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Lived experiences of students with ADHD, parents of students with ADHD, and teachers of students with ADHD with factors that support school inclusion and functioning of students with ADHD

Disertační práce

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Statement:

I hereby declare that I independently prepared my dissertation on the following theme: "The lived experience of students with ADHD, parents of students with ADHD, and teachers of students with ADHD with factors that support school inclusion and functioning of students with ADHD". My dissertation was prepared under the supervision and guidance of my advisor and listed all the materials and literature used.

In Prague on .... Signature ....

I would like to thank my friends and my husband for their psychological support and inspiring discussions during the time I was working on this dissertation. Many thanks to my supervisor for his valuable advice, insights, discussions, comments and kind and patient guidance.

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Introduction

A growing body of current empirical studies in the field of education addresses the difficulties associated with ADHD. These studies often focus on the negative manifestations of ADHD and how those manifestations complicate school and other life of children with ADHD, parents of children with ADHD, teachers, and peers. A smaller number of empirical evidence addresses factors that support school inclusion and functioning of students with ADHD. This empirical deficiency has become a challenge that the present study seeks to address by exploring the lived experiences of students with ADHD, parents of students with ADHD, and teachers of students with ADHD in the Czech Republic with factors that support school inclusion and functioning of students with ADHD. The lived experience of participants was gained through semi-structured interviews. Given the nature of the data, interpretive phenomenological analysis and thematic analysis were chosen for data analysis. These qualitative methods can lead to the identification of valuable results and insights for practice and future research. The research goals established by the research questions focused on understanding the lived experiences of students with ADHD, parents of children with ADHD, and teachers of students with ADHD with factors that support school inclusion and functioning of students with ADHD. Furthermore, the aim of the present study was to explore similarities and differences in the lived experiences of the participants.

The structure of the present study is as follows: (a) theoretical part, (b) methodology, (c) results, (d) discussion, (e) implications, (f) conclusion. The theoretical section of the present study deals with the historical development of the concept of ADHD, current theoretical approaches to ADHD, theories that may provide a theoretical background for the results of the analysis of the lived experiences of participants with respect to factors that support school inclusion and functioning of students with ADHD. The methodological section explains the methods used for data collection and analysis (interpretative phenomenological analysis and thematic analysis) as well as the ethical aspects of the study. The results section includes short narrative portraits of participants, and thematically sorted lived experiences of participants students with ADHD, parents of students with ADHD, and teachers of students with ADHD with factors supporting school inclusion and functioning of students with ADHD. The discussion focuses on comparing our findings with recent empirical and theoretical evidence in the area of school inclusion and the special educational needs of students with ADHD. Practical implications provide recommendations for students with ADHD, parents of students with ADHD, teachers of students with ADHD and other

important others that can contribute to more successful school inclusion and functioning of students with ADHD.

Theoretical part

1 History of the conceptualization of ADHD

The understanding of the concept of attention deficit hyperactivity disorder has undergone various changes in psychiatry over the last 200 years. These changes have influenced the therapeutic, educational and pedagogical approach to students with ADHD. In the history of diagnosis, we find two main ways of conceptualizing ADHD. The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association defines ADHD as a disorder in which a sufficiently strong manifestation of hyperactivity-impulsivity, inattention, or both criteria is required to assign a diagnosis. The Diagnostic Manual ICD defines ADHD as a hyperkinetic disorder. To assign a diagnosis, all symptoms, hyperactivity, impulsivity and inattention, must be observed simultaneously. Both manuals (DSM and ICD) consider inattention, hyperactivity and impulsivity as the core symptoms of ADHD.

1.1 Defect of moral control

The first references to ADHD are often associated with George Frederick Still (1868-1941) (Barkley, 2015). Still was the first to systematically observe the symptoms of inattention and hyperactivity, and he considered a disorder of "moral control" to be the cause of those symptoms. Moral control is defined as an action that leads to both the good of the individual and the good of others. Moral control, according to Still, is closely related to the quality of intellect, cognitive ability, and will. Although Still concluded, consistent with his observations, that defects in moral control persist into adulthood in some individuals, he recommended childhood for observing impaired moral control. In childhood, the intellect and the will have not yet undergone the maturation process and so the manifestations of the moral control disorder are stronger. Still divided the disorder of moral control into "Developmental disorder of moral control" and "Morbid loss of already acquired moral control". Still considered a „Developmental disorder of moral control“ to be an innate limitation in the ability to develop moral control. “Morbid loss of already acquired moral control“ was considered by Still to be a permanent, momentary or reappearing impairment of moral control related to physical illness.

In his lectures Still described cases of children who did not fall under any hitherto known mental disorder. In particular, in Still's last lecture, we find references to children who, from today's perspective, would meet the diagnostic criteria for ADHD. In his lectures Still reported on children who stole even though they were sufficiently financially and materially provided for. Still further reported on children for whom educational punishments had no effect, even though those children feared punishment. He mentioned a 10-year-old boy who deliberately hurt younger children, behaved immorally among other children, stole and was cruel to animals. This inappropriate behaviour, according to Still, occurs in both girls and boys. According to Still, the number of cases among boys is higher than the number of cases among girls.

In one of his lectures, Still drew attention to children who have problems maintaining attention. They don't show a lack of intellect, but an unusual inability to sustain attention for long periods. Still gave as an example a six-year-old boy who was bright and intelligent in communication, but could concentrate for only a very short time on any game. In school, this boy had learning problems, missed most schoolwork and fell behind.

Still also distinguished between children with moral control disorder and children with autism spectrum disorders. Still thought that, unlike children with moral control deficits, those children show a lack of natural tendency to form relationships with other people as well as with important others such as parents, siblings, and peers (Still, 2006).

1.2 Mild brain damage and mild brain dysfunction

The beginning of the twentieth century can be considered another milestone in the development of the ADHD concept. At that time, interest in attention deficit hyperactivity manifestation was associated with the Spanish flu epidemic, which caused acute encephalitis.

Ebaugh (1923) described pediatric patients who, from today's perspective, meet the criteria for attention deficit hyperactivity disorder. A group of 11 boys and 6 girls aged 2-14 years were referred to him by their parents or at the request of their school. The reasons given for treatment were failure to make sufficient progress at school and unmanageable disruptive behaviour in those children. The manifestations exhibited by those children were classified by Ebaugh into six categories: (1) general change in character with hyperkinetic states (e.g., disobedience, emotional lability), (2) insomnia symptoms, (3) hysterical reactions, (4) mental deficits, (5) tics and fears, (6) depressive-type affective disorder. Most

of the children showed impulsivity and restlessness, but in other manifestations, they varied in the strength of those manifestations. The level of intellect was not impaired in those children. Causes of inattention and hyperactivity were considered to be brain damage caused by encephalitis, traumatic head injuries or premature birth (Shirley, 1939).

Premature babies were also the subject of research by Shirley (1939). In 65 premature babies compared to 250 term-born babies, Shirley observed slower development of fine motor skills and speech. Furthermore, those children responded with great sensitivity to visual and auditory stimuli. Children's attention during play often jumped quickly from toy to toy, they could not sustain attention for long periods and were easily distracted by external stimuli. If those children were interested in an activity, they were able to pursue it with high intensity and motor errors to the point of exhaustion. Those children, despite their lack of creative ability, exhibited a sense of aesthetics Shirley (1939).

Thanks to Shirley's research and other follow-up research, the diagnosis of "mild brain damage" gradually evolved. Later, the name of the diagnosis was changed to “mild brain dysfunction“ because it was not always possible to link the cause of the disorder to a brain-damaging event (Barkley, 2015). ADHD was also previously called „Post-encephalitic behavioural disorder“ or “Hyperkinetic impulse disorder“.

1.3 Codification of ADHD in Diagnostic Manuals

The first codification of Attention Deficit Hyperactivity Disorder, nowadays abbreviated as ADHD, occurred in the late 1960s and early 1970s. Within the second edition of the DSM, some sentences characterise the disorder as "excessive activity, restlessness, distractibility, and short attention span, especially in young children, the behaviour usually decreases with adolescence“ (APA, 1968; p. 50).

Since 2022, we can observe two different theoretical approaches to this disorder. The Douglas approach summarizes four deficits underlying the manifestations of ADHD: (1) engagement, organization, and maintenance of attention and effort, (2) inhibition of impulsive response, (3) modulation of arousal levels concerning the situation, (4) an unusually strong tendency to seek immediate gratification. A second perspective on ADHD was provided by Wender. Wender described the manifestations of ADHD in six domains: (1) motor behaviour, (2) attention and perceptual-cognitive functioning, (3) learning, (4) impulse control, (5) interpersonal relationships, (6) emotions. The DSM manual followed

the Douglas model of attention deficit disorder, while the ICD followed Wender's theory of mild brain dysfunction (Barkley, 2015).

It can be noted that Douglas and the DSM manual in the conception of ADHD point out that ADHD can have a component of hyperactivity as well as inattention. Inattention is conceived as an equally significant symptom. Thus, according to Douglas's conception, ADHD is a disorder that manifests with both hyperactive-impulsive symptoms and inattention symptoms. However, this view was not accepted until the 1990s.

1.3.1 Comparison between ADHD and hyperkinetic disorders

Hyperkinetic disorder had stricter diagnostic criteria, which brought many difficulties. First, to receive a diagnosis of hyperkinetic disorder, an individual had to meet criteria for both inattention and hyperactivity-impulsivity. However, these individuals are often able to mask the hyperactive manifestations or transform those manifestations into internal symptoms, such as inner restlessness. Second, mood or anxiety disorders have been exclusionary criteria for the diagnosis of hyperkinetic disorder. However, mood and anxiety disorders tend to be a frequent comorbidity of hyperactivity and inattention. Third, as a result of the aforementioned aspects, the concept of hyperkinetic disorder was not appropriate for the diagnosis of women, because ADHD in women is more often manifested only by inattention and internal symptoms.

Due to the inappropriate setting of diagnostic criteria for hyperkinetic disorder, that disorder often went unrecognized in the adult population. For this reason, those adults were often treated only for ADHD comorbidities, and the primary cause was not treated in any way. Thus, treatment often fails. However, the difficulties with the diagnostic criteria were gradually recognised by professionals, and to remedy the situation, the European Statement on the Diagnosis and Treatment of ADHD in Adults was published in 2010.

Since its inception, the concept of ADHD has been conceptualized as a lifelong disorder. The focus was first on inattention symptoms and then on hyperkinetic symptoms. The first official anchoring of ADHD took place in 1968 in the DSM-II manual (APA, 1968). Subsequently, expert debate focused on the question of whether the inattention or hyperactivity symptom is more important. This controversy manifested itself in different diagnostic criteria for ADHD in the DSM manual and ICD manual, leading to inconsistencies in the conceptualization of ADHD with implications for diagnostics and research. In 2022, the concept of ADHD in both manuals was unified.

When the diagnostic criteria for ADHD according to the DSM-5 and the diagnostic criteria for hyperkinetic disorder according to the ICD-10 are compared in detail, some differences can be distinguished. The DSM-5 includes ADHD under Neurodevelopmental Disorders while the ICD-10 includes Hyperkinetic Disorder under Behavioral and Emotional Disorders with onset usually in childhood and adolescence. The DSM-5 considers inattention or hyperactivity-impulsivity to be the primary symptoms of ADHD, while the ICD-10 emphasizes that inattention and hyperactivity-impulsivity must both be present for the diagnosis of hyperkinetic disorder.

According to the DSM-5, individuals with ADHD often fail to follow instructions and fail to complete schoolwork, homework, or tasks at work due to impaired attention. They start a task but quickly lose focus and become easily distracted. Individuals with ADHD often fail to maintain attention during tasks or play. They have difficulty maintaining attention during a lesson, conversation, or extensive reading. Individuals with ADHD are also easily distracted by external stimuli. Older adolescents and adults with ADHD often have task-unrelated thoughts. Individuals with ADHD often avoid, dislike, or do not want to do tasks that require sustained mental effort. Older adolescents or adults with ADHD have difficulty in preparing reports, filling out forms, and reviewing long texts. Individuals with ADHD often do not pay full attention to details or make mistakes out of inattention while working at school, at work, or during other activities. Individuals with ADHD often overlook or do not notice details, their work is inaccurate. They give the impression that they are not listening to what is being said to them. Their minds are elsewhere, even when distracting stimuli are not present. Individuals with ADHD often have difficulty organizing tasks and activities. They have difficulty managing sequential tasks. They also have difficulty keeping their belongings in order, their work is messy and poorly organized, and they are unable to schedule time well or meet deadlines. They often lose things they need for certain tasks or activities (e.g. school supplies, pencils, books, tools, wallets, keys, documents, glasses, cell phones). They are forgetful during daily activities (e.g. forget their homework and errands). Older adolescents and adults with ADHD often forget phone calls, bill payments, and appointments (APA, 2013).

According to the ICM-10, individuals with hyperkinetic disorder often stop working on tasks after a short period and leave activities unfinished. Children with hyperkinetic disorder often switch from one activity to another, seemingly losing attention in one task as their attention turns to another, although laboratory studies do not usually show an unusual degree of sensory or perceptual distractibility. The main characteristic of individuals with

hyperkinetic disorder is a lack of endurance in a variety of activities that require cognitive functions (WHO, 1992).

According to the DSM-5, children with ADHD often run around or are unable to sit still in situations where it is appropriate. In adolescents or adults with ADHD, only a sense of restlessness may be present. They leave their seat in situations where they are expected to sit (e.g. leaving their seat in class, leaving the office or other workplace, or leaving their seat in situations where they are expected to stay). Individuals with ADHD often move or tap their hands or feet restlessly or fidget in their chairs. They often talk excessively. Individuals with ADHD often blurt out the answer to a question before the question has been completed (e.g. finishing others' sentences, not being able to wait for their turn in a conversation). They are often unable to wait for their turn (e.g. when waiting in line). They often interrupt or disturb others (e.g. jumping into speech, interfering with others' play or activities, and borrowing others' belongings without asking or receiving permission). Older adolescents and adults with ADHD may interfere with others' activities or take over what others are doing. They are often unable to play quietly or engage peacefully in leisure activities. Individuals with ADHD are always "on the move" as if they are "engine-driven" (e.g. they cannot be still or do not feel comfortable being still for long periods, e.g. in restaurants, or meetings). They may be perceived by others as restless or that they are difficult to keep up with (APA, 2013).

According to ICD-10, children with hyperkinetic disorder show excessive restlessness, especially in situations requiring calmness. They may run, jump, or get out of their seat when they are expected to sit. They are also excessively chatty and noisy, or restless and fidgety. Individuals with hyperkinetic disorder exhibit disinhibition in social relationships, carelessness in situations involving some danger, impulsive violations of social rules (e.g. the child intrudes on or interrupts the activities of others, or responds prematurely and hastily to questions that have not yet been completed, or they have difficulty waiting for their time to come) (WHO, 1992).

According to the DSM-5, several symptoms of inattention or hyperactivity and impulsivity must be present before the age of 12 to be assigned a diagnosis of ADHD. According to the ICD-10, hyperkinetic disorders always arise early in development, usually in the first five years of life.

According to the DSM-5, the presence of multiple symptoms of inattention or hyperactivity and impulsivity in two or more settings (e.g. home, school, or work, interacting with friends or relatives, and other activities) is required for a diagnosis of ADHD.

According to ICD-10, the main features of hyperkinetic disorder are impaired attention and hyperactivity. Both of these features are necessary for diagnosis and should be evident in more than one situation (e.g. home, school, clinic) (APA, 2013).

According to the DSM-5, for a diagnosis of ADHD to be made, there must be clear evidence that symptoms are affecting or reducing the social, school or work-related standard of living. ICD-10 does not specify a severity level of symptoms for assigning a diagnosis of hyperkinetic disorder. According to the DSM-5, if symptoms of schizophrenia, psychotic disorder, affective disorder, anxiety disorder, dissociative disorders, personality disorders, or substance intoxication are present, ADHD cannot be considered the cause of those symptoms. According to ICD-10, the exclusion criteria for the diagnosis of hyperkinetic disorders are the diagnosis of anxiety disorders, (affective) mood disorders, pervasive developmental disorders, and schizophrenia (APA, 2013).

According to the DSM-5, associated features supporting a diagnosis of ADHD are mild delays in language, motor and social development, impaired academic or occupational performance, low frustration tolerance, irritability or emotional lability, increased risk of suicide attempts, mood and behavioural disorders and substance use. According to the ICD-10, associated features supporting a diagnosis of hyperkinetic disorder are impaired cognitive abilities, specific delays and disproportions in motor and language development, reading and/or other school difficulties, dissociative behaviours, and low self-esteem (APA, 2013).

According to the DSM-5, ADHD is more common in males than females in the general population, with a ratio of approximately 2:1 in children and 1.6:1 in adults. Females are more likely than males to present predominantly inattentive traits. According to ICD-10, hyperkinetic disorders are several times more common in boys than in girls (APA, 2013).

According to the DSM 5, common comorbidities of ADHD are oppositional defiant disorder, conduct disorder, affective dysregulation disorder with dysphoria, specific learning disorders, anxiety disorders, major depression, intermittent explosive disorder, substance use disorder, antisocial and other personality disorders, obsessive-compulsive disorder, tics, and autism spectrum disorders. According to ICD-10, the comorbidity of hyperkinetic disorder is hyperkinetic behavioural disorder (APA, 2013).

1.3.2 Current conceptualizations of ADHD

As of 2022, the DSM and ICD manuals include a diagnosis of ADHD, and the concept of ADHD is very similar in both manuals. The Updated European Statement on the Diagnosis and Treatment of ADHD in Adults is also key to the conceptualisation of ADHD. The European Statement focuses on more symptoms than the manuals. Both the diagnostic manuals and the European statement agree that ADHD is a neurodevelopmental disorder with onset in childhood, manifested by three main symptoms: inattention, hyperactivity and impulsivity. The following subsection will focus first on the definition of ADHD in the DSM-5 and then on the definition of ADHD in the ICD-11. The updated European Statement on the Diagnosis and Treatment of ADHD in Adults will also be presented in more detail.

1.3.3 ADHD in DSM-5

The DSM-5 manual managed to anchor the construct of ADHD and the diagnosis of ADHD quite solidly. In this manual, ADHD is conceptualized as a disorder that accompanies an individual from childhood to adulthood. However, the DSM-5 manual has many weaknesses that should be pointed out.

DSM 5 has simplified the diagnosis of ADHD for older adolescents and adults compared to DSM 4. These changes were as follows: (a) the first manifestation of ADHD symptoms in children between 7 and 12 years of age, (b) for adults and older adolescents, five items were sufficient to assign a diagnosis, (c) the subtype designation was changed to manifestation, (d) several additional manifestations valid for adults and older adolescents were added to the list, (e) criteria for symptom severity were added to distinguish mild, moderate, and severe symptoms (APA, 2013).

Some of the DSM-4 criteria for assigning a diagnosis of ADHD for adults and adolescents were inadequate and insufficient. In the DSM-5 manual, a description is added to all symptoms, specifying what manifestations of ADHD may be typical for a particular age range.

The DSM-5, as one of the main sources for the diagnosis of ADHD, established the condition that ADHD begins in childhood and can last throughout an individual's lifetime. However, this standard has faced criticism because some individuals may not be diagnosed with ADHD until later in life. The criticism is not only focused on the concept of ADHD in the DSM-5 but on the overall approach and concept, which is reflected in the following sections of this chapter.

The DSM-5 is very similar to the DSM-IV concept. The changes found in it are intended to simplify the diagnostic process for adult patients and older adolescents. These changes are as follows: (1) shifting the criterion for first symptom onset to 12 years (from the original 7 years), (2) changing the subtype to manifestation, (3) for older adolescents and adults, it is sufficient to meet the 5 items within the criterion for diagnosis, (4) adding manifestations valid for older adolescents and adults, (4) adding a criterion for severity of symptoms to mild, moderate, severe (APA, 2013).

Some modifications were made to directly consider adolescents and adults with ADHD for whom the original diagnostic criteria did not provide a sufficiently accurate picture. There was an expansion of the descriptions relating to most symptoms, which better fits these age groups, and also the minimum age for diagnosis was raised from 7 to 12 years. This is because it can be difficult for older individuals to remember whether and how their ADHD manifested itself in childhood, especially if their environment helped them to manage their symptoms and reduce their severity. Some experts even argued that the minimum age of 12 is too strict, and have suggested moving it up to 16 years (Kooij et al., 2019).

The renaming of ADHD manifestation types is related to their variability over time. (Stefanatos & Baron, 2007) identified two main factors that may influence this variability. Symptoms of inattention usually appear later compared to other manifestations. This means that some children with ADHD may have been initially diagnosed as the hyperactive-inattentive type, but over time their manifestations changed to better match another type that better reflected their inattentive behaviour. Symptom manifestation may be age-specific. During the process of adolescence, some children may lose some manifestations because their manifestations no longer meet the established criteria. The DSM-5 has responded to this problem by adding specific manifestations that are found in adolescents and adults. However, it remains questionable whether this problem was completely resolved. It is important to remember that adulthood is the longest period of an individual's development with many changes that are less structured than at other stages of life.

We would also like to draw attention to two criticisms regarding the concept of ADHD as a whole. The first criticism is that impulsivity and hyperactivity are considered as a single factor. Other authors also suggested splitting hyperactivity and impulsivity in adults into two dimensions instead of one (Kooij et al., 2005). The second general criticism concerns the lack of a bio-psycho-social model of ADHD.

