphasizing the importance of gender-sensitive diagnostic approaches.

3.2. Symptom overlap between ADHD and depression

Differentiating ADHD from depressive disorders in adult women remains one of the major challenges in psychiatric assessment because both conditions share numerous cognitive and emotional symptoms (McIntosh et al., 2009; Powell et al., 2021).

Cognitive dysfunction represents one of the primary overlapping domains. Both ADHD and depression may involve impaired concentration, reduced working memory, indecisiveness, and diminished cognitive efficiency. However, cognitive impairments in depression are usually secondary to low mood and psychomotor slowing, whereas attentional deficits in ADHD are generally chronic, persistent, and relatively independent of emotional state (Paucke et al., 2021).

Task initiation difficulties may also appear clinically similar despite differing underlying mechanisms. In ADHD, impaired initiation is primarily associated with executive dysfunction, while in depression it is more closely related to apathy, anhedonia, and reduced emotional drive.

Fatigue and mental exhaustion occur frequently in both disorders. In depressive disorders, fatigue is commonly associated with sleep disturbances and persistently reduced energy. In ADHD, exhaustion often results from sustained cognitive effort and compensatory overfunctioning, particularly among individuals engaging in masking behaviors.

Emotional dysregulation further complicates differentiation. Women with ADHD frequently experience irritability, emotional reactivity, and heightened sensitivity to stress, all of which may resemble depressive symptomatology (Bron et al., 2016).

Despite these similarities, several features may assist in differential diagnosis. ADHD symptoms generally originate in childhood and persist across the lifespan, whereas depression typically follows an episodic course with later onset. Additionally, attentional impairments in ADHD tend to remain relatively stable, while cognitive difficulties in depression fluctuate with mood severity.

Another distinguishing characteristic is responsiveness to stimulation. Individuals with ADHD often demonstrate temporary improvement in attention and motivation during stimulating or rewarding activities. In contrast, depressive disorders are more commonly associated with diminished emotional responsiveness and reduced pleasure experience.

Table 1. Comparison of ADHD and depression in adult women

Feature	ADHD	Depression
Onset	Childhood (often unrecognized)	Usually adolescence or adulthood
Course	Chronic, persistent	Episodic
Attention difficulties	Persistent, trait-like	Fluctuating, state-dependent
Motivation	Executive dysfunction ("can't start")	Reduced motivation ("don't want to")
Mood	Reactive fluctuations	Sustained low mood
Energy levels	Variable	Persistently reduced
Sleep	Irregular patterns	Insomnia or hypersomnia
Self-esteem	Chronically affected	Reduced mainly during episodes
Response to stimulation	Temporary improvement	Limited responsiveness
Emotional regulation	Emotional reactivity	Emotional blunting
Cognitive profile	Executive dysfunction	Rumination and psychomotor slowing

Source: Developed by the author based on the reviewed literature (McIntosh et al., 2009; Paucke et al., 2021; Quinn & Madhoo, 2014; Young et al., 2020).

Importantly, ADHD and depression frequently coexist, further complicating clinical evaluation. In such cases, focusing exclusively on mood symptoms may result in incomplete treatment if underlying ADHD remains unrecognized (McIntosh et al., 2009).

Overall, symptom overlap constitutes one of the principal causes of diagnostic inaccuracy in adult women and highlights the importance of careful developmental and longitudinal assessment.

3.3. Diagnostic challenges and errors

The diagnosis of ADHD in adult women is influenced by numerous clinical and systemic barriers that contribute to delayed recognition and diagnostic inaccuracies.

One of the most significant barriers is persistent gender bias in psychiatric assessment. ADHD continues to be strongly associated with hyperactive male presentations, reducing clinician sensitivity toward inattentive and internalized female symptom profiles (Martin, 2024; Young et al., 2020). As a result, emotional symptoms frequently receive greater clinical attention than attentional dysfunction.

