What is ADHD? *A plain guide for parents.*

THE ONE-LINE ANSWER

ADHD is a neurodevelopmental difference in *self-regulation* — not a deficit of effort, character or parenting.

It affects attention, activity and impulse control, and — just as much — emotion, motivation, time and follow-through. Dr Russell Barkley puts it simply: "ADHD is a disorder of self-regulation."

WHAT'S GOING ON IN THE BRAIN

· Self-regulation skills — focus, inhibition, planning — often run **2–5 years behind** chronological age.

· Big emotions and impulsivity are **part of that delay**, not extra misbehaviour.

· **Dopamine works differently**, which changes how motivation and reward feel.

· The brain processes **bottom-up**: safety and emotion come online before reasoning does.

WHAT PARENTS ACTUALLY SEE

· Time blindness — "five more minutes" for an hour.

· Emotional flooding, then fast recovery.

· Task paralysis at the start of anything boring.

· Forgetting the thing they were told 30 seconds ago.

· Brilliant hyperfocus on what interests them.

· Poor follow-through despite genuine intent.

WHAT ADHD IS NOT

· Not laziness or lack of intelligence.

· Not a parenting failure.

· Not only hyperactive boys.

· Not caused by sugar, screens or too little discipline.

· Not "everyone's a bit ADHD" — it's a threshold of impairment.

· Not something a child simply grows out of.

Inattentive

Quieter, dreamier, disorganised. Most often missed — and most often missed in girls.

Hyperactive-impulsive

Restless, fast, interrupting, acting before thinking. Noticed early because it's visible.

Combined

Enough of both. The most commonly diagnosed presentation in children.

RARELY TRAVELS ALONE

ADHD commonly co-occurs with specific learning differences (reading, writing, maths), autism, anxiety, sleep difficulties, sensory differences, tics, and — particularly in adolescence — low mood. Co-occurring conditions change what helps, which is why a good assessment looks wider than attention alone.

The DSM-5 criteria, *in parent language.*

A summary in our own words of the DSM-5-TR framework clinicians use. It is a guide to what an assessment looks at — not a checklist you can diagnose from at home.

A · INATTENTION — NINE FEATURES

01 · Misses details; careless slips in schoolwork or chores.

02 · Hard to hold attention on tasks or play.

03 · Seems not to listen, even when spoken to directly.

04 · Starts things but doesn't finish them; gets sidetracked.

05 · Struggles to organise tasks, time and belongings.

06 · Avoids or dreads tasks needing sustained mental effort.

07 · Loses things — devices, keys, homework, drink bottles.

08 · Easily distracted by what's around or by own thoughts.

09 · Forgets daily routines, appointments and instructions.

B · HYPERACTIVITY & IMPULSIVITY — NINE FEATURES

01 · Fidgets, squirms, taps, can't keep hands still.

02 · Leaves the seat when staying seated is expected.

03 · Runs or climbs at the wrong moments; restless in teens.

04 · Can't settle to quiet play or downtime.

05 · "Driven by a motor" — always on the go.

06 · Talks a great deal.

07 · Blurts answers; finishes other people's sentences.

08 · Finds waiting and turn-taking genuinely hard.

09 · Interrupts or takes over others' games and conversations.

THE THRESHOLDS THAT TURN FEATURES INTO A DIAGNOSIS

· **Number:** six or more features from A and/or B for children up to 16; five or more from age 17.

· **Onset:** several features present before age 12.

· **Impact:** genuinely interfering with learning, relationships or daily functioning.

· **Duration:** present for at least six months, beyond what's expected for their age.

· **Settings:** showing up in two or more — home, school, work, social.

· **Not better explained** by another condition — anxiety, trauma, sleep, learning difference, mood.

PRESENTATION & SEVERITY

A diagnosis names the presentation — **combined**, **predominantly inattentive**, or **predominantly hyperactive-impulsive** — and a severity: mild, moderate or severe. Both can change over time; presentation often shifts as children grow, with visible hyperactivity settling and organisation and emotion regulation remaining the harder parts.

WHAT AN ASSESSMENT INVOLVES

· Developmental and family history.

· Standardised rating scales from home and school.

· Information from more than one setting.

· Screening for co-occurring and alternative explanations.

· In Aotearoa: a paediatrician, psychiatrist or psychologist, depending on pathway and age.

Please note. This page paraphrases diagnostic criteria for education only. It is not a diagnostic tool and does not replace assessment by a qualified clinician. Many children show some of these features some of the time; a diagnosis rests on number, duration, onset, settings and genuine impact — assessed properly, by someone qualified to do it.

FREQUENTLY ASKED

The questions parents *actually ask us.*

Is this my parenting?

No. ADHD is neurodevelopmental and strongly heritable — parenting does not cause it. What parenting does change is the conditions around it: predictability, co-regulation and repair make an enormous difference to how a child's life goes. That's the part you can work on, and it's what the workshop is for.

Will medication fix it?

Medication can meaningfully help attention and impulse control for many children — but it doesn't teach skills, build routines or repair a relationship. Skills, structure and connection do the rest. Prescribing decisions sit with your paediatrician or psychiatrist; we don't advise on medication.

Will they grow out of it?

Most don't grow out of it; they grow into it. Visible hyperactivity usually settles, while organisation, time and emotion regulation stay the working edges into adulthood. With the right scaffolding, those edges become manageable — and often become strengths.

Why is my child fine at school and impossible at home?

Holding it together all day is expensive. Many children mask at school and release at home, where it's safest to fall apart. It isn't manipulation, and it isn't evidence that the difficulty isn't real.

Should we tell the school? And our child?

Usually yes to both. Schools can put supports in place they can't offer without information. Children generally do better knowing — a name for how their brain works, framed as difference rather than defect, tends to reduce shame rather than add to it.

We don't have a diagnosis yet — is this workshop still for us?

Yes. Everything we teach is about regulation, capacity and repair, and none of it requires a diagnosis to be useful. Plenty of parents come while on a waitlist, or while still working out what's going on.

I think I might be ADHD too.

Very common — and worth taking seriously, because your own regulation is the lever with the most reach. Both facilitators are ADHD parents, and the material is built to be used by a brain that forgets things.

WHERE TO NEXT

Start where you are.

A short, confidential intake and we'll match you to the right pathway — workshop, individual work, or a referral.

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