1.3.4 ADHD in ICD-11

We have already discussed the similarities between the DSM-5 and the ICD-11 manuals. The ICD-11 differs significantly from the DSM-5 only in not differentiating ADHD by severity. It only calls attention to the more severe form of the disorder, which it calls hyperkinetic disorder. At this severity, individuals have a combined manifestation of severe inattention and hyperactivity-impulsivity, and they do so in most situations that the individual encounter (WHO, 2022).

In the ICD-11, the symptom structure is divided into inattentive and hyperactive-impulsive groups. These are further subdivided into 3 subcategories for inattentive and 4 for hyperactive-impulsive symptoms.

These subcategories of inattention are described in ICD-11:

- „Difficulty sustaining to tasks to do not provide a high level of stimulation or reward or require sustained mental effort; lacking attention to detail; making careless mistakes in school or work assignments; not completing tasks;
- Easily distracted by extraneous stimuli or thoughts not related to the task at hand; often does not seem to listen when spoken directly; frequently appears to be daydreaming or to have mind elsewhere;
- Loses things; is forgetful in daily activities; has difficulty remembering to complete upcoming daily tasks or activities; difficulty planning, managing and organizing schoolwork, tasks and other activities.“ (WHO, 2022)

For hyperactive-impulsive manifestations, the following can be found in ICD-11:

- “Excessive motor activity; leaves the seat when expected to sit still; often runs about; has difficulty sitting still without fidgeting (younger children); feelings of physical restlessness, a sense of discomfort with being quiet or sitting still (adolescent and adults);
- Blurts out answers in school, comments at work; difficulty waiting for a turn in conversation, games, or activities; interrupts or intrudes on others' conversations or games;
- Difficulty engaging in activities quietly; talks too much;

- A tendency to act in response to immediate stimuli without deliberation or consideration of risks and consequences (e.g., engaging in behaviours with potential for physical injury; impulsive decisions; reckless driving) (WHO, 2022)

The ICD-11 describes that the manifestations of ADHD change throughout development and distinguishes between current manifestations, which may be predominantly inattentive, predominantly hyperactive-impulsive, or combined. Older children may have a predominantly inattentive manifestation without hyperactive symptoms. These manifestations are characterized by daydreaming, mind-wandering, and a lack of focus. These children are sometimes referred to as exhibiting a restrictive inattentive pattern of symptoms or sluggish cognitive tempo (WHO, 2022).

Among other manifestations of ADHD, ICD-11 includes: "emotional dysregulation, low frustration tolerance, and subtle clumsiness and other minor neurological abnormalities in sensory and motor performance in the absence of any identifiable brain pathology" (WHO, 2022).

1.3.5 ADHD according to Updated European Statement on the Diagnosis and Treatment of ADHD in Adults

Many experts, mostly from European countries, have worked on the Updated European Statement on the Diagnosis and Treatment of ADHD in Adults (UECS). Professor Pavla Mohr, M.D., Ph.D., participated in the development of the manual for the Czech Republic. The work of these experts was supported by the European Psychiatric Association (EPA), especially its Section for Neurodevelopmental Disorders in the Life Course (NDAL).

The advantages of the UECS are as follows: (1) it responds to the shortcomings of the concept of hyperkinetic disorders, (2) it more quickly captures the latest scientific knowledge and experience from practice and incorporates this knowledge and experience into the concepts of ADHD, (3) it can serve as a supplementary material to the DSM and ICD manuals.

UECS addresses the following domains in association with ADHD (a) heritability and environment, candidate genes, Genome wide association studies (GWAS), environmental factors, (b) neurobiology of ADHD, neuro-imaging: evidence for atypical gray and white matter areas, functional neuroimaging, neuropsychological and electrophysiological tests, (c) ICD and DSM criteria for ADHD, clinical picture: inattention

and hyperfocus, hyperactivity, impulsivity, emotional dysregulation, excessive mind wandering, behavioural selfregulation (executive function deficit), burden of ADHD, (d) prevalence of ADHD across the lifespan, sex issues, transition of adolescents to adult mental health services, late-onset ADHD, (e) screening and diagnostic assessment, screening, diagnostic assessment, the assessment process of ADHD and comorbidity, ADHD and criminality, (f) treatment, effective treatments, treatment focus in comorbid ADHD, psychoeducation on ADHD, pharmacotherapy for ADHD, considerations when treating special groups with pharmacotherapy, cognitive behaviour therapy (CBT) and coaching for ADHD, (g) cost and cost effectiveness, (h) stigma surrounding ADHD, combatting stigma (Kooij et al., 2019).

UECS also uses terms such as hyperfocus, mind wandering and executive function disorder. The UECS differs from the DSM and CDI manuals by defining hyperactivity and impulsivity as separate categories of ADHD (DSM and CDI manuals define hyperactivity-impulsivity as one category).

The UECS provides the following criteria for defining inattention: forgetfulness; distractibility, chaotic presentation difficulty in organizing and planning, difficulty in listening, difficulty with punctuality (arriving either too late or too early), temporary hyperfocus for highly salient tasks, but no control of attention when required or for many essential activities of daily life, getting lost in details, doubtfulness (unable to make decisions or solve problems), needing too much time to complete tasks, difficulty starting and finishing tasks (Kooij et al., 2019).

The UECS provides the following criteria for defining impulsivity: acting without thinking, difficulty waiting for a turn (linked to feelings of irritability), blurting things out that cause distress to others, interrupting others, impatience and difficulty waiting for a turn, spending too much, walking out of jobs, starting relationships quickly, not being able to postpone gratification, sensation seeking and risk-taking behaviours, binge eating (Kooij et al., 2019).

The UECS provides the following criteria for defining hyperactivity: inner restlessness, difficulty relaxing, pacing up and down, talking too much and too loud, fidgeting, rocking, tapping, not being able to bear an office job because of restlessness, knocking things over because of excessive mobility, being able to sit still but this comes with muscle strain, restless sleep (Kooij et al., 2019).

1.4 Causes of ADHD

ADHD is, according to the medical approach, a neurodevelopmental disorder (Jadidian et al., 2015). Anatomical anomalies of the prefrontal cortex and its connections to other groups of nerve cells in the subcortical centres (of which the cerebellum and basal ganglia are particularly important for the development of ADHD) are considered to be the cause of ADHD. Neurological measurements further suggest that there is an overall smaller brain volume in ADHD patients, by as much as 3-4 percent.

Insight into how the brains of ADHD patients function during various tasks is provided by modern medical screening methods. Compared to individuals without ADHD, children and adults with ADHD can be observed to have a different pattern of engagement of different brain regions, e.g. lower levels of activity in the prefrontal cortex and basal ganglia. EEG (a method that monitors the electrical activity of the brain) examinations reveal that the brain wave ratio of ADHD patients is comparable to that of younger individuals.

The causes of ADHD can be considered primarily in anatomical anomalies in the above-mentioned brain regions. The prefrontal cortex probably plays a central role. An important function of the prefrontal cortex is behavioural inhibition, or dampening the tendency to react to all internal and external stimuli and impulses (Goetz, 2013). The ability of behavioural inhibition, in other words, self-control, changes with age. In children with ADHD, it is possible to identify uneven and delayed brain maturation and therefore highly variable manifestations of ADHD during development and adolescence. Younger children with ADHD are impulsive and sensitive to new stimuli. As the brain matures, the capacity for self-control and control improves. As a result, older children with ADHD can engage in an activity more consistently and for longer periods, or to plan an activity. Increasing levels of self-control are further reflected in improved endurance, reliability and more consistent behaviour. The lay public often associates these abilities with willpower, which is considered to be the result of education and training. However, in children with ADHD, the ability to will is impaired. Public perceptions of willpower as a capacity for self-control often lead to the perception of ADHD manifestations as moral failings or the consequences of poor parenting (Speerforck et al., 2019).

However, ADHD disorder is also the result of the interplay of many conditions. One of the main conditions is a genetic condition. Research and studies confirm that ADHD has a hereditary basis and up to 80 percent (Dark et al., 2018). The external environment, upbringing, and biological factors such as the course of pregnancy are mostly of secondary

importance. These findings are confirmed, for example, by research on identical twins growing up separately. The occurrence of ADHD in one of the twins represented up to an 80 per cent probability of the disorder occurring in the other sibling. However, an 80 percent hereditary probability does not mean that a parent with ADHD has up to an 80 percent chance of having a child with ADHD. A study comparing the prevalence of ADHD among the offspring of ADHD patients concludes that the incidence of the disorder is five times higher in the children of parents with ADHD. At the same time, studies suggest that if a parent's ADHD symptoms persist into adulthood, the likelihood of passing the disorder on to the offspring is even higher (Goetz, 2013).

In addition to genetic influences, some external factors may also be important, but their effects can nevertheless be more easily influenced. For example, the healthy development of the child's brain functions can be supported from pregnancy until adulthood by sufficient oxygen supply (Dark et al., 2018).

Sensitive areas of the brain about ADHD also include the subcortical region, especially the basal ganglia. Empirical evidence suggests that the main negative impact is caused by events that reduce the oxygen supply to these areas of the brain over a long period, e.g. maternal infection during pregnancy. ADHD also occurs in greater numbers in preterm, lower birth-weight babies. There is also an increased incidence of ADHD in children of mothers who used psychoactive substances during pregnancy (Goetz, 2013).

Many unsubstantiated theories and misleading information are circulating in the public about the causes of ADHD. One of these is the hypothesis of the influence of diet. Some research has looked at whether sugars and food additives exacerbate the symptoms of impulsivity and inattention in children with ADHD, and whether sugars and additives can trigger ADHD symptoms in children without ADHD. Although some parents report seeing increased inattention and increased hyperactivity in their children after eating sugar, no studies have confirmed this effect of sugar.

1.5 Symptoms of ADHD

This chapter focuses on introducing the different symptoms of ADHD in more detail. Using descriptions from the DSM-5, ICD-11, and UECS, we will compare the definitions of ADHD from these manuals and how they are similar or different. For each of the core symptoms, we will also list the specific manifestations that are thought to be related to that particular symptom (Kooij et al., 2019).

1.5.1 Inattention

What all approaches have in common is that they mainly highlight the difficulty and problems of regulating attention. As the general public often thinks, it is about a lack of willpower. However, the manuals say that this inability to regulate does not stem from volitional processes, nor does it stem from reduced or inadequate cognitive abilities.

UECS defines inattention as follows: “Patients with mainly inattention problems are often slow to think and formulate due to distractions. They may formulate things in a long-winded and tangential way, losing themselves in irrelevant details and having difficulty making decisions.”(Kooij et al., 2019).

The DSM-5 defines inattention as follows: “Inattention manifest behaviorally in ADHD as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension” (APA, 2013/2015).

ICD-11 defines inattention as follows: “Inattention refers to significant difficulty in sustaining attention to tasks that do not provide a high level of stimulation or frequent rewards, distractibility, and problems with organization.” (WHO, 2022).

1.5.2 Hyperactivity

The manuals mentioned above take a similar stance in that they consider hyperactivity to be excessive motor activity. This activity is difficult to control behaviourally. In childhood, it is more outwardly pronounced, but in adulthood, it changes to a feeling of inner restlessness.

UECS defines hyperactivity as follows: “Concerning hyperactivity, adults do not present in the same way as children. Their hyperactivity usually manifests more subtly. Clinicians need to assess their feelings of restlessness. A first impression of mobility is not definitive; sitting calmly during the diagnostic assessment does not exclude any ADHD. Hyperactivity in adults often manifests itself as feelings of continuous inner restlessness or agitation, talking too much, ceaseless mental activity, not being able to relax properly or needing alcohol or drugs to relax and/or sleep. Hyperactivity and/or restlessness may be temporarily relieved by the patient engaging in excessive sports activities, and in such cases, the person may suffer physical ailments as the body may have insufficient time to recover and/or due to sustained injuries.” (Kooij et al., 2019).

The DSM-5 defines hyperactivity as follows: ”Hyperactivity refers to excessive motor activity (such as a child running around) when it is not appropriate, or excessive

fidgeting, tapping, or talkativeness. In adults, hyperactivity may manifest as extreme restlessness or wearing others out with their activity." (APA, 2013/2015).

ICD-11 defines hyperactivity as follows:" Hyperactivity refers to excessive motor activity and difficulties with remaining still, most evident in structured situations that require behavioural self-control." (WHO, 2022).

1.5.3 Impulsivity

For this symptom, the manuals mainly refer to the need to respond immediately to stimuli. This is further related to higher levels of risk-taking behaviour. Some manuals also point to compulsive behaviour to gain immediate reward. The manifestations of this behaviour vary and are individual.

UECS defines impulsivity as follows: "Impulsive behaviour and associated interpersonal conflicts often have consequences for relationships with family, friends, colleagues, and employers. It may also seriously impact personal finance when impulsive spending causes debt. Impulsive binge behaviours may also be present (e.g. binge eating), often to combat restlessness or due to a need for immediate gratification. Closely related to impulsivity are 'sensation seeking' behaviors when patients may seek out excitement from novel and thrilling stimuli. These often involve risk-taking behaviours such as playing with fire, reckless driving, sexual risks, and provocative behaviour leading to fights."(Kooij et al., 2019).

DSM-5 defines impulsivity as follows: "Impulsivity refers to hasty actions that occur at the moment without forethought and that have high potential for harm to the individual (e.g., darting into the street without looking). Impulsivity may reflect a desire for immediate rewards or an inability to delay gratification. Impulsive behaviours may manifest as social intrusiveness (e.g., interrupting others excessively) and/or as making important decisions without consideration of long-term consequences (e.g., taking a job without adequate information)." (APA, 2013/2015).

ICD-11 defines impulsivity as follows: "Impulsivity is a tendency to act in response to immediate stimuli, without deliberation or consideration of the risks and consequences." (WHO, 2022).

1.6 Comorbidities of ADHD

The occurrence of multiple disorders associated with the main disorder (comorbidities) in a single patient is not rare nowadays. In individuals with ADHD, the presence of another disorder is 60-70 percent more likely to occur. The age of the individual also plays a role. The severity of comorbidities usually increases with increasing age (Canu, 2010).

Up to 30 per cent of children with ADHD suffer from disorders such as dyslexia, dysgraphia, and dyscalculia (Goetz, 2013). Learning disabilities, along with inattention, make it difficult for these students to meet their school obligations (Faedda et al., 2019). Some children with ADHD also experience delays in motor development and coordination (de Gregorio et al., 2019), speech and language (Rabie et al., 2015). These children appear less coordinated, their writing is unorganized, and errors in pronunciation occur.

Another common disorder co-occurring with ADHD is oppositional defiant disorder (ODD) (Dourish et al., 2016). Characteristic manifestations include defiance of authority, arguing with adults, disrespecting and deliberately breaking rules. Children with oppositional defiance are often irritable and react confrontationally.

Many children with ADHD also have conduct disorders (Shoham et al., 2021). These disorders come on at an older age and escalate during adolescence. Individuals with conduct disorder show disrespect for the property, rights and health of others. They are often the perpetrators of bullying and fighting and are involved in criminal behaviour and substance abuse in adolescence.

Some individuals with ADHD suffer from anxiety (D'Agati et al., 2019). A common feature tends to be fear and feelings of tension related to a specific situation (e.g., going to school), but also unrelated to a specific situation. Unpleasant feelings of tension tend to be accompanied by physical manifestations such as trembling, sweating, palpitations, chest pressure, and dry mouth. Anxious children with ADHD tend to be less noticeable due to the absence of impulsive symptoms. They also have impaired working memory, which makes it difficult for them to perform multiple thought operations at once.

Other comorbidities include mood disorders (Goodman, 2019), which can be encountered in various forms. Depression is one of them (Mochrie et al., 2020). Around 4 percent of school children with ADHD suffer from depression. In adolescence, the incidence is even more common. These individuals are characterized by sad or irritable moods, tearfulness, and disinterest in activities. In addition, we may also encounter comorbidity with bipolar affective disorder, in which depressed mood alternates with phases of mania in which

the patient experiences a heightened state of energy. Distinguishing bipolar disorder from ADHD is clinically very important, as medications given to treat ADHD can exacerbate manic phases (Caye et al., 2021).

ICD-11 also mentions speech and language disorders, tic disorders and primary tics, as well as increased risk for obsessive-compulsive disorder and epilepsy. Tic disorder can be seen in up to 10 percent of children with ADHD. It is usually manifested by repetitive movements or sounds (twitching, blinking, coughing). Tics usually occur only in certain situations (Goetz, 2013). ADHD is also frequently associated with hyper and hypo-reactivity to sensory stimuli (Panagiotidi et al., 2018), autism (Rau et al., 2020) allergies (Pelsser et al., 2009) and asthma (Grizenko et al., 2015).

Adults with ADHD also have higher rates of participation in criminal (Freckelton, 2019) and risky sexual activities (Pandiyan & Kumar, 2018). UECS also notes that hyperactivity and resulting problems with rest and sleep may be related to some forms of self-harming behaviour (e.g. excessive sports activity, drug and alcohol use) and suicidal behaviour (Beauchaine et al., 2019).

1.6.1 ADHD and sleep disorders

ADHD in general can negatively affect sleep quality. Both hyperactivity and inattention seem to be responsible symptoms. Nightmares, sleepwalking, sleep talking, and night terrors have been reported (Langberg et al., 2020). Sleep disturbances are increased in children with ADHD when coexisting with depression and anxiety. Sleep disturbances need to be identified as a primary or secondary disorder because if the sleep disorder is primary, its consequences, such as inattention or restlessness, can easily be mistaken for ADHD symptoms.

Some studies suggest that ADHD symptoms are more likely to correlate with sleep apnea and insomnia. People with ADHD often have difficulty falling asleep and also with consistent sleep throughout the night (Vogel et al., 2017). Self-reported restless legs syndrome and involuntary leg movements during sleep are associated with symptoms of attention deficit hyperactivity disorder (Didriksen et al., 2019). These problems correlate mostly with the symptoms of hyperactivity. Other research studies, on the other hand, show a relationship between the inattention symptom and problems with delayed sleep (Bron et al., 2016). Further research on a group of adults with ADHD confirmed a higher likelihood

of sleep disturbance and sleepiness related to inattention. Specifically, individuals with inattention problems had higher rates of daytime sleepiness (Ito et al., 2017).

Finally, we should also mention a study that found a relationship between ADHD symptoms and symptoms of circadian sleep disorder and seasonal depression (Wynchank et al., 2016). The relationship between emotional lability, mind wandering, ADHD symptoms and poor sleep quality has also been confirmed. Due to poorer quality sleep, individuals with ADHD experience mind wandering and this in turn affects emotional lability, leading to worsening ADHD symptoms (Helfer et al., 2019).

1.6.2 Risk behaviour

Some studies have found that individuals with ADHD, compared to individuals without the disorder, have reduced scores on a cognitive flexibility questionnaire, reduced scores on reasonable risk-taking, and shorter reaction times (Roshani et al., 2020). Research has found that a diagnosis of ADHD is significantly associated with psychological distress. Some studies suggest a relationship between psychological distress, problem gambling and hazardous drinking (McDonald et al., 2021).

In contrast, research by Wickens et al. (2017) shows that increased risk behaviours in adults may be due more to antisocial personality disorder than to attention deficit hyperactivity disorder alone. These individuals were more likely to have a sexually transmitted disease, had more head injuries and more emergency room admissions, and also engaged in risky driving (Wickens et al., 2017). A longitudinal study by Chen et al. (2018) found that adolescents and adults with ADHD are at greater risk of contracting sexually transmitted diseases. The same threat applies to substance use. We will stop at this issue in more detail in the next chapter.

Higher rates of risky behaviour are confirmed in individuals with ADHD when driving. For example, young adolescent drivers with ADHD in their first two years of driving are more likely to be at fault in crashes than drivers without ADHD (Curry et al., 2022). The study by Timmermans et al. (2020) also paid attention to young drivers with ADHD. Inappropriate driving behaviour led to violations, aggressive behaviour and breakdowns. The research found that inappropriate behaviour behind the wheel was related in males to impulsive and hyperactive symptoms. At the same time, a study by Sobanski et al. (2013) confirmed that adult drivers improved while taking antamoxetine medication. Improvements were noted in attention, and self-control, and drivers took fewer risks (Sobanski et al., 2013).

Other research has followed two groups of individuals over a very long period. From birth to their 40s. The study focused on criminal behaviour and driving behaviour. One group were healthy individuals, the other consisted of individuals with ADHD. All of the healthy group of individuals lived to the age of 40. In contrast, for the group of individuals with ADHD, 11 did not live to that age (3 died of illness, 3 by suicide, 2 in a car accident, 2 as a result of substance abuse, and one was murdered). The study found that drivers with ADHD were more likely to drive under the influence of alcohol and also more likely to drive without a license. Further, individuals with ADHD were more likely to be victims of crime, but also more likely to commit the crime themselves, both in the form of violent behaviour and economic crime (Koisaari et al., 2015).

Let's also mention the relationship between ADHD and obesity. Individuals with ADHD have a higher risk of food addiction and binge eating (Brunault et al., 2019). A relationship has been found between binge eating in women with ADHD and symptoms of inattention and impulsivity, as well as depressive symptoms (Nazar et al., 2014).

Suicidal thoughts and actions are other risky behaviours that occur in individuals with ADHD. Suicidal thoughts may be associated with stress that individuals perceive (Gbessemehlan et al., 2020). Mood disorders also influence higher rates of suicidal behaviour. This comorbid disorder significantly increased the likelihood of suicide attempts (Forte et al., 2021).

As another study shows, medication has a positive effect. Pharmacological treatment with stimulants in individuals with ADHD reduces the likelihood of suicide attempts. When treated with non-stimulant medication, this effect was not significant (Chang et al., 2020).