Another important challenge is inadequate exploration of developmental history. Because ADHD is a neurodevelopmental disorder, childhood symptom onset represents a key diagnostic criterion (American Psychiatric Association, 2013). However, many women report that early symptoms were minimized or interpreted as personality traits rather than clinically meaningful impairments.

High rates of psychiatric comorbidity additionally complicate assessment. ADHD commonly co-occurs with depression and anxiety disorders, which may overshadow executive dysfunction and attentional symptoms during clinical evaluation (Fu et al., 2025).

Masking and compensatory coping strategies further reduce diagnostic visibility. Women frequently compensate through perfectionism, excessive organization, overpreparation, and rigid routines (Lynch &

Davison, 2022; Mylett et al., 2026). Although these strategies may preserve external functioning, they can conceal clinically significant impairments and contribute to underestimation of symptom severity.

Limitations of currently available diagnostic instruments also contribute to underdiagnosis. Many screening tools were developed primarily using male populations and may inadequately capture emotional dysregulation and inattentive presentations more typical in women. Consequently, false-negative results may occur (Ustun et al., 2017).

Healthcare system limitations additionally affect diagnostic quality. Comprehensive ADHD assessment requires detailed developmental history-taking, evaluation of functional impairment, and differential diagnosis. However, limited consultation time often promotes rapid symptom classification rather than longitudinal assessment.

Cultural interpretations of behavior may also influence diagnostic reasoning. Difficulties with organization, distractibility, or emotional sensitivity are frequently normalized or attributed to stress, personality style, or lifestyle-related factors instead of being recognized as manifestations of ADHD.

The consequences of these diagnostic challenges are substantial. Women with undiagnosed ADHD often undergo multiple ineffective treatment attempts focused primarily on depressive symptoms, leading to frustration, worsening psychological outcomes, and reduced trust in healthcare systems (Attoe & Climie, 2023; Holden & Kobayashi-Wood, 2025).

Figure 1. Suggested diagnostic approach for distinguishing ADHD from depression in adult women