Individuals with ADHD are at higher risk of mortality from unnatural causes. The serious consequences for individuals with ADHD increase with the number of comorbidities. First of all, let us mention comorbidities such as mood disorders, conduct disorder and oppositional defiance disorder. However, studies differ on whether ADHD is a major cause of risky behaviour (Stickley et al., 2016) whether comorbid disorders are the main influence (Wickens et al., 2017) or whether it is a joint effect of ADHD and a particular comorbid disorder (Forte et al., 2021).

Finally, we should mention the importance of pharmacological treatment and medication support that can reduce the risks. This is true for both stimulant (Chang et al., 2020) and non-stimulant medication (Sobanski et al., 2013). Identification and treatment itself can also be an important support, as can various correctional facilities that help with rehabilitation and reintegration into society.

1.6.3 Substance abuse

Substance use in association with ADHD is a well-mapped topic. Substance use is associated primarily with the impulsivity subtype (De Alwis et al., 2014). Studies have repeatedly confirmed that adolescents with ADHD are more prone to substance abuse. The risk increases when ADHD is associated with behavioural disorders. The first experimentation with smoking and alcohol, as well as with other psychoactive substances, occurs at an earlier age in individuals with ADHD.

An interesting finding of one study was that not only are individuals with ADHD more prone to substance abuse, but their family members also have a higher risk of substance abuse, even if the individual with ADHD does not use any substances themselves (Yule et al., 2017).

A study by Miranda et al. (2016) found that individuals with ADHD and SUD (substance use disorder) have higher rates of alcohol, marijuana, and tobacco use than those with SUD alone. At the same time, comorbid oppositional defiant disorder increased the risk of SUD more than ADHD. Another study found a significant relationship between all subtypes of ADHD and SUD. However, the study shows that the relationship between SUD and hyperactive and impulsive symptoms is more consistent than the relationship between SUD and inattentive symptoms (De Alwis et al., 2014).

ADHD was confirmed in 10.1% of individuals in a representative sample of the Australian population. Alcohol, illicit substances and nicotine use were significantly more common in these individuals than in those without ADHD (Riegler et al., 2017). Another study found that 19.4% of the patients treated for heroin addiction had ADHD. These patients also smoked tobacco at a high rate, had more severe levels of addiction, were more likely to address the topic of unemployment, and had confirmed other comorbid psychiatric disorders (Lugoboni et al., 2017).

Research by Bidwell et al. (2014) examined the relationship between marijuana use and ADHD. In this study, they looked at the specific role of individual ADHD symptoms. While inattention in childhood led to more severe marijuana use and craving, hyperactivity-impulsivity symptoms in childhood were related to the earlier start of substance use. Other research has examined the relationship between cognition, and impulsivity in individuals with ADHD and cocaine abuse. The study found that individuals with ADHD and cocaine abuse had significantly lower mean IQ and higher motor impulsivity (Miguel et al., 2016).

A study by Crunelle et al. (2013) found that individuals with ADHD and SUD showed significantly higher rates of motor and cognitive impulsivity than individuals with ADHD alone and healthy adults. At the same time, cocaine abusers who had ADHD had more impulsive symptoms than cocaine addicts without ADHD. Other research has examined whether and possibly how quickly cocaine withdrawal improves in individuals with ADHD when ADHD symptoms are treated. In 24% of patients, abstinence was confirmed to be preceded by improvement in ADHD symptoms (Levin et al., 2018). One study looked at the change and frequency of ADHD symptoms after one year of abstinence in these patients. It showed that there was a significant reduction in ADHD symptoms after this time. Therefore, follow-up examination and diagnosis after this time is recommended to avoid false positive diagnoses of ADHD Hagen et al. (2017).

Research by Muld et al. (2015) looked at the long-term outcomes of patients with ADHD and severe SUD who were given pharmaceuticals and individuals who were not so treated. The pharmacologically treated group had fewer relapses, individuals voluntarily participated in various rehabilitation options and programs, were more likely to live in sheltered housing and also had higher employment rates than those in the untreated group.

As can be seen, the relationship between ADHD and SUD is very complex. ADHD is certainly a risk factor for the development of SUD (Skutle et al., 2015). Individuals with ADHD with more severe impulsivity (Crunelle et al., 2013) and individuals with ADHD with other comorbidities are more at risk (Miranda et al., 2016). At the same time, a recommendation to do confirmatory testing for ADHD after prolonged abstinence is in place (Hagen et al., 2017). Treatment of ADHD with comorbid SUD is possible and usually has a positive effect on the treatment of SUD itself (Bihlar Muld et al., 2015). For these reasons, it is important to be aware of this relationship when treating patients with SUDs, where identifying and treating unrecognized ADHD can positively influence SUD treatment and outcomes.

1.6.4 Injuries caused by an accident

Studies show that individuals with ADHD are more susceptible to various types of injuries. This risk increases if ADHD is accompanied by conduct disorder and oppositional defiance disorder. Adults with ADHD have been shown to have significantly higher rates of head injuries, internal injuries, contusions, fractures, poisonings, and other unspecified injuries.

When treated with methylphenidate, the risk of injury was significantly reduced (Chien et al., 2017).

A significant association has been found between traumatic brain injury (TBI) and ADHD. Patients with ADHD are more likely to have TBIs such as skull fractures, concussions, contusions and brain haemorrhages due to injury (Liou et al., 2018). Furthermore, a significant association between pedestrian injury and ADHD was found independent of age, gender, education level and economic status (Sadeghpour et al., 2020). Other research has focused on the relationship between individuals with ADHD and eye injury. They noted increased scores on the behavioural problems/impulsivity subscale in patients who had eye injuries associated with outdoor activities (Keles et al., 2022).

Although the effect of ADHD on accident-related injuries is not entirely clear (Amiri et al., 2020), it is consistently found across studies (Chien et al., 2017). The possibility of injury appears to increase with ADHD symptom severity, which may be increased by other comorbid diagnoses (conduct disorder, oppositional defiance disorder) or as a result of current stress levels (Wolff et al., 2019).

1.7 Theoretical background of the present study

This subsection includes the theories and theoretical approaches used in the present study to theoretically ground the results of the thematic data analysis regarding factors that support school functioning and inclusion for students with ADHD. These theories and theoretical approaches also underpin the discussion section of the present study.

1.7.1 Theoretical approaches to ADHD

Attention-deficit/hyperactivity disorder (ADHD) can be defined as a disorder with a genetic and neurodevelopmental basis (medical approach) or as a chronic condition also involving environmental, social and cultural causes (conditional approach). The medical definition of ADHD (Taylor, 2013) delineated ADHD as a neurodevelopmental disorder defined by impairing levels of inattention, disorganisation, and/or hyperactivity-impulsivity, which have, a predominantly hyperactive-impulsive (Sagvolden et al., 2005), a predominantly inattentive (Saad et al., 2018) and a combined subtype (Saad et al., 2018). The hyperactive-impulsive subtype of ADHD is more prevalent in boys, while girls suffer more from the inattentive subtype (Skogli et al., 2013). The medical definition of ADHD is often criticised, because it conceptualises ADHD as a disorder caused primarily by genetic (Akutagava-

Martins et al., 2016; te Meerman et al., 2019) and neurodevelopmental determinants (Dark et al., 2018) that may be associated with stigmatising individuals with ADHD (Mueller et al., 2012). In contrast to the medical approach, the conditional approach understands ADHD as a chronic condition (Furman, 2005) that leads to increased inattention, hyperactivity and impulsivity. This conditional definition of ADHD does not consider only the genetic and neurodevelopmental factors but also the environmental (Martin et al., 2019), social (Norwich 2016), cultural (Asherson et al., 2012) and other factors (Sagiv et al., 2013).

1.7.2 Definition of special educational needs

ADHD makes it difficult for students with ADHD to learn and therefore those students have special educational needs. Special educational needs are usually generally defined as learning difficulties or disabilities which make learning more difficult for a student than for other students of the same age and which call for a special educational provision (Wedell, 2017). There is also a tendency to consider the special educational needs of gifted students (Stava, 2016), which helps develop their exceptional potential. Furthermore, some authors conceptualise special educational needs by using a biopsychosocial model (Norwich, 2016), which also takes into account the social conditions of ADHD.

1.7.3 Mentalisation theory

The theory of mentalization may provide an explanation of how important others' interpretations of the needs of students with ADHD influence the quality of school inclusion and functioning of those students. The theory of mentalization is concerned predominantly with preconscious, subjective, imaginative mental activity through which individuals make efforts to interpret other people's intentional acts (e.g., needs, desires, feelings, beliefs, goals, purposes, reasons), which are manifested in other people's behaviour (Diamond & Kernberg, 2011; Fonagy et al., 2019). In accordance with the principles of mentalisation theory, it is assumed that if important others (family members, teachers, other helping professions, classmates) are able to satisfactorily mentalise the needs of children with ADHD, the rate of inappropriate interpretation of ADHD children's behaviour will be reduced (Conway et al., 2019). This may then lead to the formation of friendlier relationship between important others and children with ADHD (Gershy & Gray, 2020), thus establishing an empathetic and supportive school environment (Swan & Riley, 2015).

1.7.4 The theory of social referencing

The theory of social referencing provides prerequisites for explanation the way in which it is possible to influence the quality of upbringing and educating of students with ADHD. The theory of social referencing (Feinman, 1982; Walden, 1991) assumes that children regulate their behaviour toward objects (e.g., persons, situations, things) based on the important others' affective expressions associated with those objects. This means, e.g., that if the children observe the mother react to an object with fear, the children evaluate the object as dangerous and may tend to avoid it. Thus, e.g., teachers' warm and joyful affective expressions in response to an ADHD student's prosocial behaviour or correct way of solving a learning task may reinforce this type of behaviour in that student.

1.7.5 Attachment theory

Attachment theory may be a suitable theoretical background for the present study because it provides a framework to explain the quality of the emotional-relational attachment of students with ADHD that influences their ability and capacity to cope with the demands of school. Attachment is defined as an affectively experienced bond to important others (parents, caregivers, friends, partners, , etc.) that is established through experience with sufficient sensitivity and responsiveness of those important others. If important others are sufficiently sensitive and responsive, an individual develops a secure attachment, which is characterised by an internal sense of security. This internal sense of security facilitates healthy psychosocial development and exploration of the world (Bowlby, 1982; Krtek et al., 2022; Rutter, 1989). If important others are not sufficiently sensitive and responsive, an individual develops an insecure attachment, which is linked with poor psychosocial development and health (Massengale et al., 2017).

1.7.6 Dimension of closeness and conflict in the interaction between the teacher and the student with ADHD

Theoretically, the quality of the relationship of the teacher with the student with ADHD can be approached through the dimension of closeness and conflict in the interaction between the teacher and the student with ADHD (Mason et al., 2017). The dimension of conflict captures the degree of negative and conflicting relationships and the dimension of closeness involves the degree of acceptance, warmth and care (Zendarski et al., 2020). These

dimensions capture both the negative and positive aspects of the quality of the teacher-student with ADHD relationship (Pianta & Stuhlman, 2004).

1.7.7 Labelling theory

Another theory that can provide an understanding of some factors influencing the quality of school inclusion and functioning of student with ADHD is labelling theory (Bernburg, 2009). Labelling theory assumes that the behaviour and self-identity of individuals can be conditioned by the terms by which they are classified or described. This means that the majority tends to consider minority's behaviour inconsistent with standard cultural norms to be deviant, which can lead to self-fulfilling prophecy (Jussim, 1986). A self-fulfilling prophecy is a vicious circle in which the pressure of the expectation of others evokes in the individual a reaction that corresponds to the others' expectations. Thus, if teachers expect disruptive behaviour from ADHD students, the pressure of this expectation may actually trigger that disruptive behaviour of those students (Wiener et al., 2012).

1.7.8 Policy of inclusive education

Effective school functioning and inclusion of ADHD students can be significantly supported by a policy of inclusive education. This strategy is delineated as promoting acceptance and cooperation between students, families, and educators, and valuing diversity, highlighting the contributions of all students and their right to be educated alongside their peers in standard classes at high-quality schools (Liontou, 2019; Salend, 2011). High quality schools can be characterised by safe, clean and well-managed environment (Uline, 2009), where the staff establishes high expectations and creates an engaging and orderly inclusive atmosphere to foster learning for all (Corbett, 2002). In such a supportive school environment, students with ADHD can better cope with study demands, and develop positive qualities and talents, motivation to study, and friendly relationships with peers and teachers (Krtek et al., 2022; Krtkova et al., 2022).

1.7.9 Inclusive special education

Inclusive special education (Hornby, 2015) is one of the dimensions of inclusion which is very influential and also provides a suitable background for the present study. Inclusive special education should focus on both assessment and interventions. Assessment strategies are suggested to help to assess the SEN of the students. Universal Design for Learning (King-

Sears, 2009), Response to Intervention (Burns & Gibbons, 2012), Positive Behaviour Interventions and Supports (Jensen) are concrete examples of such assessment strategies. In contrast, the intervention strategies are used for improving teaching effectiveness, cooperation between parents, school staff, and other professionals and for interventions that also consider the specific family or cultural background of the students (Trainor & Robertson). Peer tutoring, instructional and assistive technologies, the teaching of meta-cognitive strategies, or co-operative learning are examples of intervention strategies that can be used in the education of students with SEN (Hornby, 2011).

1.7.10 Structure of policy of educational inclusion in the Czech Republic

The policy of inclusive education in the Czech Republic is in line with the policy of the European Union and the national Czech policy on education of children with special educational needs (Ministry of Education, 2019). The implementation of these strategies leads to the integration of methods of working with children with special educational needs into the teachers‘ education system. Furthermore, the policy of inclusive education in the Czech Republic leads to use specific teaching materials, adapted textbooks, compensatory and rehabilitation equipment and tools, support of counselling services, additional support staff and additional teaching in specific subjects.

The current structure of inclusive education in the Czech Republic is summarised in more detail in the "Action Plan for Inclusive Education", which consists of seven points. First, the public and professionals should be informed in a comprehensible way about the progress of inclusive education through available data and analysis. Secondly, there is a need for strengthening teachers and teaching assistants' competences, skills, evaluation, and sharing examples of good practice. Improving teachers' competencies is achieved through undergraduate teachers' education practice focused on working with children with individual learning plans, different learning needs, and working with heterogeneous groups of children. Third, the policy of inclusive education promotes the availability of individualised and diversified counselling services in schools and school counselling centres. Fourth, the policy of inclusive education seeks to promote the availability of minor health care in schools. Fifth, provide immediate and accessible language training to all children entering the school with varying levels of Czech language proficiency. This is especially the case for those children for whom Czech is a second language. Sixth, reduce the administrative burden on teachers. Seventh, reduce segregation processes (reduction of external differentiation at the level of

preschool, primary and secondary education). This means analysing the impact of catchment areas on the composition of school groups, considering the socio-economic status of pupils' families or different cultural backgrounds.

2 Methodology

This chapter first describes how the research questions emerged from the data. This chapter also presents the qualitative methods that were chosen to analyse the data, the reasons for the choice of research methods and the logic of the research process. Furthermore, the theory of thematic analysis and phenomenological interpretative analysis (IPA) is briefly introduced, followed by a subsection on participant demographics, data collection procedures and research ethics.

2.1 Research questions

The main research questions are based on the epistemological position of the researcher, who uses a phenomenological framework to understand the individual and unique experiences of the participants with the factors supporting school inclusion and functioning of students with ADHD, and also to understand the meaning and significance those participants attributed to their experiences. Successful use of the research questions relies on participants' willingness to share and explain in a comprehensible manner their lived experiences of factors supporting school inclusion and functioning for students with ADHD.

Due to the nature of the data, the initial research question emerged prior to the first stages of analysis: “*What is the lived experience of students with ADHD, parents of children with ADHD, and teachers of students with ADHD with factors supporting school inclusion and functioning of students with ADHD?”* As the interview transcripts were reread, similarities and differences in the lived experiences of the participants began to emerge. From there, another research question emerged: "*What are the similarities and differences in the lived experiences of participants with factors that support school inclusion and functioning of students with ADHD?*”

Table 1. Primary and secondary research questions

Primary research question	Secondary research question
What is the lived experience of students with ADHD, parents of children with ADHD, and teachers of students with ADHD with factors supporting school inclusion and functioning of students with ADHD?	What are the similarities and differences in the lived experiences of participants with factors that support school inclusion and functioning of students with ADHD?

2.2 Measures and Procedures

Our study was inspired by the DIPEx methodology (Database of Personal Experiences of Health and Ilness), which was developed by researchers at the University of Oxford (Ziebland & McPherson, 2006). The aim of DIPEx methodology is to gain an insight into the lived experiences of people with various illnesses and health and with professional care.

DIPEx methodology includes the following main phases: (a) study of scientific literature, (b) compilation of interview schedule and advisory panel, (c) pilot study, (d) clarifying of interview schedule, study plan and participant recruitment strategy, (e) participant recruitment, (f) data collection, (g) data coding, data analysis (thematic analysis), (h) production of final report. The final report of DIPEx provides a thematically structured lived experience of participants, e.g. how the disease affects family life, work, education and leisure, how to manage the disease or how professional care can be improved. The acquired knowledge is used in health policy and can influence changes in health or social care.

The present study followed the qualitative approach aiming to assess the experience of participants, as described by (O'Connor & McNicholas, 2020). These authors explored the first-hand lived experience of participants in the context of child and adolescent psychiatry.

Prior to recruiting participants, we developed a semi-structured interview schedule. The interview schedule was designed as an aid to researchers to remind them of the important themes that the participants may not have mentioned on their own. Interview schedule items were constructed based on recent studies concerning ADHD (Brock et al., 2009; Feranska, 2018; Greene et al., 2002; Rushton et al., 2020), especially in the context of school. The interview schedule items were formulated as open-ended questions, but there was a space

for flexibility to create variants of pre-prepared questions or completely new questions as the participants introduced new ideas. The main items of the interview schedule for participants students with ADHD were as follows: (a) experience of the school environment, (b) relationships with teachers, (c) the pedagogical approach at school, (d) expectations and requirements at school, (e) relationships with peers at school, (f) communication about school with parents, (g) school equipment and special teaching aids, (h) helping professionals, (i) wishes of ADHD students (for more detail information about items and questions from the interview schedule for participants students with ADHD, see table ?)

The main items of the interview schedule for participants parents of students with ADHD were as follows: (a) ADHD students and school, (b) personality of a teacher and a student with ADHD (c) the pedagogical approach to students with ADHD, (d) how to meet the special educational needs of ADHD students, (e) classmates and ADHD students, (f) school equipment and special teaching aids, (g) cooperation between parents and teachers, (h) cooperation with other professionals. The main items of the interview schedule for participants teachers of students with ADHD were as follows: (a) free storytelling about ADHD, (b) teachers' attitudes, (c) manifestations of student behaviour, (d) teacher-student relationship, (e) teachers' education about ADHD, (f) coping strategies, (g) class collective, (h) communication with parents, (i) teaching assistants, (j) school and colleagues, (k) medication, (l) spiritual aspects, and (m) messages to others.

The interview schedule was inspired by (Blank, 2013; Majid et al., 2017; Wood, 1974). Questions of interview's schedule were piloted and validated through three phases before use in the major study. First, the researchers sought to construct questions in a way that would lead participants to the report in accordance with the main study objective. Second, the members of the advisory panel revised the relevancy and language quality of the interview schedule questions. Third, the revised questions were tested in the pilot study, in which 4 participants participated (The pilot study's participants did not participate in the main study). These participants were selected in accordance with the criteria for selecting participants for the major study. Researchers also asked the participant of the pilot study which questions in the interview schedule required further clarification. The aim of the pilot study was also to allow researchers to test and improve their interviewing skills with students with ADHD, parents of students with ADHD and teachers of ADHD students.

2.4 Participants

The sample included 20 students with ADHD, 20 parents of students with ADHD and 15 teachers of students with ADHD. The median age of ADHD students was 13 years (For a more detailed description of the demographics of the participants students with ADHD, see Table 1.). The median age of parents of children with ADHD was 37 years (For a more detailed description of the demographics of the participants parents of students with ADHD, see Table 2.). The median age of teachers of students with ADHD was 42 years (For a more detailed description of the demographics of the participants teachers of students with ADHD, see Table 3.).

Table 1. Demographic status of ADHD students aged 12–14 years

Pseudonym	Gender	ADHD comorbidities	number of siblings	Date of interview
Pavel	Boy		0	9/6/2018
Marcela	Girl		1	9/14/2018
Petr	Boy	autism	1	8/23/2018
Matej	Boy	asthma	0	11/13/2018
Boris	Boy		2	11/28/2018
Vendelin	Boy	opposition defiance disorder and substance abuse	1	12/5/2018
Karel	Boy		1	12/8/2018
Lucie	Girl	self-harm, substance abuse, sleeping and depressive disorders	1	1/27/2019
Vojta	Boy	Asperger's syndrome	1	1/27/2019
Dalibor	Boy	opposition defiance disorder and substance abuse	1	3/12/2019
Ales	Boy		3	3/13/2019
Ondra	Boy	dyslexia, dysgraphia and dysphasia	0	3/19/2019
Jan	Boy		2	3/19/2019
Josef	Boy	opposition defiance disorder and substance abuse	1	4/9/2019
Jirka	Boy	dyslexia, dysgraphia and dysphasia	1	4/9/2019
Fanda	Boy		0	4/10/2019
David	Boy		1	4/19/2019
Adam	Boy		1	5/6/2019
Vera	Girl	self-harm, substance abuse, sleeping and depressive disorders	0	6/5/2019
Filip	Boy		1	6/6/2019

Table 2. Demographic status of parents of students with ADHD

Age group	Participants	Marital status	Number of children	Education	Employment
30-39	Mother	Married	1	higher education	manager
	Mother	Married	2	higher education	teacher
	Mother	Mother	2	secondary education	nurse
	Mother	Divorced	1	higher education	official
	Father	Married	3	primary education	businessman
	Father	Divorced	2	higher education	psychologist
40-49	Mother	Married	2	higher education	nurse
	Mother	Married	2	primary education	unemployed
	Mother	Married	2	higher education	teacher
	Mother	Married	2	secondary education	secretary
	Mother	Married	4	secondary education	social worker
	Mother	Married	1	higher education	manager
	Mother	Divorced	3	higher education	teacher
	Father	Married	2	higher education	therapist
	Father	Married	2	primary education	worker
	Father	Married	1	secondary education	official
	Father	Divorced	2	higher education	manager
50-59	Mother	Married	2	higher education	teacher
	Mother	Married	1	primary education	secretary
	Father	Divorced	2	secondary education	businessman

Table 3. Demographic status of teachers working with students with ADHD

Age group	Gender	Pseudonym	Years of teachers' experience	Subjects taught by teachers	Second profession	The date of the interview
20-29	Woman	Alena	4	Chemistry, Physics	No other profession	3/2/2020
30-39	Woman	Jana	7	Geography	No other profession	17/5/2020
	Woman	Petra	8	Native language	No other profession	2/4/2020
	Woman	Marketa	9	Native language, History	Special education teacher	5/6/2020
	Woman	Johana	5	Mathematics	Teaching assistant	19/3/2020
	Man	Karel	13	History	Educator in a children's home	4/5/2021
40-49	Woman	Marta	12	Native language, social Sciences	No other profession	13/7/2020
	Woman	Jitka	6	Music, Art Education	Singing teacher	16/4/2020
	Woman	Vera	15	Biology	No other profession	21/3/2020
	Man	Ales	12	Physical Education, Social	Psychotherapist	15/10/2019
	Man	David	15	Sciences	Tennis trainer	26/5/2020
	Man	Richard	17	Physical Education	No other profession	4/1/2021
50-59	Woman	Vendula	22	Social Sciences, History	Director of the school	10/9/2019
	Man	Matej	15	Native language, History	Educator in a children's home	18/5/2020
	Man	Josef	18	Geography	No other profession	

Participants students with ADHD were recruited through advertisements in relevant periodicals and snowball sampling recruitment strategy and the selection criteria were as follows: ADHD students aged 12–14 years, all regions of the Czech Republic, ADHD diagnosed by clinical psychologists according to DSM-5 (Lee et al., 2020). The criteria for selecting participants parents of children with ADHD through advertisements in relevant periodicals and snowball sampling recruitment strategy were as follows: parents of ADHD adolescents (aged 12–14 years), ADHD in adolescents diagnosed by clinical psychologists in accordance with DSM-5 (Lee et al., 2020). The criteria for selecting participants teachers of children with ADHD through advertisements in relevant periodicals and snowball sampling recruitment strategy were as follows: teachers working with students with ADHD aged 12-14 years, at least 2 years of teaching experience in teaching students with ADHD, teachers were informed about the diagnosis of ADHD by the parents of the students with ADHD, ADHD in students diagnosed by clinical psychologists in accordance with DSM-5 (Lee et al., 2020). Thus, the teachers were not selected on the basis of whether they knew much or little about ADHD. According to the Czech educational system standards, all the teachers underwent only common seminars presenting basic information for working with ADHD students.

The participants were recruited both by direct (i.e., through advertisements in relevant periodicals) and indirect (i.e., the snowball sampling) recruitment strategy. Direct recruitment was carried out through advertisements in periodicals of magazines. The indirect recruitment method was based on the snowball method (Noy, 2008). It was carried out only as a marginal and complementary strategy in which the members of the advisory panel were asked to contact potential participants they knew from their professional practice. The advisory panel was composed of professionals who have experience working with children with ADHD, i.e., doctors, psychiatrists, teachers, special pedagogues, teaching assistants, psychologists, but also students with ADHD and their parents. Other members of the advisory panel were the researchers leading the project, and the project supervisor.

The snowball method was used in our research with full knowledge of its advantages, disadvantages (Audemard, 2020; Lee & Spratling, 2019) and potential biases. So-called "community bias" was considered particularly problematic. This bias means that the researcher or participant may tend to recruit new participants from a particular subgroup and there is no branching out of that narrow community (Sadler et al., 2010). This bias was in the present research reduced by the primary use of direct recruitment and by the fact that all members of the advisory panel helped with searching for participants.

The snowball method had two phases. In the first phase, a sample of suitable participants was identified and contacted, and in the second phase, the participants identified in the first phase helped to recruit other suitable participants until the number of participants in the sample was satisfactory.

2.5 Data collection procedures

The interviews in our study were conducted by three experienced researchers, who were part of the project team members. They had many years of experience in qualitative research and psychotherapy and underwent professional training in conducting interviews within the DIPEx methodology. The place and time of the interviews adapted to the possibilities of the participants. The interviews were recorded in the works or homes of the participants in rooms without the presence of other people and distractions.

The average length of the interviews was 56 minutes. The interviews were audio and digitally recorded. During the transcription process, the participants were assigned a pseudonym and care was taken to remove all personally identifiable information that could

identify actual people, children, or places when using data extracts. The transcribed interviews were checked and anonymized in accordance with the DIPEX methodology.

2.6 Data analysis

For the data analysis, it was chosen the method of interpretive phenomenological analysis and the method thematic analysis (Jordan, 2018). This way of processing data is suitable for understanding the students with ADHDs', parents of children with ADHDs' teachers of students with ADHDs' lived experiences regarding the factors supporting school inclusion and functioning of students with ADHD.

Interpretative phenomenological analysis (IPA) was used to create short portraits of the participant students with ADHD. The aim of IPA is to understand the phenomenon through what is known as the hermeneutic circle. That is, the participant seeks to understand his or her lived experience and reports that experience in the research interview, and the researcher seeks to understand how the participant comes to understand his or her own experience. The researcher inserts his or her own meanings, and pre-understandings into the participant's report (Wiggins, 2002). The researcher's pre-understanding is thus linked to the lived experience of the participant. The resulting findings are therefore the joint product of the researcher and the participant. In IPA, then, the researcher's preunderstanding is not seen as unacceptable and undesirable, but as a way of allowing the participant's meanings to emerge from this researcher's preunderstanding. However, in the interest of transparency in the research process, the researcher needs to be able to reflect as much as possible on how his or her presetting affects the way in which he or she treats and grasps the participant's meanings. The IPA tries to avoid the risk of the researcher's interpretations moving too far away from the participant's meanings as much as possible by making the researcher's reflection on his or her presets public, by presenting his or her interpretations in a way that leaves room for further interpretations, and by relating his or her interpretations back to the primary data. In this way, the reader of the resulting findings gains insight into how both the participant and the researcher construct their meanings. However, the reader also gains this insight through his or her pre-understanding and pre-setting. IPA method is also appropriate for processing our data because it focuses on understanding specific individuals in the context of their unique life situation (an idiographic approach).

Thematic analysis was used in the present study because it was suitable for the organization and descriptions of the identified themes in the data. This way of processing

data is suitable for understanding the students with ADHDs', parents of children with ADHDs' teachers of students with ADHDs' experiences regarding the factors supporting school inclusion and functioning of students with ADHD. Another benefit of the thematic analysis is that it allows the identification of the similarities and differences in different perspectives of the participants, the new insights into the issue and the summary of the key themes and their structuring into a final report (Nowell et al., 2017). The thematic analysis has several phases, which involve familiarizing researchers with data, generating initial codes, and searching, reviewing, and defining themes. Familiarizing researchers with data usually take place through transcribing audio recording, reading through the text and taking initial notes, and generally looking through the data. The coding phase involves highlighting parts of the text and creating labels or "codes" that concisely express the content of the parts of the text. The phase of searching, reviewing and defining themes involves bringing the codes into clusters and finding thematic connections between the clusters and the codes (Braun & Clarke, 2014).

Prior to our thematic analysis, the researchers repeatedly and carefully read the transcripts of the interviews. Three researchers projected each transcript on a projection screen and read it together in the next step. The text of the transcripts was marked by thematic codes and sub-codes (names of more generally emerging themes and subthemes). Some passages of the texts were marked with multiple codes because they contained multiple meanings. The resulting list of thematic codes and sub-codes was then assessed using the NVIVO 12 program. Researchers made a node of the same name for each thematic code and inserted the appropriate sub-nodes for each. In the second phase, the transcript files of the interviews were uploaded by researchers to the program NVIVO 12. Consequently, researchers sorted and inserted the text of the transcripts under the relevant nodes and sub-nodes. At this phase, the researchers continuously discovered some other sub-nodes (sub-codes) that enriched the already existing tree of sub-nodes.

Subsequently, the researchers read the texts assigned under the nodes and sub-nodes. They wrote the participants' statements out on a clean paper and marked them with identification labels to visualise which participants were involved. Next, the statements were cut and, based on their relation, placed side by side. Thus, the researchers created several clusters and labelled them by abstracting a more general meaning of the statements. Furthermore, the researchers looked for thematic connections between the statements within one cluster and thematic connections between clusters and between the statements of different clusters.

2.7 Example of thematic data analysis

The researchers carefully and repeatedly read the transcripts of the interviews prior to the thematic analysis. Subsequently, the text of the transcripts was marked by thematic codes and sub-codes (names of more generally emerging themes and subthemes). This means that, e.g., all the statements of the participants concerning school led researchers to establish the code (theme) "school", and statements about school comprised various meanings from which the researchers identified sub-codes (subthemes), such as the "*teacher*" or the "methods of work".

The resulting list of thematic codes and sub-codes was then inserted into the NVIVO 12 program by researchers, creating a node of the same name for each thematic code and inserting the appropriate sub-nodes for each node. In the next phase, the transcript files of the interviews were uploaded by researchers to the NVIVO 12 program. Consequently, researchers sorted and inserted the text of the transcripts under the relevant nodes and sub-nodes. This means, e.g., that the following statements were copied under the 'teacher' sub-node: *"It is good if the teacher perceives the success of a student with ADHD as part of the result of his/her work. He/she's just interested in those kids.",* or *"The teacher should use the positive qualities of ADHD children, such as their liveliness and acting talent, to make this child popular with classmates."* In this phase, the researchers continuously discovered some other sub-nodes (sub-codes) that enriched the already existing sub-nodes tree. Thus, e.g., the node of 'school' was enriched with the sub-node of "*classmates*".

Furthermore, the researchers read the texts assigned under the nodes and sub-nodes and wrote statements of the participants out on clean paper and marked them with identification labels, so that the researchers could trace back which participants were involved. The statements were then cut out of the paper and placed side by side, depending on how they were related. Through this procedure, the researchers created several clusters, which they named by abstracting more general meaning from the statements contained under the individual clusters. In this way, e.g., the "*teacher's personality*" cluster was created, which comprised all the participants' statements about the quality of the teacher's personality. Examples of statements concerning the teacher's personality are as follows: "*The teacher should use the positive qualities of ADHD children, such as their liveliness and acting talent, to make this child popular with the classmates.",* or *"On the one hand, the teacher must have empathy for students with ADHD, but on the other hand, the teacher must*

be firm and consistent in his/her decisions." Furthermore, the researchers looked for thematic connections between statements within one cluster, but also thematic connections between clusters and between statements of different clusters. The structure and content of the results were based on these themes. In this way, e.g., the title and content of the result chapter of 'teacher's personality and awareness of ADHD' was created. This chapter mainly integrates statements from the cluster of 'teacher's personality' and connects them with the content of the cluster of "*ADHD knowledge*".

2.8 Ethics

The research was guided by ethical rules and standards based on the DIPEX methodology of Oxford University. The ethical approach of the research was further ensured by the approval of the Ethics Committee of the Cyril and Methodius Faculty of Theology in Olomouc, number (2018/01), by training of all members of the research team on ethical issues, consulting on ethical issues with a supervisor, ethical experts at the university and the advisory panel. The advisory panel was also set up to help researchers refine participant recruitment strategies, interview schedule and the research process.

First, the participants were informed of their rights in the research and they signed informed consent. Informed consent procedures involved written information sheets that were given to participants, verbal information, and opportunities to ask questions prior to participation in the study. Participants were also informed that they can withdraw from the study at any stage and that they will have an opportunity to authorize an anonymized version of texts. Next, the participants were given the researchers' contact details and received reimbursement for their time.

Regarding the handling of the information, the audio recordings and the transcripts were stored securely in accordance with relevant legal requirements and with current Czech and European legislation on personal data protection (Freitas et al., 2017; Verschuuren et al., 2008).

Conducting some interviews was mentally exhausting because researchers had to work in various home or work environments of the participants and conducted interviews in which participants reported difficult themes. Therefore, psychotherapeutic support was also available to the researchers.

Empirical part

3 Results

The results are divided into three main sections. The first section contains short narrative portraits of the participants. The second section contains factors that participants considered supportive for school inclusion and functioning of students with ADHD. The third section compares the lived experiences of students with ADHD, parents of children with ADHD, and teachers of students with ADHD with factors promoting school functioning and inclusion of students with ADHD

3.1 Portraits of participants

3.1.1 Portraits of students with ADHD

Vendelin's ADHD comorbidities were oppositional defiance disorder and substance abuse. Vendelín grew up in an orphanage. He was expelled from several elementary schools because of disciplinary infractions and conflicts with teachers. After he was diagnosed with ADHD, he began taking medication. At the time of the research interview, he refused to take medication because he believed it made him tired. Vendelin loved freedom and sport. The classic manifestations of Vedelin's ADHD at school were inattention and hyperactivity. His specific manifestations of ADHD and comorbidities were as follows: defiance of teachers' instructions, impulsive behaviour, physical aggression toward some classmates, and pervitin abuse. The following factors adversely affected Vendelin's school functioning and inclusion: some harsh teachers' punishments and strong negative emotions, some teachers' belief that Vendelin was badly behaved, some peers from the orphanage and classmates who bullied him. The following factors had a positive impact on Vendelin's school functioning and inclusion: teachers who loved and supported Vendelin despite his manifestations of ADHD and comorbidities, father who always fought for Vendelin's rights at school, empathetic and supportive classmates, football talent, thanks to which Vendelín had respect and acceptance from his classmates.

Lucie suffered by the following ADHD comorbidities: self-harm, substance abuse, sleeping and depressive disorders. Lucie first become aware of her difference from her peers in primary school. She didn't get along with her classmates because they mocked her for her ADHD symptoms. Lucie's hobbies included sports and watching soap operas. Lucie suffered

mainly from inattention at school. Her specific manifestations of ADHD and comorbidities were as follows: impulsive behaviour, vulgar language, defiance of teachers' instructions, alcohol abuse, depression and self-harm after emotionally challenging situations. The following factors adversely affected Lucie's school functioning and inclusion: bullying by some classmates, some teachers do not acknowledge the existence of an ADHD diagnosis, pressure from teachers for performance and flawlessness, alcohol abuse. The following factors had a positive impact on Lucie's school functioning and inclusion: supportive and loving mother, secure family environment, some accepting and warm teachers, some empathetic and supportive friends, handball talent.

Pavel did not suffer from any ADHD comorbidity His hobbies included football and spending time with friends. From an early age he had problems with concentration and excess energy. Pavel refused medication because he believed that it changes his personality. He also believed that ADHD has advantages, such as having enough energy for sports. Paul suffered by a strong hyperactivity at school. His specific manifestations of ADHD and comorbidities were as follows: physical aggression towards classmates and teachers, trembling of the legs and hands, nail biting, bad mood and fatigue. The following factors adversely affected Pavel's school functioning and inclusion: disagreements and conflicts with some teachers and classmates, lack of strong some teachers' leadership, insufficient parental support. The following factors had a positive impact on Pavel's school functioning and inclusion: some teachers non-invasively repeating instructions, some teachers respecting his pace of learning and the need for practical interpretation of the curriculum, a large number of friends in and out of school.

Vojta's ADHD comorbidity was Asperger's syndrome. Vojta's hobbies were paper modelling and studying dinosaurs. Vojta was taking medication. He had several good friends who helped him to cope with the demands of school. His specific manifestations of ADHD and comorbidities were as follows: physical assault of classmates, inappropriate sexual behaviour, vulgar language, coordination problems, impulsive and dangerous behaviour. Vojta reported only the following factors that helped him with his school functioning and inclusion: loving and supportive mother, a warm and accepting teacher, some accepting and helpful classmates.

Ondra's ADHD comorbidities were dyslexia, dysgraphia and dysphasia. Ondra's hobbies were playing online computer games, watching documentaries and philosophy. Ondra often went to a low-threshold centre where he made many friends. At school, he struggled most with inattention and fatigue. His specific manifestations of ADHD and

comorbidities were as follows: problems with reading and writing, stuttering in speech. The following factors adversely affected Ondra's school functioning and inclusion: disagreements with some classmates, excessive demands from the some teachers, grandparents not acknowledging the existence of ADHD. The following factors had a positive impact on Ondra's school functioning and inclusion: a girl friend who also had ADHD, special charts to help with reading and writing, parental help with school preparation.

Marcela did not suffer by any ADHD comorbidities. Marcela's parents were divorced. Her father did not accept the existence of a diagnosis of ADHD and was fundamentally opposed to Marcela taking medication. Arguments between mother and father caused Marcela anxiety and self-harm. Marcela's hobby was horse riding. At school, she struggled most with inattention and anxiety. Her specific manifestations of ADHD and comorbidities were as follows: depression, and self-harm. The following factors adversely affected Marcela's school functioning and inclusion: disagreements between mother and father, not taking medication. The following factors had a positive impact on Marcela's school functioning and inclusion: s supportive and loving mother, artistic talent, supporting friends.

Petr's ADHD comorbidity was mild autism. Peter's parents were divorced, but they lived together. Frequent arguments between parents increased Peter's aggressive and defiant behaviour. Peter's hobby was tennis. He liked tennis despite the fact that he didn't consider himself very skilled. His motivation for good tennis results was an accepting and supportive tennis coach. At school, he struggled with a strong hyperactivity. His specific manifestations of ADHD and comorbidities were as follows: defiant and oppositional behaviour towards authority, coordination problems. The following factors adversely affected Petr's school functioning and inclusion: disagreements between mother and father, an insecure teacher. The following factors had a positive impact on Petr's school functioning and inclusion: one teacher who set clear rules for behaviour and school preparation and warm tennis coach.

Matej's ADHD comorbidity was asthma. Matej's parents were divorced. Matej's father was a physician and his mother a therapist. The father did not acknowledge the existence of a diagnosis of ADHD and did not respect Matej's special educational needs. Matej attended art school where he loved acting and dancing. He especially struggled with attention deficit. Matej's specific manifestations of ADHD and comorbidities were as follows: breathing difficulties and defiant behaviour. The following factor adversely affected Mate's school functioning and inclusion: father rejecting the ADHD diagnosis and Matej's

art school studies. The following factors had a positive impact on Matej's school functioning and inclusion: supportive and secure family atmosphere at the mother's home, joint activities with classmates, acting talent.

Karel' did not have any ADHD comorbidities. Karel praised the family atmosphere and relationships. His hobbies were parkour and playing computer games. Karel suffered only from mild manifestations of inattention and hyperactivity. He did not report any specific manifestations of ADHD. The following factors adversely affected Karel's school functioning and inclusion: a burned-out teacher, an argument with a classmate. The following factors had a positive impact on Karel's school functioning and inclusion: parents who taught Karl to perceive the inner restless energy of ADHD by using the metaphor of a lion, who has to tame his energy at school and can release and develop this energy outside the school.

Dalibor's ADHD comorbidity was opposition defiance disorder and substance abuse. Dalibor was very sensitive to the opinion of others about his person. He did not tolerate any criticism and easily got into verbal and physical conflicts with teachers and peers. His hobbies were sports and spending time with friends. He struggled primarily with attention deficit disorders. Dalibor's specific manifestations of ADHD and comorbidities were as follows: defiance of teachers' instructions and criticism from classmates, vandalism and abuse of alcohol. The following factors adversely affected Dalibor's school functioning and inclusion: hatred of his person by some teachers and peers. The following factors had a positive impact on Dalibor's school functioning and inclusion: friends, a supportive teacher, talent for sports.

Vera's ADHD comorbidity was self-harm, substance abuse, sleeping and depressive disorders. Vera was diagnosed with ADHD after starting school. She was under the care of a psychiatrist and a psychologist. She had a teaching assistant at school. In her free time she enjoyed playing sports and caring for animals. She would like to be a veterinarian. Vera suffered by inattention at school. Vera's specific manifestations of ADHD and comorbidities were as follows: intolerance to emotionally stressful school situations and fatigue. The following factors adversely affected Vera's school functioning and inclusion: conflicts with classmates, and alcohol abuse by the mother. The following factors had a positive impact on Vera's school functioning and inclusion: warm and supportive personality of the teaching assistant, hobbies in animal care, friends with ADHD.

Josef's ADHD comorbidity was opposition defiance disorder and substance abuse. Joseph's family was characterized by an atmosphere in which conflicts alternated with

periods of peace and mutual support. Josef's favourite school subject was biology, he disliked mathematics and Czech language. He had only a few good friends and did not get along well with most of his classmates. He had many sports hobbies, but he could not stay with any sport for long. Joseph had problems with impulsive behaviour at school. Josef's specific manifestations of ADHD and comorbidities were as follows: verbal and physical conflicts with teachers and classmates, conflicts with school over substance abuse. The following factors adversely affected Josef's school functioning and inclusion: teachers not acknowledging the existence of oppositional defiance disorder, provocative classmates. The following factor had a positive impact on Josef's school functioning and inclusion: one teacher, who accepted Joseph and at the same time was able to give him firm rules of conduct.