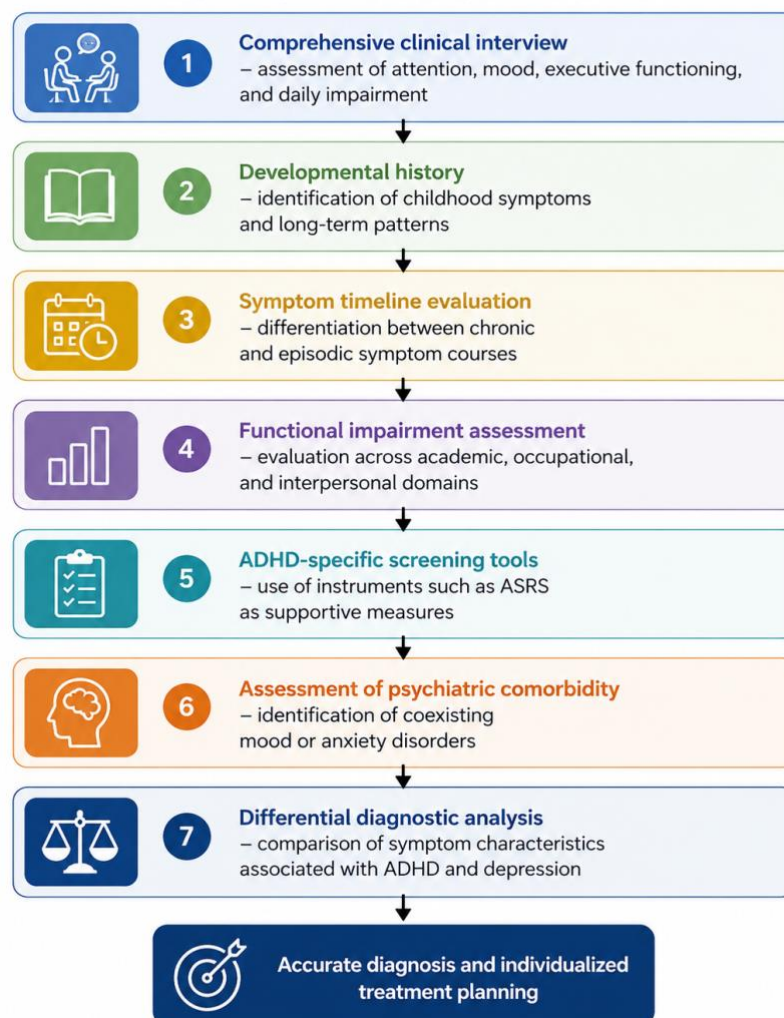


Fig. 1. Suggested diagnostic approach for distinguishing ADHD from depression in adult women

Source: Author's own elaboration based on Sibley (2021), McIntosh et al. (2009), Young et al. (2020), and Ustun et al. (2017).

4. Discussion

4.1. Interpretation of findings

The findings of this review indicate that ADHD in adult women remains substantially underrecognized and is frequently misdiagnosed as depression or anxiety disorders. The reviewed evidence suggests that this issue results from the interaction of overlapping symptom profiles, gender-specific symptom expression, masking behaviors, and limited clinician awareness.

Many women receive an ADHD diagnosis only after years of unsuccessful psychiatric treatment focused primarily on mood disorders, despite longstanding histories of attentional and executive functioning difficulties (Quinn & Madhoo, 2014; Martin, 2024; Krebs & Donnellan-Fernandez, 2025).

4.2. Symptom overlap and diagnostic complexity

A major contributor to diagnostic inaccuracy is the overlap between ADHD and depressive symptomatology. Concentration problems, fatigue, reduced productivity, and emotional instability may occur in both conditions, making clinical differentiation difficult.

However, the reviewed studies demonstrate that ADHD-related impairments are generally chronic and developmentally persistent, whereas depressive symptoms are typically episodic and mood-dependent (Paucke et al., 2021; McIntosh et al., 2009). Failure to evaluate symptom chronology may therefore contribute to diagnostic errors and incomplete treatment planning.

4.3. The role of gender and masking

The evidence also highlights the importance of gender-related differences in symptom presentation. Women are more likely to demonstrate inattentive and internalized symptoms rather than disruptive hyperactivity, which reduces the likelihood of early clinical referral (Quinn & Madhoo, 2014).

Masking behaviors additionally complicate recognition. Many women compensate for executive dysfunction through perfectionism, excessive effort, and rigid organizational strategies (Mylett et al., 2026). Although these mechanisms may initially support daily functioning, they are associated with significant psychological burden and may eventually contribute to burnout and secondary mood symptoms.

Importantly, ADHD often becomes clinically apparent only when environmental demands exceed compensatory capacities, particularly during higher education, professional development, or parenthood.

4.4. Clinical consequences of delayed diagnosis

The reviewed literature demonstrates that delayed diagnosis is associated with substantial psychological and functional consequences. Treatment focused exclusively on depression may fail to address core attentional and executive impairments, resulting in persistent dysfunction across educational, occupational, and interpersonal domains.

Untreated ADHD is also associated with increased risk of anxiety disorders, chronic stress, low self-esteem, and additional psychiatric complications (Fu et al., 2025; Yavuzlar Civan & Berkol, 2025). Conversely, accurate recognition of ADHD appears to improve treatment effectiveness, self-understanding, and quality of life.

4.5. Neurocognitive differentiation

The literature further suggests that ADHD and depression may be differentiated through characteristic neurocognitive profiles. ADHD is primarily associated with deficits in inhibitory control, working memory, and cognitive flexibility, whereas depression is more strongly linked to psychomotor slowing and affective cognitive bias (Willcutt et al., 2012; Paucke et al., 2021).

These findings support the importance of structured diagnostic assessment integrating developmental history, executive functioning evaluation, and longitudinal symptom analysis rather than relying exclusively on current emotional presentation.