Jan did not suffer from any ADHD comorbidities. Jan lived with his mum, dad and two younger brothers. He reported that ADHD affects only his school functioning, not leisure activities. He had his own tricks to help him concentrate. His favourite activities include playing computer games, swimming and other sports like football and basketball. Jan suffered from severe inattention at school. His specific ADHD manifestation was leg tremor. Jan did not report any factors that impaired his school functioning and inclusion. The following factors had a positive impact on Josef's school functioning and inclusion: some accepting teachers and own strategies against leg tremor, when he firmly rested his foot on the floor. Then the tremor eased a little and it was not so visible for classmates.

Jirka's ADHD comorbidities were dyslexia, dysgraphia and dysphasia. Jirka lived with his mother and sister. Jirka shared a room with his sister and would really like to have his own room. He and his sister often got angry and competed with each other. Jirka attended a special school. His school was specialised in ADHD and lessons were taught by one teacher and the students were also helped by two teaching assistants. In addition to Jirka's inattention, he had strong problems with reading, writing and stuttering at school. Jirka's functioning and inclusion was sometimes hindered by classmates with various diagnoses who took away the attention of teachers and teaching assistants. The following factors had a positive impact on Jirka's school functioning and inclusion: parents who provided a secure family environment, accepting teachers and teaching assistants, some friends with ADHD.

Boris did not suffer from any ADHD comorbidities. Boris described that he did not see his ADHD as a handicap. He did not feel it bothered him and thought he was managing his diagnosis well. He learnt to cope with the limitations it brought. Boris struggled mainly with attention deficit disorder at school. His specific manifestation of ADHD was frequent

fatigue and irritable mood. The following factor had a negative impact on Boris's school functioning and inclusion: some teachers not acknowledging the existence of an ADHD diagnosis. The following factor had a positive impact on Boris's school functioning and inclusion: Boris' desire to fight and overcome the manifestations of ADHD.

Fanda did not suffer by any ADHD comorbidity. Fanda came from a complete family with mostly good relations. He was first told that he had ADHD by his parents. He saw a child psychologist regularly but did not take medication. He did not enjoy school very much, but he made friends in class with whom he liked to spend his free time. If he did not understand something at school, he had an assistant who also helped several other classmates. His hobbies were boxing, and playing video games. Fanda suffered by attention deficit and hyperactivity at school. He did not report any other manifestations of ADHD and negative factors affecting school functioning and inclusion. The following factor had a positive impact on Fanda's school functioning and inclusion: secure family relationships and friends.

David was first introduced to his ADHD diagnosis by his first-grade teacher. Neither David's mother nor David wanted the entire class to be aware of his diagnosis, but it happened anyway. The diagnosis was made by a psychiatrist who also prescribed medication for him. David also saw a psychologist. David considered the cause of his ADHD to be the bad relationship between his parents in previous years. David's manifestation of ADHD at school was primarily inattention and hyperactivity. David's specific manifestation of ADHD at school was disregard for teachers' instructions. The following factor had a negative impact on David's school functioning and inclusion: conflicts with some classmates. The following factor had a positive impact on David's school functioning and inclusion: secure family environment, friends.

Ales had no ADHD comorbidities Ales believed that he had more energy than his peers. He did not take medication or using any other alternative treatments. He enjoyed spending time with his friends and got along well with his classmates and teachers. Ales's manifestation of ADHD at school was hyperactivity. Ales's specific manifestation of ADHD at school was vulgar language and impulsive behaviour. The following factor had a negative impact on Ales's school functioning and inclusion: Ales father disrespecting the existence of the ADHD diagnosis. The following factors had a positive impact on Ales's school functioning and inclusion: secure family environment, friends.

Adam did not have any ADHD comorbidities. Adam's hobbies were playing video games with his friends. He considered premature birth and an unhealthy diet to be the cause

of his ADHD disorder. In the future, he wished to be a physician who would figure out how to cure ADHD. Ales suffered from severe hyperactivity at school. Specific manifestations of Ales' ADHD were resistance to the directive style of some teachers and anxiety. It didn't help with Ales' anxieties at school if some teachers thought he was making it up. On the contrary, he was helped with his anxieties by the attitude of some other teachers who gave him some relief in his school work.

Filip did not have any ADHD comorbidities. Philip reported that he was very quick and hasty. He often spoke before he thought at school, which he always regretted later because he could be rude to his classmates and teachers. Philip felt like he didn't have an emergency brake. He simply got an idea, a feeling or a thought and acted on it immediately. Moreover, he suffered from an inattention that was sometimes weaker sometimes stronger. He was helped with his school functioning and inclusion primarily by his parents, who taught him that it is almost always possible to apologize after problematic behaviour and thus repair school relationships.

3.1.2 Portraits of parents of children with ADHD

Julie works in healthcare. She lives with her husband and two children in the big city. The older of the children, a boy, has been diagnosed with ADHD. After an uncomplicated pregnancy, Julie had a complicated cesarean delivery. According to Julie, the boy initially developed as a normal healthy child. During the toddler period, Julie began to notice that her son was acting differently than other children when playing in the sandbox. He did not fit in well with the group, was disobedient and at times unmanageable. At just under three years old, the boy started kindergarten. Julie noticed that her son began to demand attention at this time. For Julia, her son's aggressive displays were particularly burdensome. Later at school, the boy's problem behaviour continued to escalate. Julie felt helpless as the family and the school tried a wide range of pedagogical and educational approaches without success. Julie's son started going to the pedagogical-psychological counselling centre and also to the family centre. The techniques and compensatory mechanisms learned at the centre have helped to better manage unwanted behaviours in the home environment and have improved my son's and the family's communication. This was only a partial relief for Julie because the successes from home could not be transferred to the school environment. Starting in second class, the family, in consultation with the psychiatrist, plans to try medication for ADHD. The whole family, with the support of professionals, is helping to manage the symptoms of ADHD. The

son's communication has improved, often preventing conflicts in the family and at school. However, there are situations when it is impossible to avoid escalating reactions after unpleasant manifestations of my son's ADHD.

Pavla has a five-year-old son diagnosed with ADHD and developmental dysphasia. Pavla first confided in her doctor with concerns that something was wrong with her son when he was a year and a half old. The boy was acting out aggressively. He was pinching, and scratching and could not be unlearned. An EEG examination did not confirm the suspicion of ADHD, but further psychological tests revealed developmental dysphasia and ADHD. Due to developmental dysphasia, the boy is not understood, has a low vocabulary, often repeats words and jumps into others' speech. The family and other people, but often not even Pavla, do not understand the boy. The son reacts to this with aggression. At school, the boy was transferred to a speech therapy class on the recommendation of the psychologist. There are fewer children in these classes, 2 teachers and a teaching assistant. The boy is progressively making progress not only in speech but also in behaviour. She has been successful in setting boundaries in home education while respecting her son's need for self-order. It is important to keep insisting on rules but also to constantly communicate the possibility of compromise arising from the situation. She enjoys successes but is sometimes hurt by the lack of understanding of her environment and other family members.

Hanka B. has two children. Her second-born son was diagnosed with ADHD in the first class. At first, Hanka B. did not notice that her son was any different than the other children. 17 years ago, ADHD was not talked about much. It wasn't until a first-class teacher pointed out the boy's unusual symptoms. The teacher had experience working with children with special educational needs. She recommended a visit to a pedagogical-psychological counselling centre. The son had a very unstable school performance. Although he had above-average intelligence, he was not completing his homework, forgetting, and unable to concentrate and sit still. Therefore, the first years of school were very challenging, and it was difficult to find a way to manage the manifestations of ADHD. His restless behaviour sometimes caused conflict with his classmates. Hanka B. mentioned that attending a club for children with ADHD, where he learned through games how his expressions affected others, helped her son. He also learned to understand the causes of his reactions to different situations and learned mechanisms to correct and manage these reactions. Hanka B. also had to learn, especially how to get along with her son. Meeting other parents of children with ADHD helped her a lot. In this parent group, they supported each other and passed on their experiences. Understanding the diagnosis of ADHD helped her to adjust to the demands she

had on her son, which were sometimes too much. She learned to be more patient in preparing for school, spent more time learning together, included frequent breaks and did not force her son to sit still. Her son's grades are not important to Hanka B.. Above all, she tries to ensure that her son has knowledge that applies to life and future work. During puberty, her son's ADHD symptoms have calmed down and today, according to Hanka B., he is no longer limited by his ADHD diagnosis. The boy has now completed his first year of high school in a field he enjoys. Hanka has no doubts about her son's future career and life.

Klara's family consists of a husband, a son with ADHD and a daughter. In the beginning, Klara did not notice any special difficulties with her son. It was her first child and therefore she had no experience with the behaviour and development of a healthy child. From the beginning, she noticed that her son's development was irregular. On the one hand, he walked and talked very early, on the other hand, he was unpredictable and uncoordinated in more complex activities and had to wear nappies for quite a long time. With the start of kindergarten, Klara's son's aggressiveness, challenging other children, not listening to teachers and not sleeping in the afternoon became apparent. Klara was very satisfied with the attitude of the teachers in his kindergarten. The teachers, in her opinion, understood the boy's difficulties and knew how to handle them and recommended a visit to specialists. Klara and her son visited a psychiatrist who diagnosed ADHD. Based on the information about ADHD, Klara became afraid that her son would be severely limited by this disorder in his adult life. Klara was worried because she had learned on the Internet that many children with ADHD have difficulty with crime, work, and choosing a life partner as adults. Regarding medication for ADHD, Klara was happy with Ritalin. It helped her son reduce his inner tension and aggression and increased his ability to concentrate. She considers her son's biggest problem to be that he blames the causes of his difficulties on others. Klara is tired of having to explain the same rules of behaviour to her son over and over again. Klara is helped to manage her son's ADHD by educational and psychological counselling, family therapy, her family and chocolate. She would like support for herself to meet parents who have children with ADHD to share and discuss experiences. When her son was three years old,

Jana realised she had a 'different' child. He was more animated and excitable from an early age, never able to sit and play in an orderly way. At first, Jana saw her son's first manifestations of ADHD as a more intense period of defiance. Other people thought this was caused by inconsistent parenting. Her son was diagnosed with ADHD at the educational and psychological counselling centre. The counselling centre was recommended by the school at the end of the first grade. However, even after receiving the recommendation from the

counselling centre, the school was not able to respond to her son's special needs and so the whole school period was very stressful and full of helplessness for Jana and her son. Throughout his schooling, her son was labelled as a problem child. Jana faced a lack of awareness on the part of the teachers, the incompetence of the later assistants assigned to her and the insensitive questioning of her educational abilities by the school authorities. Jana sees the lack of quality information about ADHD as a major problem. She had looked for information on the internet and in books but found most of it difficult to use. Professional neurological information did not help her. She needed to know how to communicate and how to work with her son. That kind of information was hard for her to find and she did not get it at school. The first hope of improvement came in 7th grade. She started working with the Educational Care Centre. Her son was able to attend the centre for some time. In the difficult moments when she thinks about why she has a child with ADHD, it helps to see this as a life experience that can take her somewhere. Her son, she says, returns the care she gives him with his love and his directness.

Ivana lives with her husband and two sons. Soon after the birth of her first son, she noticed that his development was irregular. He refused to breastfeed and was very tearful. He was diagnosed with neurofibromatosis. When he started walking, he was diagnosed with ADHD. At the time of the interview, the boy was 13 years old and other diagnoses were identified: obsessive-compulsive disorder, mental retardation and depression. The boy takes medication for all mental illnesses. Ivana has been through many diagnostic and psychological facilities with her son and has had both positive and negative experiences with these facilities. She complained about doctors' insensitive communication of results. At school, she noticed differences in teachers' approaches. Teachers who were sympathetic to her son and tried to take advantage of his specific interests and involve him in the learning process had better results and her son got better grades. Looking after her son exhausts Ivana. Ivana relaxes at work. She teaches and works with healthy children. She enjoys teaching children without health problems.

Radek lives with his girlfriend and their two children, in alternating care. His son has been diagnosed with mild ADHD. In his son's early childhood, Radek did not notice any signs of ADHD in his son. Radek described his interactions with his son as happy and well-behaved. When he observes the psychological functioning and behaviour of his son, he realises that he is likely to have a mild form of ADHD. He understands his son's impatience with learning. Radek describes his son as very talented in sports. They enjoy climbing, playing table tennis and other sports together. Unfortunately, due to his ADHD, the boy does

not last long in his sporting hobbies. Radek characterises his son as easily vulnerable. Radek notes that his son is very sensitive in relationships. The boy took the separation of his parents very hard. He had thoughts of suicide. He also talked about negative experiences with the school system, especially the lack of understanding of the needs of children with ADHD by teachers and school management. In his opinion, his son needed a personal assistant, but the school refused communication on this issue. On the other hand, Radek had positive experiences with psychologists. The psychologist explained the causes of ADHD symptoms and how to approach ADHD children. His son never needed medication. Radek described his relationship as happy and satisfied. He briefly mentioned that only more patience and tolerance is needed when educating.

Petra is a teacher and lives with her husband and their two children. Her son has been diagnosed with ADHD since entering school. He is currently on medication to help him concentrate, particularly at school. Petra shared a negative experience regarding the kindergarten's approach. The teachers did not support Petra; instead, they blamed her for her son's behaviour. They perceived him as disobedient, agitated, restless, and uncommunicative. In response, Petra sought assistance from a pedagogical-psychological counselling centre and a psychiatrist. Her son was diagnosed with a behavioural disorder. Interestingly, ADHD was not diagnosed until he reached school age. Petra had a positive experience with the school and attributes her son's success to his grandmother, a retired teacher, who helped him learn from an early age. Petra believes that teachers should maintain a balanced mix of tolerance towards ADHD children without lowering academic expectations too much. Despite the challenges, Petra's son is a gifted and enthusiastic athlete, winning numerous medals in floorball and airsoft. Petra thoroughly enjoys her son's sporting passion. The entire family, through adherence to rules and praising responsibility, has been successful in raising their son. Petra considers him very intelligent but still fears for his future, particularly the possibility of him being inclined towards addictions.

Alena has two children. The older of the two, a ten-year-old son, has been diagnosed with ADHD. Alena first noticed his heightened activity at the age of four, so the diagnosis did not come as a surprise. Teachers frequently complained about his misbehaviour, lack of attentiveness, and tendency to break things, which persisted when he entered primary school. Dyslexia was diagnosed at the age of seven, and ADHD was confirmed after three more years of consultations with specialists. Alena copes daily with her son's stubbornness, inattention, and hyperactivity. She hesitated to share his diagnosis with him, fearing he might use it as an excuse for his behaviour. As a mother, she often grapples with feelings of failure,

sensing that her son does not respect or listen to her, and she worries that her efforts are insufficient to raise him. Alena wishes her husband could spend more time with the family, as she believes her son listens to his father more. Simultaneously, Alena is concerned about the strained relationship between her two children. She perceives her son's anger and disobedience as a result of jealousy towards his two-year-old sister, fearing he wants to divert attention back to himself. Alena regrets her son being excluded from school trips due to hyperactivity, worrying that this exclusion may extend to the classroom. However, she is also anxious that his attention-seeking behaviour, restlessness, and difficulty distinguishing between "boyishness and trouble" might lead him into the wrong crowd. Alena finds her son's ADHD exhausting, struggling to see any positives in the diagnosis, and harbours concerns about his prospects.

Michal has two children, and his ten-year-old son is diagnosed with ADHD. Even at the age of four, his son displayed more energy than other children. Teachers often complained about his behaviour, describing him as naughty and unresponsive. The challenges persisted into primary school, and the ADHD diagnosis was confirmed at age 10. Michal perceives the family situation differently than his wife, feeling less difficulty. His phlegmatic nature makes him patient in situations where repetition is necessary, although he finds his son's stubbornness annoying. He appreciates his son's intelligence and notes an improvement in attention span with age. Michal is positive about the future, believing that his son's ADHD symptoms will improve over time, emphasizing his son's energetic nature in sports activities.

Hanka has three children, including a son with ADHD. Raising three children, with one having ADHD, proved exhausting. Her son's disruptive behaviour, constant movement, and emotional outbursts prompted a visit to a psychologist, resulting in an ADHD diagnosis. Hanka, despite being a seasoned mother, struggled with feelings of inadequacy and found herself balancing the needs of her ADHD son with those of her other children. Her husband, a medical doctor, did not accept the ADHD diagnosis, contributing to marital conflicts and eventual separation. Hanka faced challenges during her son's time in kindergarten, where teachers complained about his behaviour. However, she was satisfied with the supportive environment of the primary school, which understood ADHD and had a smaller class size. Living with an ADHD son taught Hanka humility and caution in judging others' behaviour without understanding the context. She experienced ambivalent feelings, recognizing her son's disorder while feeling anger at his behaviours. Through this journey, Hanka learned to accept her child's imperfections.

Frantiska lives with her husband and two sons. Frantiska talked about the fact that she, her husband and her sons have a diagnosis of ADHD. Her older son, in her words, was diagnosed with ADHD because he was very anxious when he was young and did not sleep much. Later, he added a lack of focus, conflict and inability to follow rules. She was shocked by the psychologist who misdiagnosed her son. The psychologist said her son was mentally retarded and suggested attending a special school. The diagnosis of ADHD was made rather late, according to Frantiska, but brought her some relief. She was glad that the cause of her son's symptoms had been found and that the diagnosis would be taken into account at school. She was pleased with how the medication improved her son's attention span and reduced his aggression. Raising her sons was very exhausting for Frantiska. The biggest support for Frantiska in raising her sons with ADHD was attending her therapy sessions. She was satisfied with the fact that she could talk about the topic of ADHD, learn self-reflection, and patience and find ways of adequate education. She also found it helpful to share her concerns and experiences with the mother of a boy who also had ADHD. Frantiska was also of the opinion that ADHD encourages creativity in children and the ability to engage in multiple activities at once. Children with ADHD, according to Frantiska, need to vent their accumulated energy through sufficient movement. Frantiska was worried about her son's future, especially how successful they would be as partners and friends.

Misa raises a son with ADHD and his brother who is autistic. She works from home. Misa perceives her son's marked hyperactivity and inattention from his early years. At the time of the interview, her son is still in preschool, and the parents are attending an educational-psychological counselling centre and logopedic therapy with him. They perceive their son as studious and observe problems more in fine motor activities such as drawing. Nevertheless, they are worried about the time when their son will go to school. They talk about how their son cannot stay with one toy for long and how they have to repeat everything to him all the time. She also refers to his impulsiveness and frequent tantrums. Her son jumps in her speech, does not give her privacy and gets angry if his parents cannot give him immediate attention for any reason. She admits that she does not always have patience with her son. The situation has affected Misa so much that she has decided to seek professional help and is currently taking antidepressants. She tries to find support and tips for raising her son on Facebook among parents who also have ADHD children, but does not feel that some of the techniques work. Misa admits that if she had known how challenging raising children would be, she would not have undergone artificial insemination.

Vit and his wife take care of an ADHD daughter and an autistic son. He finds raising an ADHD daughter all the more challenging because they decided to have children later in life. They can't rely on grandparents' help and often find themselves on their own for everything. Vit misses the peace, relaxation and time he could spend with his wife without children or with the hobbies he used to enjoy before children. He admits that the demands of raising their children are taking a toll on their relationship. He would be grateful for the existence of a locally available organization dedicated to the occasional care of ADHD children to give him more time to recharge his batteries for parenting and life. Vit describes the situation of raising an ADHD child as still holding up. However, he admits that now and then he blows up when it gets too much. He notes that he was worried about having children later in life because of the health risks, but eventually let his wife talk him into it. Today, he sees the situation in such a way that he is right in his opinion.

Michal mentioned that he probably has ADHD himself. To this day, he still has problems concentrating. Their household consists of his wife, two older identical twins and their younger brother. The older sons have been diagnosed with ADHD, developmental dysphasia and mild mental retardation, while the younger son has a learning disability in addition to ADHD. Looking after the children is stressful and exhausting for Michal. In the future, Michal would like to find out whether the retardation is a result of dysphasia or a result of ADHD. Therefore, he and his children will undergo further examinations in neurology and psychiatry. He also goes with the children to the special education centre, psychotherapy, logopedic therapy, phoniatry and other specialists. The children have been tried on medication for ADHD, but there have been intolerable side effects. Providing this care is mentally and physically demanding. Michal is therefore grateful that his sons have been granted a financial contribution for professional help. He is helped to cope with the whole family situation mainly by a psychotherapist, an internet blog, professional literature, a good relationship with his wife and walks in nature. Michal was mostly satisfied with the school system and professional care, dissatisfied only with the management of the kindergarten. One of the older sons has been attending a special school since the age of 8. Michal is happy that his son is simply enthusiastic about school activities, that he does his homework and has good grades. What worries Michal the most is the liveliness of his sons and their excessive trustfulness.

Peter has two sons with ADHD. Peter started noticing his children's strange behaviour soon after they were born. They slept little, cried and screamed a lot. Their poor sleeping patterns and frequent sickness were very exhausting for him. The doctors did not

give him much hope for a positive change regarding his sons and ADHD. Change was not happening yet. Nevertheless, Peter is still hopeful that his sons will be able to better correct their ADHD as adults. The demands of caring for sons with ADHD and the work overload have, in his words, led Peter to burnout syndrome. He had to seek professional help and take medication. A psychologist, medication, running and nature walks helped. Peter is sad and angry at his parents who could not cope with their grandchildren's ADHD or understand its nature. They consider their grandchildren rude and suggest physical punishment. He would also like more time together with his wife without the children present. To help them do this, a married couple who also have children with ADHD help each other with babysitting. The sons' ADHD has also negatively affected the family's financial situation. Peter is grateful to his employer for being sympathetic to his son's ADHD and allowing him to work from home.

Karla considered her preschool-age son a naturally wild child. Her only concern was that most of her son's activities took noticeably longer than they should. Later at kindergarten, the teachers pointed out the same problem and recommended that Karla go to the counseling center for a diagnosis. Karla learned of her son's diagnosis while working as a teaching assistant for a boy with ADHD. She was relieved to receive the ADHD diagnosis as she realized that the fault was not hers. She had previously worried that she was a bad mother and that her son was spoiled. She admits that restrictions and punishments do not work well on her son, something she realized before receiving the diagnosis. She thinks that ADHD children are not compatible with the Czech school system, which is based on memorization and long periods of sitting at a desk. Besides marked hyperactivity, among the symptoms of ADHD, she mentions a considerable difficulty in concentrating on anything for a long time, forgetfulness and a problem with regulating emotions. All this makes it difficult for him to function at school. Her son's diagnosis, in the context of her experience in the school system, made Karla reflect on whether she was doing what she wanted to do in life. She began to approach life more lightly and playfully. She manages her son's ADHD well. She finds it more difficult to manage her son's emotional fluctuations, but she is seeing significant improvement in this regard as well. She describes her son as very energetic, adding that it is often difficult to keep up with him. She praises his imagination, originality and affection. She tries to be a good partner for her son rather than an authority figure.

Emil has two sons. Soon after the birth of their first son, he and his wife began to notice the irregularity of his development. He refused to breastfeed and was very tearful. He was diagnosed with neurofibromatosis and by the time he started walking, he was diagnosed with ADHD. At age 13, the son received additional diagnoses: obsessive-compulsive

disorder, mental retardation and depression. The boy takes medication for all psychiatric disorders. Emil has been through many diagnostic and psychological facilities with his son. He has had both positive and negative experiences with these facilities. He is very exhausted from caring for his son. He describes life with an ADHD child as exhausting and challenging. He has to be constantly alert and responsive to his son's unpredictable behaviour. She doesn't even have the quiet time to read a book or drink tea. He finds rest in his work. Emil was saddened by the attitude of his close family and wider community towards his son's ADHD. They do not understand that a slap or a ban from television is more likely to make his symptoms and behaviour worse. Emil therefore worries about family celebrations, Christmas and visitors. Emil's son attends a school where he learns social skills and where his classmates are adapted to him. His son benefits greatly from social skills training. Unfortunately, even in such an enlightened school, he cannot avoid complaints from other parents. They complain that her son is angry with other children. Emil looks to the future with apprehension. Gradually his strength runs out, his son grows up and it is difficult to manage him fully. She is also worried about the development of her son's sexuality as he lacks social inhibitions. Another fear is that her son will be unemployable as an adult.

Melvys lives with her husband and daughter with ADHD. Raising her daughter is challenging for Melvys. In particular, she is exhausted by the constant repetition of instructions regarding routine tasks that her daughter neglects. Her daughter was officially diagnosed with ADHD before she started primary school. Melvys describes her daughter as distracted, inattentive, clumsy, playful, impulsive, energetic and above average intelligence. After her daughter's diagnosis, Melvys found many of the symptoms of ADHD in her childhood. The topic of school is crucial for her, as her daughter has difficulty both academically and fitting in because of the demands of a multi-year high school. Although her daughter prepares her materials for school, she always forgets something and needs to be constantly checked. At the same time, he forgets to write down important organizational information (homework, when the test is, etc.), which again adds to Melvys' workload. Melvys sees great hope for improvement in this regard if an assistant is assigned. He sees ADHD's benefits as curiosity and a wide range of activities. His daughter takes karate, practices parkour and plays drums. She also used to play the flute and go to floorball. Melvys tries to make sure that her daughter has a range of outlets and opportunities to fulfil herself. Above all, she would like for her daughter to be able to fit in better and make friends.

Luk**as** has two children, a son and a daughter. Both children have a diagnosis of ADHD, and the son has autism. The son was born with a congenital kidney defect. From

birth, he had poor immunity and the defect also affected the boy's development. It was because of his slowed development that they started visiting a neurologist. Lukas is concerned about the unavailability of specialist services and long waiting times. For the same reason, they put their son in a kindergarten at the age of three with special classes for combined defects. He expressed high gratitude to the special kindergarten, which made the professional help to some extent available. His son was prescribed medication for ADHD but suffered from nausea afterwards. At the same time, neither Lukas nor the teachers at school noticed any difference in his behaviour, so they decided to discontinue the ADHD medication for the time being. The marriage did not withstand the great burden that was arising from the children's health problems. Thus, extended family and a new partner are helping with parenting. His sister, who also has a child with developmental delays, helps him the most with the children. Lukas also has regular working hours, and he and his partner have coordinated their work so that someone can always be with the children. He often encounters views that his son is just spoilt or not normal, including from some family members. At the same time, he faces the problems of alternating children with his ex-wife, where the children have trouble re-learning the home-fixed routine. Thus, feelings of exhaustion, despair and helplessness often come to the forefront of Lukas's experience. Lukas would like more rest for himself.

3.1.3 Portraits of teachers of students with ADHD

David works as a physical education teacher at a primary school and also as a tennis coach. David graduated from the Faculty of Education, but he only learned how to work properly with ADHD children through practice. He can teach classes with ADHD children mainly due to his good lesson plan preparation. He addresses any inappropriate behaviour of ADHD children by setting clear rules. He tries to leave negative emotions aside and not let them affect his actions. David has found through experience that anger, raised voices and punishment are not appropriate for children with ADHD, on the contrary, the situation tends to escalate. David finds it frustrating that young children with ADHD are often cast in the role of the "class clown" by the class, disrupting the learning process. He considers a teaching assistant to be a good solution and a significant help. In David's opinion, the overall atmosphere at school is important. He and his colleagues discuss pedagogical difficulties with each other and can support each other. David has thus received understanding and good advice on several occasions about how to proceed when teaching pupils with ADHD. When

he coaches children with ADHD tennis, he prefers individual lessons. Although these charges are characterized by variable concentration, he appreciates their fearlessness and good fitness. However, they rarely make it to performance and elite tennis because they often change activities and clubs. Group training with a child with ADHD is very problematic for David. Usually the ADHD symptoms disrupt the training and other parents see these manifestations as misbehaviour.

Vendula works as a high school principal. She has many years of experience in teaching children with special educational needs. She finds this work challenging. She considers pedagogical work with these children to be very respectable but demanding. Vendula believes that the poor set-up of the current education system contributes to the difficulty of the work: a lot of so-called paperwork, excessive demands, little appreciation and low financial payment. She perceives that young teachers come into practice underprepared and that older colleagues often reject new knowledge and methods. According to Vendula, children with ADHD experience inner restlessness and tension. They are unfocused and hyperactive, which in turn manifests itself in strong gesticulations, shouting and sometimes sudden fatigue. Their expressions appear rude and boorish, but Vendula believes they cannot help themselves, unable to control their symptoms by will. She sees it as a challenge to find an adequate channel of communication to these pupils. They tend to be singled out and rejected by the class. Children with ADHD establish relationships in non-standard ways that the rest of the class may not understand. That is why Vendula recommends bonding prevention programmes or, in more complex cases, interventions by specialists from the pedagogical-psychological counselling centre. Vendula believes that teaching children with ADHD should be based on what can engage them. Teachers should be patient, accepting and supportive. They should have their creativity, improvisation and ability to motivate. Jitka recommends that children with ADHD should be assessed on effort rather than results. According to Vendula, sometimes an unbridgeable gap is dug between school and parents. Some teachers are under the impression that parents are dropping off their ADHD children at school for re-education. In some cases, parents hear nothing but whining and complaints from teachers. In these disagreements, there are no signs of constructive discussion and efforts to pass on information about what helps and works in the work and education of children with ADHD.

Johana has been working with children with ADHD for a long time as a teaching assistant and has a child with this diagnosis at home herself. She considers the most important thing in this work is to promote motivation for learning and acceptable behaviour

within the classroom. This primarily means eliminating behaviours that endanger themselves, others, or school property. She considers the beginning of cooperation to be the most difficult moment. She perceives that it is not easy to set rules for children with ADHD and get them to consistently perform their school duties. Johana talked about the fact that she does not only focus on satisfactory school results for children with ADHD. She tries to support their friendships, and ability to manage ADHD symptoms and crises. She considers the essence of school success for children with ADHD to be cultivating the following skills: the ability to select essential information, the ability to concentrate for longer periods, and the ability to work on themselves. According to Johana, it is important to talk openly about ADHD not only with the student and his parents but also with other children in the classroom. She also tries to involve the classroom team for the benefit of children with ADHD. Teaching children to understand each other and to be empathetic is essential. She has an established diary with the parents in which they communicate important information to each other about the child's progress and difficulties. She is willing to meet her parents in her free time.

Vera is an educator with many years of experience in working with children with ADHD. She has gained information about ADHD and similar diagnoses by studying at university, in seminars, in professional literature or on the internet. In her opinion, the diagnosis of ADHD was not well known before and children with ADHD were considered to be ill-mannered. Although Vera disagreed with this perception, she had witnessed situations where some parents tried to mask their child's misbehaviour with the diagnosis. She perceived inner tension and chaos in children with ADHD. As a result, they are often stylized by the class collective into the role of clowns. Yet she feels that they are well accepted by the collective. In the early days of her teaching work with these children, she felt helpless. She had no idea what to do with restless pupils. For example, the children jumped around the desks like animals. Setting clear rules helped. She also perceives good cooperation between parents, teachers and professionals as a working mechanism. Vera had both positive and negative experiences in cooperation with teaching assistants. Some of them helped her in her lessons, while others had to explain everything to her, which practically hindered the progress of the lesson. Teachers should be more accepting and praise the positive personality aspects of children with ADHD more. It is also effective to settle these children in places where they are disturbed as little as possible by unwanted external stimuli. Vera keeps a diary for each pupil with ADHD in which they write together what happened that day at school. The child then tells the parents about these events.

Petra is a tennis coach. She has many years of experience working with children with ADHD. Petra finds coaching children with ADHD challenging. Petra describes her relationship with children with ADHD as ambivalent. On one hand, she likes children with ADHD for their immediacy, physical talent and enthusiasm for play, on the other hand, she gets annoyed by their unexpected acts of aggression and sass towards others. Petra would describe children with ADHD as full of energy, enthusiasm, drive and constantly on the move. On the other hand, she perceives that these children have problems with respecting rules and with discipline. It has been her experience that some children are aware of which rules they should not break, but cannot resist their inner impulses. Petra perceives that in conflicts children with ADHD blame others, can elevate themselves above other children and thus spoil the training mood and cooperation. Petra has noticed that they do not like to lose and quickly lose focus. Petra thinks that sometimes these children deliberately abuse their diagnosis and try to gain advantages. Petra prefers to work with children with ADHD more in individual sessions. She would advise the coaches to resolve any conflicts with the children immediately, as well as conflicts with the children's parents. She would also recommend that coaches get plenty of rest and have a supportive and understanding coaching team around them.

Karel is an educator and also a caregiver in a child's home. He considers the children from the orphanage as his second family. He finds working with children with ADHD challenging but is happy when he manages to make small progress with them. Children with ADHD, in his opinion, suffer from inner restlessness, inattention and the urge to move. They have reduced self-control and emotional regulation. At school, he sees that after a short time, they cannot sit still, are distracted and play with their mobile phones. Karel considers this behaviour to be poorly developed self-control and emotional regulation. He believes this is the cause of verbal and physical aggression towards classmates and teachers in some cases. Karel's approach to children with ADHD is about patience, consistency and clearly defined rules. Furthermore, a stable order and regimen of the day. He observed that engaging in manual activities helps children with ADHD to concentrate better in school. So, for example, he scrapes potatoes or cleans up with them when they are learning for school. Learning with them also takes the form of play. He incorporates school material into board games or building Lego, for example. An accepting relationship with the child, empathy and communication without strong emotions are important. Karel gets information about ADHD on the internet, in specialist literature, and at seminars and training courses. His experience with medication for ADHD is rather negative. He felt that medication stifles children too

much. He also considers the cooperation between teachers, mental health professionals, schools and families as a prerequisite for successful work with children with ADHD.

Marketa is a nurse and special education teacher. She enjoys working with children. In her opinion, a teacher should be strict, kind, perceptive, accepting and if possible, always well prepared for teaching. She also finds pedagogical work with children with ADHD challenging, especially because of the high number of pupils in the class. She would recommend that every classroom should have a teaching assistant. Adequate relational boundaries and clear rules need to be set specifically towards children with ADHD. Any conflicts and misunderstandings, she said, must be dealt with immediately and on the spot. When communicating with children with ADHD, she tries to emphasize their positives. She doesn't push them too hard into activities they don't like. She recommends that every school should have a well-coordinated and communicating teaching team and counselling centre. The counselling team, consisting of a school psychologist, a special educator and a prevention worker, meets once a month at Marketa's school to address the school needs of specific pupils. She considers cooperation between the school and the family to be one of the most important factors for working with children with special educational needs. Marketa considers her studies at the university as sufficiently covering theoretical information and practical experience regarding pupils with special educational needs. She gets further knowledge from the Internet, seminars and training courses. When she is not sure about something, she consults the pedagogical-psychological counselling service. She would tell parents to respect the authority of the teacher and to try to cooperate with the school. For children with ADHD, she recommends more extracurricular activities so that children can express themselves in a different light than at school.

Matej is a caregiver in a child's home. He has a degree in Special Education and Ethopedics and is a former member of the Philharmonic Orchestra. He is finishing his PhD on "The influence of musical activities on the development of social-educational competencies of schoolchildren". He enjoys working with children with ADHD. He uses the valuable experience from this work in his academic career. He believed that the public and professionals do not have enough information about ADHD. Pedagogues often perceive children with ADHD as bad. Children with ADHD are restless in class, disrupt lessons, cannot concentrate, and have difficulty controlling aggressive impulses. He believes that few teachers can see that their different behaviour is due to ADHD and a disrupted family environment. However, Matej gives teachers credit for the fact that in some cases, the diagnosis of ADHD is indeed misused by parents to excuse their child's behaviour and to get

school breaks for their child. In schools, Matej says, children don't have it easy. They are stigmatised by being in an orphanage and by the manifestations of ADHD. Children with ADHD need the support of a trained team where there is good communication between the school, parents and caregivers from the children's home. In terms of medication for ADHD, Matej has had rather negative experiences. The children were, in his words, more sleepy, apathetic or fat after medication and their livers were damaged. In the orphanage, they benefit from a mature caregiver who has aligned moral values. From such an educator the children learn by imitation. For everything to work properly, a firm clear order and clear rules need to be defined.

Ales is a teacher and school psychologist. He has worked as a teacher in a private special school, as well as in primary, secondary and university. In the role of a school psychologist, he is better positioned than teachers to work with children with ADHD. The advantage is the space for individual meetings and more direct communication with teachers and parents. Ales has got information about ADHD from literature, the internet and his practice. The Faculty of Education provided him with almost no theoretical or practical education about ADHD. In the teacher education system, he would mainly introduce practice so that teachers would have direct experience with children with ADHD. From his own experience, he does not recommend using hard disciplinary methods on children with ADHD. In retrospect, he considers his first attempts to work with children with ADHD as unfortunate. He tried to discipline and calm the children, which had a rather negative effect. The frontal way of teaching did not suit him either. After he started teaching in an alternative way, the situation improved a lot. He was able to harness the energy of restless and disruptive students to the benefit of the learning process. He also believes that it is possible to set up and create an environment that is suitable for any student. Especially when group work is used, activities are rotated and children are allowed to play. He sees a supportive and accepting relationship with teachers as essential to the school success of children with ADHD. In schools, he would like to see improved relationships and collaboration between educators, increased awareness of ADHD, and the development of educators' ability to establish supportive and accepting relationships with students with ADHD.

Alena started as a primary school teacher right after her studies. She teaches mainly chemistry and physics at a lower secondary school. During her studies, she gained a lot of information about teaching students with special educational needs, but she admits that after her first experiences with children with ADHD, she felt completely unprepared and incompetent. Alena felt helpless with children with ADHD and made great demands on her

attention. She perceived students with ADHD as unmanageable and sometimes found it difficult to differentiate between manifestations of ADHD and attempts to break rules and push boundaries. Alena welcomed the assignment of a teacher assistant for the boy with ADHD to help him with writing down the material and doing his homework. The assistant was also supportive and helpful in resolving conflicts with classmates. Alena sees the functioning team as a great support for children with ADHD. She believes that the teacher plays an important role in explaining ADHD and its manifestations to a child's classmates. Alena tried to work with students with ADHD using an individual approach and good communication with their parents. However, she faced the reluctance of some parents to cooperate and felt they were putting the demands of re-educating their children on her. She recommends that beginning teachers should not be intimidated and see ADHD not only as a disorder but also for the positives it brings. She enjoys working with students with ADHD for their creativity and enthusiasm for new things.

Jana has been working as a teacher for 10 years. Jana perceived a big difference in the approach of the management of each school to these students. Her first experience in primary school was that the diagnosis of ADHD was seen by colleagues and school management as an excuse for parents and their misbehaving children. She thinks that the traditional school system is not well set up towards students with ADHD, especially when it comes to the long periods of sitting at desks, which is very difficult for restless children to endure. This makes these children more likely to shout and disrupt lessons. Other children therefore exclude them from the group and look down on children with ADHD as naughty and spoiling the class atmosphere. Children with ADHD build relationships in a non-standard way and therefore Jana included various bonding games in the classroom. She missed that the school did not take advantage of the bonding prevention programs. It was also challenging for Jana to coordinate her approach and rules with other colleagues. Older colleagues often rejected new knowledge and methods. Jana, on the other hand, prefers alternative ways of teaching and tries to fully involve all students. For example, she uses outings outside the classroom, visits to museums and an interactive teaching style. She used to be more exhausted from teaching, but when she learned to harness the pupils' energy into the lesson and not have to fight with them all the time, Jana and, in her opinion, the students themselves were relieved.

Richard is a primary school teacher. He considers his work as a teacher as his mission. He believes that successful education of children with ADHD requires patience, creativity and the ability to see the world through their eyes. Richard criticizes the current

education system for its rigidity and lack of support for children with special needs. He says the system over-emphasises standardised tests and neglects individual attention. He describes children with ADHD as highly intelligent but quickly distracted and struggling to maintain attention and consequent rapid fatigue. He notes that traditional teaching methods often fail and favour a play-based approach and hands-on activities. Richard highlights the importance of working with a school psychologist, who can provide more individual attention to children with ADHD. He believes that the performance of children with ADHD is influenced not only by the school's facilities and the teachers' approach but also by the supportive environment of the parents, who can teach the children how to deal with the manifestations of ADHD. Although he faces challenges from his students and tends to be very tired at the end of the week, he believes his work is meaningful and important. Richard remains optimistic and believes that every child can achieve success that is not just reflected in grades. His goal is to create a climate where children with ADHD feel safe and are motivated to learn and discover, not just memorize.

Josef believes in an individual and respectful approach to children with ADHD. He tries to understand their unique needs and help them develop their abilities and skills. His approach to work is based on encouraging positive behaviour and building a trusting relationship with each child. He considers a mutually respectful relationship to be the key. Josef works to adopt a partnership approach and not treat children with ADHD from a position of authority. He tries to see both the devil and angel sides of children with ADHD. Josef also tries to raise awareness about ADHD and fight the stigma of children with the disorder. He is also involved in an academic career and contributes to scientific research in the field of education and special education. Josef likes the cooperation with the Pedagogical-Psychological Counselling Centre, which often gives him good suggestions in adjusting the requirements for his students. He recalls the time when he started as a young enthusiastic teacher and had excessive expectations of his students. Josef considers it important to approach each child individually. An approach and technique that worked in communicating with one student with ADHD did not work for another student. Josef is pleased with the positive feedback from parents of children with ADHD. He is considered an inspirational teacher who can create change in children's lives not only in education but also in social skills.

Jitka worked with children with ADHD as a teaching assistant and later as a music teacher. Jitka aims not only to achieve good academic results for ADHD students but also to support their friendships and their ability to manage ADHD symptoms and crises on their

own. Jitka tries to be supportive of students with ADHD while providing them with the structure and safety they need. Her approach is based on empathy and understanding, although she keeps clear boundaries in her relationship with the children. In her teaching, she seeks to develop the ability of students with ADHD to select essential information, concentrate for longer periods and break down work into smaller chunks. She has often struggled with the reluctance of children with ADHD to take on longer and more challenging tasks. Jitka uses a variety of techniques appropriate for children with ADHD, such as traffic lights, smiley faces, and feeling diagrams. She collaborates with parents by using a diary to exchange important information about the child's progress and difficulties. She communicates with parents outside of work hours when needed. Parents sometimes write a warning message to Jitka if the child leaves for school in a bad mood.

Marta meets with students with ADHD as part of her social studies class. Every day, she says, brings new challenges, but also new opportunities. Knowledge is not the main goal of her teaching, but a way to discover and fulfil each child's potential. Marta sees an advantage over her colleagues in the subject she teaches, which gives her enough freedom to accommodate students with ADHD. These students excel in her subject, are very intelligent and imaginative, and often surprise her with an interesting insight or idea. At the same time, she sees in students with ADHD a great sense of justice and truth, which they can argue and fight hard for. She remembers a situation where her ADHD student disagreed with a classmate's opinion and the dispute finally ended in a fight. In those moments, she feels weak as a woman and gets scared of students with ADHD. Marta believes that teaching children with ADHD should be based on what can engage them. In Marta's opinion, teachers should show their creativity in their teaching, be able to improvise and find ways to motivate students and awaken their curiosity. Marta recommends that children with ADHD should be assessed primarily on effort. If children with ADHD are restless, a teacher can incorporate physical activity, according to Marta.