4.6. Implications for healthcare education

An important implication emerging from this review is the need for improved education regarding adult ADHD in women. Existing diagnostic frameworks remain strongly influenced by male-centered symptom models, contributing to underrecognition of female presentations.

Healthcare professionals should receive enhanced training in:

- gender-specific manifestations of ADHD,
- recognition of masking behaviors,
- differential diagnosis between ADHD and depressive disorders,
- interpretation of adult ADHD screening tools,
- lifespan-oriented neurodevelopmental assessment.

Improved interdisciplinary collaboration between psychiatry, psychology, and primary care may additionally facilitate earlier identification and more effective management.

4.7. Summary of implications

Overall, the reviewed evidence suggests that misdiagnosis of ADHD in women reflects broader structural and conceptual limitations within mental healthcare systems rather than isolated clinical mistakes. Improving diagnostic accuracy requires greater awareness of gender-related symptom variability, comprehensive developmental assessment, and broader implementation of neurodevelopmentally informed diagnostic approaches.

4.8. Limitations of the review

This narrative review has several limitations. First, the included studies varied considerably in methodology, sample characteristics, and diagnostic criteria, which may limit direct comparability of findings. Second, as a narrative rather than systematic review, the study is subject to potential selection bias and does not provide quantitative synthesis of evidence. Additionally, the growing body of literature on ADHD in women remains relatively recent, and long-term longitudinal data are still limited. Despite these limitations, the review provides a comprehensive overview of current evidence regarding the misdiagnosis of ADHD as depression in adult women.

5. Conclusions

Adult Attention-Deficit/Hyperactivity Disorder (ADHD) in women remains a significantly underrecognized and frequently misdiagnosed clinical condition, most commonly confused with depressive and anxiety disorders. This narrative review highlights that such misdiagnosis is not an isolated diagnostic error but rather the result of a complex interaction between symptom overlap, gender-specific presentation patterns, compensatory masking behaviors, and systemic limitations within healthcare practice.

The reviewed literature consistently demonstrates that women with ADHD are more likely to present with predominantly inattentive symptoms, emotional dysregulation, and internalizing psychopathology. These features often mimic depressive disorders, leading to diagnostic overshadowing and delayed recognition of the underlying neurodevelopmental condition. As a consequence, many patients receive treatment targeting mood symptoms without adequate improvement in core executive dysfunction.

A key finding across studies is the critical role of masking and social compensation strategies, which allow many women to partially maintain academic and occupational functioning while simultaneously obscuring clinical symptoms. However, these strategies are associated with high psychological burden and may contribute to burnout, anxiety, and secondary depressive symptoms.

From a clinical perspective, delayed or incorrect diagnosis of ADHD in women has substantial consequences, including reduced treatment effectiveness, prolonged functional impairment, increased psychiatric comorbidity, and negative impacts on self-esteem and identity formation. Importantly, evidence suggests that accurate diagnosis and targeted ADHD treatment can significantly improve both functional outcomes and quality of life.

The review also emphasizes the importance of improving healthcare education and clinical awareness regarding gender-specific manifestations of ADHD. Incorporating structured screening tools, comprehensive developmental histories, and differential diagnostic frameworks into routine psychiatric assessment may reduce diagnostic errors and improve early identification.

In conclusion, adult ADHD in women should be systematically considered in all cases of recurrent, treatment-resistant, or atypical depression presentations. Improving recognition of ADHD in women is essential not only for diagnostic accuracy, but also for reducing long-term psychological burden and improving overall quality of life.

Author's Contribution:

Conceptualization: AJT, NP, AC, JP, EB, WW.

Methodology: AJT, JP.

Software: AJT, EB, WW.

Validation: NP, AC.

Formal analysis: WW, EB, JP.

Investigation: AJT, NP.

Resources: AC, WW.

Data curation: EB, JP.

Writing – original draft preparation: AJT, NP, AC.

Writing – review and editing: AJT, JP, EB, WW.

Supervision: AC, JP.

All authors have read and agreed to the published version of the manuscript.

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