3.2 Results of thematic analysis of lived experiences of students with ADHD, parents of students with ADHD, teachers of students with ADHD with factors supporting school inclusion and functioning of students with ADHD

3.2.1 The lived experience of children with ADHD with factors supporting school inclusion and functioning of students with ADHD

3.2.1.1 Parents

Most of the participants children with ADHD appreciated how the parents tried to respond promptly, consistently, and correctly to the difficulties related to ADHD and taught them how to manage ADHD in school. Only a few participants children with ADHD reported that their parents did not teach them how to manage ADHD at school. Based on this experience, these participants children with ADHD nevertheless attempted to define what parental approaches regarding the school would be supportive for them. We identified six recommendations for parents of ADHD students in the participants children with ADHD' reports.

First, participants children with ADHD suggested that parents should inform their ADHD children about ADHD determinants and how ADHD manifestations can be managed in school preparation and with schoolwork. In this sense, some participants children with ADHD reported that they would like their parents to have taught them to summarise and plan the school day. Second, parents were expected to teach children with ADHD to follow a regular daily routine, so that children with ADHD do not get tired at school. Third, parents should know and develop the talents and strengths of an ADHD child and find hobbies, schools or teachers who can work with this positive potential. In this sense, one participant child with ADHD enthusiastically reported how the transition to a school that was in line with his personality, talents and needs benefited him greatly: "*The high school was awful, still memorising and sitting in one place, and the teachers weren't interested in me and I didn't get along with my classmates at all. In my second year, we agreed that I would leave the high school. I went to an art school, where I learn acting, dancing and singing. Here the teachers are interested in me; they have an individual approach to me and a closer relationship with me, and I enjoy those subjects; I direct all the accumulated energy into those subjects.*" Fourth, parents should be prepared for the possibility that their ADHD child will have difficulties with managing school duties. In such a case, parents should rather appreciate the child's efforts and not put excessive pressure on the child's school performance. Fifth, parents may involve other family members in the school preparation of an ADHD child. Sixth, some participants children with ADHD reported that if parents have a consistent approach to their ADHD child and if there is a secure atmosphere in the family,

then the ADHD student's sense of inner security increases, which contributes to better managing with the school demands.

3.2.1.2 Extracurricular and school friendships

Some participants children with ADHD reported that establishing secure friendships with peers who did not attend the same school was an important factor for the experience of inclusion in the classroom. Extracurricular friendships were formed, e.g., in group psychotherapies, low-threshold facilities for children, hobby groups or in playing online computer games. Thanks to these friendships, the participants children with ADHD gained the feeling that they were not alone with their problems and that they were able to make friends at school: "*In that low-threshold facility, I met children who had the same problems as me, and I found that I was not alone in it. We became friends and I suddenly felt that the great wall between me and the world no longer existed, that I have a place in the world. Thanks to these groups, I gradually managed to make friends even in class at school.*"

Some participants children with ADHD also reported that they made friendships first in the classroom, and their classmates didn't know about their ADHD. These friendships were based on sharing similar interests or style of dressing, but also mutual assistance in managing school demands. Furthermore, a few participants children with ADHD reported that they explained the determinants and manifestations of ADHD to their classmates. These explanations of ADHD, however, had ambivalent effects on class relationships to them. Some classmates became friendlier, while others began to avoid them: "*When I explained to my classmates what ADHD is and how it affects my behaviour, some understood it and became my friends, but some began to avoid me. But that's their problem, what they think of me. Let them do what they want.*" Some participants children with ADHD reported that they did not mind the fact that some of their classmates began to avoid them, but there was bitterness and anger in the tone of their voices.

Some participants children with ADHD reported a link between the characteristics of a teacher and their school results. Warmth and a kind approach of teachers motivated ADHD students to a higher engagement in school tasks. These teachers were empathetic and had an understanding of the specific difficulties related to ADHD students; they were able to perceive the positive qualities of those students despite the disruptive manifestations of ADHD: *"She was very kind and warm. She could also be very loud, firm and consistent. She does not perceive me as a problem; she sees my good sides. When she taught me last year, I had no problem with that subject."*

3.2.1.3 ADHD students' recommendations for teachers

Some participants children with ADHD reported many suggestions about how teachers can support the educational process in the classroom. They would like the teacher to point out the essential parts of a lecture to which they should pay an increased attention and the less important parts of the lecture where they may not be so attentive: "*All I can do is to listen to the part of the lesson that is essential. I pay attention to this essential part, because I can't keep my attention on the whole lecture. I write down a substantial part of the lecture in a notebook and then learn from it for the test.*"

Participants also recommended that teachers should alternate theoretical parts of lectures with teaching through games, examples and interesting curiosities from practice. The lecture should not be given in a monotonous voice and by literally reading the text of the textbook.

Another group of participants children with ADHD' recommendations for teachers was as follows: adequate study requirements, an individual approach to students with ADHD, checking whether the student had written down all the essential information, and checking the correct understanding of the test or curriculum.

Teachers should also be interested in the hobbies of ADHD students in order to be more engaged in teaching and to develop ADHD students' self-esteem and self-confidence. A few participants children with ADHD reported that if the interests and hobbies of ADHD students are included in the teaching, these students are able to work intently without any disruptive manifestations of ADHD: *"My classmate also has ADHD. In class, for example, he gets up and starts yelling, playing music and the teacher reprimands him. He is interested in fish; all his life is about fish. He loves fish very much. When we have biology, he likes biology. In biology, he is calm, he is careful, he speaks in a calm voice, he does not run at all, he writes down, he is completely calm.*"

3.2.1.4 ADHD students' ways of manage the manifestations of ADHD at school

A very few participants children with ADHD reported that they found ways to partially manage ADHD manifestations in the school environment thanks to the application of theoretical knowledge of ADHD: "*Gradually, I learned that when I have some misunderstanding with my classmates and I feel the accumulated anger and aggression, then I prefer to leave and avoid these classmates for a while and wait until it fades from me.'*
Some other participants children with ADHD emphasised that they learned to ask teachers

to let them run down the hall, lie on a blanket or squeeze a rubber ball when they were tired, losing attention or overwhelmed by tension. One participant child with ADHD reported on how he could manage the physical manifestations of ADHD so as not to negatively affect his school performance: '*When I'm tested, the tension usually increases so that my legs start to shake a lot and then I can't even stand at the blackboard. I found that if I pressed my heel hard to the ground, the shaking would stop a little, and the others wouldn't see him anyway."*

3.2.2 The lived experience of parents of children with ADHD with factors supporting school inclusion and functioning of students with ADHD

This chapter is divided into three main parts. The first part provides examples of stories that parents have experienced with their ADHD children. The second part focuses on the adaptive coping strategies of parents of children with ADHD, which those parents considered to be a factor that indirectly and directly supported school functioning and inclusion of students with ADHD. The second part also suggests maladaptive coping strategies of parents of students with ADHD that do not support school functioning and inclusion of students with ADHD. The third section provides a description of other factors that parents of children with ADHD reported as supporting school inclusion and functioning of students with ADHD.

3.2.2.1 Tragicomic experiences of parents of children with ADHD with children with ADHD

Many participants parents of children with ADHD narrated short stories about their children with ADHD, which evoked horror, astonishment, anxiety, but also amusement among the participants and researchers. According to the participants, these and other similar experience was significantly associated with parent coping strategies.

The first story describes the behaviour of an ADHD boy on a playground: *"So, the children were playing there and my two-year-old boy ran after them to be like a dinosaur and started biting them and pulling them to the ground. I was horrified, there was panic, and the five-year-old, six-year-old boys and girls had horror in their eyes, screaming and trying to run away from my little boy. The teachers shouted at me to catch my uncontrollable child. I didn't understand why I should catch him. That's how all children behave, isn't it? It was my first child. I had no comparison and did not know that these were the symptoms of the disorder."*

In other participants parents of children with ADHDs' stories, an ADHD boy

strangled a teacher at a school for a moment because she did not allow him to play mobile games with his classmates. Another boy made dryers, ovens and crematoriums made of cardboard paper, in which he imaginarily dried or baked his enemies: *"He pulled large cartons of paper from the trash can and made a two-meter dryer with all the details and he is currently drying his enemies."* Another boy liked screws and disassembled furniture, whether he was at home or in the waiting room at the psychologist. This furniture then posed a risk of harm to people, as it could have fallen apart. Another case was represented by twins, who wrapped the decorated Christmas tree back into a box, skilfully opened some locked cupboards and scattered washing powder all over the apartment. The mother of the twins remarked with a smile that, thanks to the washing powder, they had a fragrant Christmas. Another boy tested whether the tablecloth on the table was made of flammable substances: *"It just went through his head. Is it flammable? He took a lighter and tried it."*

Other experiences of parents with students with ADHD were called the following: "*Stories of the League of Justice and Public Order*". Also, this second type of stories had an influence on the formation of parent coping strategies. The heroes in these stories were again different boys. For example, a boy with ADHD who, instead of waiting in line at the cash register, gathered and sorted all the empty shopping baskets in the supermarket to the pickup point. Another boy defended himself and his classmates in the event of any slight injustice, and another boy repeatedly greeted construction workers until they also greeted him: *"He never ceases to amaze me. He walked past the construction workers and greeted them, and they did nothing. So he greeted them again and again until he received a greeting back."* Another boy took considerate care of his mother when she was ill and another boy fearlessly went to ask the pastor the reasons for closing the church.

3.2.2.2 Coping strategies of parents of ADHD children

Participants parents of children with ADHD reported that they responded to their ADHD children's behaviour with various adaptive coping strategies that indirectly and directly supported their ADHD children's school functioning and inclusion. We identified in the data nine types of adaptive coping strategies: problem-focused strategy, testing alternative solutions, the authoritative approach of upbringing, searching for professional help, emotional regulation, rest, cognitive restructuring, gaining knowledge of ADHD, and a sense of humour. In contrast to this, we also identified nine maladaptive strategies.

The first adaptive strategy was problem-focused. Many of the participants parents of children with ADHD could put aside their own feelings of guilt and the need to blame their

children with ADHD, and began to look for causes and solutions: *"I realized I couldn't blame myself for that, and I couldn't blame him either. Then you can start looking for things that will help you and him."* The opposite of this adaptive strategy was to ignore the focus on solving the problem. Participants parents of children with ADHD remained stuck in criticising and accusing the child. This approach intensified the negative emotions of children and parents: "*There is no point in telling him again and again what he did wrong. I kept analysing it in detail and blaming him, criticize him. He and I were getting more and more aggressive, upset and sad, it didn't lead anywhere."*

The second adaptive coping strategy was based on overview and testing alternative solutions. Participants parents of children with ADHD usually used this coping strategy only after long-term experience with children with ADHD, when the original strategy was proven to be non-functional: *"Over time, we have learned to be alternative in some things. For example, we had a swimming pool in the living room at one time. The boys had a phobia of the bathtub and did not want to bathe in it, but they liked the pool. We learned to deal with some things differently."* The non-adaptive counterpart of this strategy was to repeatedly use only one dysfunctional way of raising a child with ADHD: "*It is not good to strictly follow certain general recommendations on how to raise children with ADHD because every child is unique and clinging to certain general rules just didn't work for us."*

The third adaptive coping strategy was based on the authoritative approach of the parents. Participants parents of children with ADHD reported on setting up and adhering to a system and order in the upbringing of the ADHD children: *"The son always had fixed rules, very hard, because if he didn't have them, he was uncontrollable. Now the rules give us many benefits."* The effectiveness of this coping strategy was verified by participants parents of children with ADHD comparing the effect of non-authoritative upbringing: "*It's not good to be completely benevolent. By that I mean go to sleep when you want, eat when you want, etc. The child can't guard any order. He is then much more tired, unpleasant, aggressive."*

The fourth adaptive coping strategy was to search for professional help. The long state of emotional and physical exhaustion led parents to use this coping strategy. Another factor was the experience that using professional services improves their health. Then they could better manage their children with ADHD: *"I fought with complete emotional and physical exhaustion. I was at the end of my strength. I didn't even have the strength to ask for help. It took me a long time to get out of it, and it was with the help of psychotherapy and medication. The therapy helps me to reach a level where I can live and function. Without*

outside help, we could not do that." Another type of this strategy was to seek the professional help for children with ADHD. This strategy was recommended to some parents by teachers or other professionals. Participants parents of children with ADHD tried to find schools where teachers understood ADHD and could work with it, as well as where were tolerant and accepting classmates. Participants also tried to find psychologists, therapists, and teaching assistants for their children. The opposite of this adaptive strategy was the opinion of the participants that they have to manage everything only by their own forces: "*I thought I had to be a good parent, so I had to be responsible and always handle the situation by myself. But you are not a robot and a mistake always happens. And then I was full of the remorse."*

The fifth coping strategy was based on emotional regulation. Some participants parents of children with ADHD were gradually better able to reflect and understand their own emotions and emotions of their children: *"When we start arguing with our son, he explodes with anger and we start fighting, we'd better take a break. I tell him I know it annoys him and we let it be. At that moment we still can't find a solution because we're both angry and we can't think normally, we'll wait for it to pass and then try to solve it again."* At the beginning of the use of this strategy was the parental understanding of the maladaptive strategy of stirring and reacting from negative emotions. This led to a mutual verbal injury, but not a constructive solution to the situation. Another adaptive coping strategy based on emotional regulation includes parents rejoicing in small successes and nice things: "*Raising a child with ADHD is very demanding and exhausting. You have to learn to enjoy the little things, such as the sun, which shines nicely outside.*"

The sixth adaptive coping strategy was a rest break. Participants parents of children with ADHD began using this strategy when they found they had no strength left to cope with children with ADHD without including rest (maladaptive strategy). As part of this strategy, they have learned to simplify the operation of the household: *"It's good to relax when I can. I should take this advice to heart and apply it more, but it's hard. There are still certain responsibilities, cleaning, cooking, etc. I'm tired, but I tell myself that I just have to take a break. So, I buy a large supply of pizza, put it in the freezer and the food is taken care of. So I can give myself free time for myself and rest."*

The seventh adaptive coping strategy was based on cognitive restructuring. Many participants parents of children with ADHD reframed ADHD from a negative to a positive meaning: *"Maybe children with ADHD are a new type of human development. Unlike us, they are not afraid to say what they think and they can force others to meet their needs."* In

the case of this reframing, some participants parents of children with ADHD could get inspired in some aspects by children with ADHD. Like their children with ADHD, these parents would like to learn how to meet their needs, enforce their views, defend justice, spontaneously express emotions verbally and non-verbally, and try new unconventional possibilities. It is also possible to include in cognitive restructuring the finding of parents that certain behaviour of their children with ADHD would never change, distinguishing important things and situations from insignificant ones, not judging the behaviour of others at first sight and believing that human nature is good. However, most participants parents of children with ADHD reported that positive reframing usually occurred only after a prolonged experience with ADHD children. From the beginning, ADHD was rather denied: *"I thought every parent was probably experiencing similar events, I thought it was definitely normal, or that he would grow out of it. In addition, it was my first child, so I had no comparison with other behaviours."* The maladaptive opposite of the cognitive re-framing strategy was a repeatedly and long-term focus only on the negatives of a child with ADHD: "*The dangerous strategy is to get stuck in thinking only about the negative and forget about good things. Then we were all in convulsions, there was an unpleasant atmosphere at home. And then the child reacts even more negatively. It's a vicious circle."*

The eighth adaptive coping strategy was based on education and understanding the symptoms of ADHD: *"I looked for information about ADHD on the Internet and in psychology literature. I also got advice from psychologists."* The opposite of this adaptive strategy was to ignore the indications that the child was behaving in a non-standard manner: *"I thought that every child probably behaves like this, so why go for a psychological examination? I had no comparison, it was our first child."*

The ninth adaptive coping strategy was a sense of humour: *"It is necessary to take it with foresight and humour. It will help you handle even difficult situations."* In addition, a sense of humour emanated from many participants parents of children with ADHD as they told the stories they had with children with ADHD. The opposite of this adaptive strategy was taking situations too seriously and drowning in negative emotions: *"I also went through a period of doing things that just didn't work. For example, the son had a terrible mess in the room, dice scattered everywhere. So I stood there trying to teach him to clean. Take the dice and put them in the box. Nothing happened. So I showed it to him. Nothing happened. So I slapped him and gradually raised my voice. Nothing happened. He resisted me for twenty minutes and didn't clean the box anyway. Negative motivation, yelling and beating do not work for these children."*

3.2.2.3 Other factors supporting school inclusion and functioning of students with ADHD from parents' perspectives

3.2.2.3.1 Teacher's personality and awareness of ADHD disorder

Most of the participants parents of children with ADHD highlighted the associations between the personality of a teacher and the school results of the students with ADHD. Openness and a kind approach were perceived to motivate ADHD students to a higher engagement in school tasks, even though they dislike them. These types of teachers motivated ADHD students to work even on hated tasks in an effort 'to make their favourite teacher happy: "*He hates writing. A pencil is the biggest enemy. But he writes the whole spelling exercise because he likes his teacher. He works it out for him.*"

According to the participants parents of children with ADHD, the accepting attitudes and behaviours of the teachers stemmed from the nature of their personality, but there was also another related supporting factor: the teacher's awareness and knowledge of the ADHD disorder. Teachers who were well-informed about the symptoms and behaviours related to ADHD were also more prone to accept the specific behavioural expressions of ADHD students. Moreover, well-informed teachers could also distinguish the positive personality traits of students with ADHD as expressed by one participant. According to participants parents of children with ADHD, a good teacher should be generally able to recognise the symptoms of ADHD, and this should enable him/her not to be influenced by their negative emotions so much in communication with the ADHD students.

Some participants parents of children with ADHD also reported that teachers should perceive the success of a student with ADHD as their own success. This means that the teachers should consider the quality of the school's success with a student with ADHD to be part of his or her professional identity. The teacher's spontaneous interest in the student is also important. *"It is good if the teacher perceives the success of a student with ADHD as part of the result of his/her work. He/she's just interested in those kids."*

3.2.2.3.2 Parents' recommendations to teachers on how to meet the special educational needs of students with ADHD

Some participants parents of children with ADHD expressed many suggestions about how a teacher can support students with ADHD. For example, it was suggested that a student with

ADHD should work at his or her own pace and manner. It is also important that he/she does not always have to complete all the tasks and should be provided with the opportunity to work away from the school desk. "*It was very interesting that she was lying on the carpet, reading a children's book. But when I asked her something I was talking about, she knew everything and could answer correctly.*"

Another group of recommendations was related to the methods of school evaluations. The parents suggested the use of helping aids, instructions for correcting mistakes, motivating games and rewards. They also highlighted the importance of appreciating the effort, not only the use grades for evaluations. An individual approach to each student with ADHD was suggested as a way of improving school success.

Another issue was how to check the schoolwork of an ADHD student during the course of classes. The participants parents of children with ADHD suggested the teachers should check whether the student has written down all the essential information. It is useful to check the key information from the subject matter in the workbook, but also a list of homework tasks needed for the next day in the student's notebook.

It was also suggested that teachers prevent bullying. According to several participants parents of children with ADHD, teachers promoted healthy relationships in the classroom when they explained to the other students the needs of ADHD students and how they could help them. Moreover, the teachers were recommended not to resolve a conflict with a student with ADHD face-to-face in front of other students in the classroom, but separately outside the classroom.

Furthermore, the participants parents of children with ADHD suggested using the energy and activity of the student with ADHD in meaningful ways, for example, highlighting positive personal qualities of these students in front of their classmates: "*The teacher should use the positive qualities of ADHD children, such as their liveliness and acting talent, to make this child popular with the classmates.*"

3.2.2.3.3 The influence of classmates in meeting the special needs of students with ADHD

A minority of the participants parents of children with ADHD reported that classmates can be of great help with an ADHD student in coping with school demands. Some friends really motivated the ADHD student to go to school and try to proceed to the next years of study. The primary motivation was the friendly relationships that the student with ADHD wanted to maintain.

The participants parents of children with ADHD also reported that some classmates recognised when the symptoms complicated an ADHD student's mastering of school situations. In such cases, they could stop the ADHD students and guide them towards the right behaviour or call for help from a teacher.

3.2.2.3.4 Special aids and school equipment

Some participants parents of children with ADHD reported a variety of ideas for school equipment that would help ADHD students. They suggested special tables for easy writing, alternative school curricula with plenty of physical activities, a supervised separated room where an overloaded student could go to relax, special relaxation zones in the classroom, no more than 15 students in one class and more training of teachers working with ADHD students. *"It would be great if there was a separate room where an ADHD student could go in case of accumulated tension. There would be the supervision of a psychologist, teacher, or assistant. There, the student could have a chat, some physical activity or relax."*

3.2.2.3.5 Cooperation between parents and teachers

Most of the participants parents of children with ADHD reflected that cooperation between parents and teachers was essential for the effective functioning of an ADHD student at school. On the one hand, it was reported that it is very useful when a teacher wrote to the parents how the student behaved at school, what the student learned and what textbooks, exercise books, and other school supplies would be needed for the next school day. On the other hand, the participants parents of children with ADHD also stressed that they are aware of the increased demand on the teachers' job when he or she has a student with ADHD in the classroom.

At the same time, participants parents of children with ADHD also mentioned that it is beneficial if a parent informs the teacher about the current mood and health status of a student with ADHD and a mutual transfer of information about proven methods of upbringing and learning: "*I inform the teacher that my son is coming to school in a bad mood, that he slept badly and would not be able to concentrate very well. The teacher is thus prepared for what is to come and can choose the appropriate approach. After school, the teacher tells me how my son did at school, what needs to be learned and brought to school the next day"*

3.2.2.3.6 The support of psychiatrists, psychologists, and therapists

In most cases, having a wider team of professionals involved in helping ADHD students was positively perceived. This team should best include school management, psychiatrists, psychologists, teachers, teaching assistants, therapists, social workers and pastors: "*I would like a psychiatrist, a psychologist, and a therapist to work together. Because then the psychiatrist judges only from ten minutes, when he sees my son and he lacks a broader context of my son's behaviour and the manifestations of ADHD.*"

The participants parents of children with ADHD evaluated very positively when the school management organised case conferences. The purpose of these conferences was to find ways for teachers and their students with ADHD to better manage the symptoms of ADHD. There was also an effort to fine-tune the individual education plan for the student with ADHD: *"A case conference was held to find out how to better manage my son's symptoms with ADHD at school and how to set up his individual educational plan.*"

Some participants parents of children with ADHD reported how psychiatrists tried to fine-tune drug combinations in a way that reduced the degree of impulsivity for students with ADHD and allowed them to concentrate better at school. This effort was successful in some cases, although it was usually a longer process in which the students occasionally experienced adverse side effects.

3.2.3 The lived experience of teachers of students with ADHD with factors supporting school inclusion and functioning of students with ADHD

This chapter is divided into two main parts. The first part focuses on the quality of the relationship teacher-student with ADHD, which teachers considered to be an important factor in supporting school inclusion and functioning for students with ADHD. The second part focuses on other main factors that teachers considered to support school inclusion and functioning of students with ADHD.

3.2.3.1 Quality of the relationship teacher-student with ADHD

Our findings suggest a strong ambivalent teachers' bond with students with ADHD, filled with negative and positive emotions influencing the quality of the teacher-student with ADHD relationship and so influencing the well-being of the teachers and the students with ADHD. These emotions were associated with the teachers' experiences with ADHD

students, beliefs about the causes of the ADHD students' behaviour, and other attitudes and practical approaches of teachers.

3.2.3.1.1 Strong ambivalent bond with students with ADHD

Most participants teachers of children with ADHD reported ambivalent emotions in relation to students with ADHD, but also about a strong emotional bond. One participant described these strong and ambivalent emotions in his relationship to a student with ADHD as follows: *"He is an amazing boy, I sometimes love him very much and I know he loves me too, but when it comes to him, he is unbearable and endangers other children. Our relationship is neither positive nor negative, but it is definitely stronger."*

3.2.3.1.2 Negative emotions in a relationship with a student with ADHD

In some cases, problems with students with ADHD accumulated so much that negative emotions prevailed and the participants teachers of children with ADHD began to have negative expectations about the students with ADHD. The participants teachers of children with ADHD may have started to experience the relationship with the students with ADHD negatively because their belief that the behaviour of the student with ADHD must gradually improve was not fulfilled: *If there are a lot of problems with a child with ADHD and they are all getting worse, then the feelings are only negative. If it doesn't improve, the relationship gets worse and worse. And I have to say that after a long time I had mostly negative feelings towards the child and sometimes I just hated him*."

Another participant teacher of students with ADHD expressed relief from anxiety when one student with ADHD withdrew from her optional subject: "*Although I quite like the student with ADHD, I was really relieved from the anxiety when the student withdrew from my music education."*

Several participants teachers of children with ADHD described various situations where the disruptive behaviour of the students with ADHD negatively influenced the teacher's lecture and the concentration of the other students: *"I teach in two classes where there are children with ADHD. There is one boy in each class with quite a strong attention deficit disorder. Both are very disturbing factors, they often interrupt me and try to attract my attention and the attention of the other students whenever they get a chance. It happens that some students, who are normally calm, get seduced by this and start to disturb as well."*

The participants teachers of children with ADHD perceived the students with ADHD to be unable to concentrate during the whole lesson, their motor restlessness to increase

gradually, and sometimes to be unpredictable or even dangerous. In such cases, some participants teachers of children with ADHD experienced helplessness and insecurity from losing control over the situation in the classroom: *"They can do almost anything at any time. It's totally unpredictable. When that happens, the class is usually surprised because no one knows what's going on. Sometimes I really have no idea what to do."*

The participants teachers of children with ADHD admitted that when these situations frequently recurred, they felt increasing anxiety during the progress of the class. They felt trapped and without any possibility to handle the chaotic and confusing situation induced by the students with ADHD.

3.2.3.1.3 Positive emotions in a relationship with a student with ADHD

Other participants teachers of children with ADHD reported a predominance of positive emotions in relation to students with ADHD. They enjoyed the liveliness, creativity and spontaneity of these students: *"I like them, they are much better than passive children. I like their liveliness, spontaneity and creativity."*

A few participants teachers of children with ADHD considered the relationship with the students with ADHD to be mostly good because they enjoy the sense of humour of the students with ADHD. One participant teacher of students with ADHD reported how he enjoyed the jokes of one ADHD student: "*My relationship with the students with ADHD is great, perfect! It's a lot of fun with them. They have the skill to make fun and jokes.*"

Another participant emphasised, that her relationship with a student with ADHD was characterized by closeness because she admired the student's painting talent.

3.2.3.1.4 ADHD as an excuse for inappropriate behaviour

Some participants teachers of children with ADHD reported about their experiences and beliefs that some parents and their children (students) with ADHD overused one of the benefits of behaviour theory. In a way, such labelling allows students diagnosed with ADHD not to accept guilt for the negative consequences of their disruptive behaviour because it is believed that ADHD causes the disruptive behaviour. Participant Milos complained that some parents and their children with ADHD constantly made excuses that their child cannot be blamed for inappropriate behaviour because it is caused by ADHD. Parents and ADHD students were also hiding in the role of victims of bad behaviour by classmates, bad teachers' methods that cause their child to behave inappropriately so that their child would not have to be held responsible for his behaviour and his parents for poor parenting. One participant

teacher of student with ADHD described his experience and beliefs about the abuse of ADHD by some ADHD students and parents as follows: *"They're just hiding behind it. Do they say what you want from us? We were diagnosed with ADHD. They play the role of the victim and say that the teacher uses bad methods and other children treat a child with ADHD ugly, which is why a child with ADHD reacts so aggressively. These parents try to hide their parental failure behind ADHD."*

Several participants teachers of students with ADHD also reported abusing the diagnosis of ADHD by a student: *"He knows everything about his diagnosis and acts as if his ADHD entitles him to do whatever he wants and not learn anything he doesn't want. He thus successfully avoids school duties and learning."*

The participants teachers of children with ADHD with this type of experience and beliefs about the students with ADHD and their parents more often reported a feeling of less closeness and tolerance in their relationships to those students because they did not believe that disruptive ADHD students' school behaviour was conditioned by ADHD. These participants teachers of children with ADHD considered the personality of ADHD students to be spoiled by poor parenting. This means that those students deliberately avoid responsibility and put intentional resistance to educational efforts because they are used to do only entertaining activities that bring them immediate satisfaction.

3.2.3.1.5 The behaviours of children with ADHD perceived intentionally or unintentionally

Some participants teachers of children with ADHD reported experiences and beliefs that ADHD students understood their instructions and knew that their behaviour was inappropriate, but they are not able to control the behaviour and to behave according to the rules due to a higher level of impulsivity: *"I feel that they know me well and know what bothers me and what they should not do. I'm sure they know that if they do something wrong, trouble will come. To be honest, I'm not convinced they can't help themselves. They have no emergency brake."*

The participants teachers of children with ADHD with these types of experiences and beliefs reported more closeness in the teacher-student with ADHD relationship and their efforts to tolerate and understand the students with ADHD and to empathize with them, because they perceived the disruptive behaviour as unintentional and as a consequence of the disorder, not as part of the students' personality.

A few participants teachers of children with ADHD expressed the belief that certain behaviour in children with ADHD was undoubtedly the symptoms of ADHD, and different behaviour was completely intentional and the diagnosis of ADHD was misused as an excuse: "*I know that his behaviour is a symptom of ADHD, usually only after the outburst of a stronger rage. This does not happen with my own children who do not have ADHD. But then I also know of an ADHD boy who abuses the diagnosis of ADHD and claims that he can't do any work because of it."*

The participants teachers of children with ADHD with this type of belief often tried to distinguish between the boundaries of the behaviour caused by ADHD, and the behaviour caused by poor parenting. According to the participants' personal opinion, the distinction between behaviour caused by ADHD and by poor parenting may help to reduce conflicts in the relationship between the participants teachers of children with ADHD and their ADHD students. The conflict was reduced because the teachers stopped blaming the ADHD students for the ADHD-conditioned behaviour.

3.2.3.1.6 How to positively influence the quality of the teacher-student with ADHD relationship

Most of the participants teachers of children with ADHD reported that they experience ambivalent emotions towards students with ADHD. Negative emotions were often evoked by the fact that working with students with ADHD was demanding and consuming a considerable amount of energy: *"Working with him (ADHD student) was frustrating. I gave him a thousand percent of my attention and that's completely exhausting. It happened to me that I blew up in a rage a few times, because you are doing your best and there are still problems and incidents with him, and that is annoying."*

Other participants teachers of children with ADHD reported that the desire of the students with ADHD for a teacher's attention is bottomless. Some teachers pointed out that they often feel overwhelmed by this, because they also have to work with thirty other students in the classroom.

The participants teachers of children with ADHD emphasized that despite the strong negative emotions that students with ADHD sometimes evoke, it is necessary for the teacher to try to remain calm and think a few steps ahead. Such a teacher's approach has the advantage of not destroying the closeness of the teacher-student with ADHD relationship through excessive negative emotions of the teacher and acute conflict: *"Children with ADHD often surprise me and I am upset, but I try to think ahead. When I go to this lesson to*

meet this child, I have to mentally prepare for it and I have to tell myself, the problem may come, stay calm, you have to solve it calmly. You can't yell at him, it won't help him anyway, it won't help anyone." With this attitude, the teachers set their consciousness to a "standby mode" in which they expect that the disruptive behaviour of a student with ADHD to occur, and that such behaviour needs to be responded to quickly but calmly. This way of mental preparedness allows teachers to alleviate their own shock from unexpected events, to better regulate strong emotions and also prevent the stress of a student with ADHD from a possible over-emotional reaction of the teacher. Other participants teachers of children with ADHD reported that their relationship with a student with ADHD improved when they agreed with a student with ADHD on what to do in order for the collaboration to work better: "*It was really challenging and exhausting with him. It helped that I told him that we spent more time at school together during the week than his parents spent at home with him, and that together we had to figure out how to do it to feel better and work better together."* Such teachers' approach is characterized by an offer of closeness and mutual responsibility in the teacher-student with ADHD relationship, teacher acceptance of a student with ADHD and an offer of more equal cooperation. Several participants teachers of children with ADHD were able to reduce conflicts in the teacher-student with ADHD relationship by explaining to an ADHD student that it is possible to respond to ADHD symptoms with more adaptable behaviour and also by trying to be a positive role model: "*The number of conflicts reduced when I explained to him that ADHD did not cause him to be unable to perform his duties, but that ADHD was only about being inattentive and in inner tension. It is therefore necessary to find a way to work with inattention and tension. I also tried to be a role model for him and honestly perform my duties.*"

Furthermore, the quality of the teacher-student with ADHD relationship improved when the participants allowed the student to communicate openly about current needs. For example, one participant teacher of children with ADHD entered into an agreement with a student with ADHD based on mutual trust that a student with ADHD could truthfully tell that he was already overwhelmed by learning. In this case, the participants allowed the student with ADHD to walk or run down the hall. When the student relaxed, he returned to class. Most participants teachers of children with ADHD also reported that the quality of the teacher-student with ADHD relationship tends to gradually improve after several years of mutual cooperation because the teacher and the student get to know each other's strengths and weaknesses and thus can respect each other more: "*It took us about two years to understand what we can expect from each other, what works, what doesn't work, and where*

we need to refine our cooperation." This mutual attitude presupposes the will to try to re-establish closeness despite recurring conflicts.

Some participants teachers of children with ADHD sought to improve the relationship with the students with ADHD by deliberately drawing attention to the positive skills of the students with ADHD. When teachers were able to take advantage of the positive qualities of a student with ADHD in behaviour of teaching the whole class, the quality of the teacher-student with ADHD relationship improved. This teacher's approach also improved the self-esteem of the students with ADHD and class social status of the student with ADHD: "*I tried to focus not only on the bad, but above all on the good. Praise him for it. Point it out. Show him that you also notice what he can do. One of those ADHD boys could draw beautifully. So, I used it. When we were discussing a topic in a subject, I asked him to draw something on that topic. And he drew it very beautifully. And then he knew that I was interested in him and also that I would exhibit the pictures. And thanks to that, he knew that he was not just the boy who was naughty, he already knew that he could do something, and his classmates began to take him seriously and appreciate him."*

Some participants teachers of children with ADHD reported that their motivation to work on a good relationship with a student with ADHD is based on the joy of being able to make some progress and success with these students. Furthermore, the motivation is based on the desire to manage the challenge of working with ADHD students, to better understand the hidden causes of ADHD and to be a good professional: "*I feel satisfaction from it. Although the result is never completely perfect, I enjoy the work. And every little success does me good. It makes me happy to be able to work with children with ADHD."*

Two participants teachers of children with ADHD described their experiences with children with ADHD very confidently and conceitedly. They argued that they mastered the teaching of students with ADHD flawlessly and reported that they excluded all emotionality from the relationship with the students with ADHD. They also did not mention any conflicts with students with ADHD. These participants teachers of children with ADHD gave the researcher the impression that they were trying to protect their low professional self-esteem: *"I graduated from three universities focused on special pedagogy and I work perfectly with children with ADHD, I do not have any problems. And how do I experience a relationship with students with ADHD? I don't experience it. It doesn't make sense to deal with emotions. All you have to do is to do things right*

Participants teachers of children with ADHD reported three key factors supporting school inclusion and the functioning of students with ADHD. First, the personality of

important others and students with ADHD; second, the ability of important others to sufficiently recognise and meet the school needs of students with ADHD, and third, approaches and methods for raising and educating students with ADHD. According to the participants teachers of children with ADHDs' reports, the interaction of the first two factors is a prerequisite for important others to choose appropriate approaches and methods for raising and teaching students with ADHD.

3.2.3.2 Other factors that teachers of students with ADHD considered supportive of school inclusion and functioning for students with ADHD

3.2.3.2.1 Personality of important others and students with ADHD

Most of the participants teachers of children with ADHD were convinced that the success of school inclusion of students with ADHD is increased when important others possess the following character traits: warmth, compassion, empathy, thoughtfulness, patience, tolerance, acceptance, a willingness to help students with ADHD, trustworthiness and kindness, combined with strictness. Important others with these personality characteristics enjoy relationships and work with students with ADHD. They are also interested in new scientific knowledge about ADHD and educational approaches with respect to the individual needs of each student with ADHD. Through this attitude of important others, the self-confidence, self-esteem, self-worth and academic motivation of students with ADHD are all enhanced.

Participants teachers of children with ADHD also reported that some students with ADHD have character traits and abilities that contribute to their school functioning. These character traits and abilities are as follows: good-heartedness, energy, inquisitiveness, a sense of humour, an ability to enjoy little things, the ability to live in the present moment, the ability to reflect well on body signals, talents for certain sports and artistic activities, an openness to challenges and a tendency towards specific vocational interests (e.g., certain sections of biology, computer technology, palaeontology). However, participants teachers of children with ADHD pointed out that those traits and abilities benefit students with ADHD more when important others are open to creatively capitalising on those character traits and abilities in the important-other–students-with-ADHD relationship and in the educational process. Participants teachers of children with ADHD also cautioned against a one-sided approach to students with ADHD that focuses too much on either the positive

aspects of students with ADHD or the negative manifestations of ADHD: "*One mom of a student with ADHD just never wanted to admit that her son had a problem. He was kicked out of all his schools even though he was above average intelligence, but she kept saying they didn't understand her son's genius. The student was hurting others, even physically, and the mom always blamed it on the other kids. There was just no way to handle things soberly with this mom.*"

Some participants teachers of children with ADHD further emphasised that specific personality and school behaviours of students with ADHD may help to reveal deficiencies in teachers' pedagogical methods and the educational system. If a student with ADHD does not benefit from certain teacher methods, this may be a signal that those methods will prove inappropriate for other students in the longer term. In this case, the teacher should look for new, more variable, interactive, cooperative and practical teaching methods: "*When something doesn't work for a student with ADHD, it usually doesn't work for other students after a while. The ADHD student is often such a detector for you to think of something different, change something, teach something differently, more creatively or more fun.*"

3.2.3.2.2 The ability of important others to satisfactorily recognise and meet the school needs of students with ADHD

Some participants teachers of children with ADHD were of the opinion that the skill of important others to satisfactorily recognise and meet the school needs of students with ADHD helps to build the inner sense of security of students with ADHD, which is associated with the courage of those students to attempt to manage school demands. Nevertheless, participants teachers of children with ADHD reported that the skill of important others to satisfactorily recognise and meet the school needs of students with ADHD can be interfered with by important others' unprocessed negative life experiences. The unconscious projection of negative life experiences into interpretations of ADHD students' behaviour may make it difficult for an important other to realistically assess the intentions and school needs of students with ADHD: "*I come from a family where the upbringing was too benevolent and too caring. So, for a long time I thought that the world must revolve only around my needs, that it must always be my way. We had some teachers in primary school that didn't want to accommodate me in some ways; I thought they didn't like me. I started making fun and trouble for them. For example, I threw my school supplies off the desk onto the floor during a lesson on purpose, as if by mistake. Then, as a teacher, when I saw the same behaviour in my ADHD students, of course, at first, I thought they were doing it on purpose. So, I often*

disciplined those students and gave them extra homework as punishment. It wasn't until I was in self-experience training that I realised that it was my unconscious projection that they weren't doing it on purpose often enough, that their behaviour was influenced by ADHD."

Some participants teachers of children with ADHD described five ways in which important others can limit the influence of the projection of negative life experiences into interpretations of the behaviour of students with ADHD. First, important others need to map their spontaneous responses to the behaviours of students with ADHD. Second, important others should consider (preferably in self-experience training, individual psychotherapy or supervision) how those spontaneous responses to behaviours of students with ADHD are associated with cognitive-emotional-behavioural responses to past negative life experiences. The assessment that the spontaneous response to the behaviours of students with ADHD is inappropriate (influenced by past negative experiences and inadequate to the real causes of the behaviours of students with ADHD) is the starting point for the ability of important others to control those inadequate reactions and choose more appropriate responses. Fourth, important others should strive to identify misconceptions about ADHD by studying the latest theoretical and empirical evidence on ADHD and appropriate approaches to students with ADHD. Fifth, important others should gain positive corrective experiences with students with ADHD. This means that if important others' reactions to students with ADHD are consistent with the current theoretical and empirical literature dealing with ADHD and special pedagogy, the important others may gain the experience that it is possible to get along and work better with students with ADHD. In this way, attitudes of important others toward students with ADHD may become more positive.

Some participants teachers of children with ADHD pointed out that it is helpful for important others to consciously use all past experiences when recognising the needs of students with ADHD and choosing responses to those needs. Therefore, the important others' cognitive-emotional charge of difficult life experiences should also be taken into account, because this charge can to some extent indicate a real component of the meaning of the current situation. One participant teacher of children with ADHD described how this map of past experiences is important and necessary to distinguish to what extent the disruptive behaviour of a student with ADHD is caused by e.g., ADHD, poor parenting or family conflicts: "*The way it works, I think, is that we need to be aware of the map of our past experiences, which is also knowledge about ADHD, which we then project onto an interpretation of the behaviour of students with ADHD. That doesn't mean the projections*

are wrong. They're not wrong. Those projections of our experiences are the only thing we have that allows us to evaluate quite realistically how much of the disruptive behaviour of a student with ADHD is for reasons such as poor parenting, family conflict or ADHD. And then we can choose the appropriate intervention. It seems simple, but behind that successful process of realistic estimation is a lot of work on the teacher's knowledge of ADHD and awareness of the teacher's mental pre-set. Most importantly, it also means going through a lot of time and practice in which the teacher humbly tries to make the most accurate estimates and learns from mistakes."

Some participants teachers of children with ADHD further reported that school inclusion and the functioning of students with ADHD support when important others can set a balance between identifying and meeting their needs and the school needs of students with ADHD. This balance can benefit students with ADHD in three ways. First, students with ADHD learn from important others by imitating them to take care of their own needs. Second, the state of sufficiently but not fully met school needs of students with ADHD may initiate those students to make some effort to identify and meet their own needs and to communicate and cooperate with important others. Third, if important others have their needs sufficiently met, they have enough energy to care for the school needs of students with ADHD. Some participants teachers of children with ADHD in their reports also warned that an excessive focus on recognising and meeting the needs of students with ADHD can lead important others to burnout syndrome and to a feeling of inner insecurity and an excessive lack of independence of students with ADHD.

Participants teachers of children with ADHD further emphasised the importance of students with ADHD and important others to improve the skill of identifying and meeting the needs of others. Developing this skill contributes to creating a secure environment in which important others and students with ADHD try to work together to address the difficulties caused by ADHD.

3.2.3.2.3 Approaches and methods for educating and teaching students with ADHD

Most of the participants teachers of children with ADHD reported that teachers, teaching assistants and parents who are empathetic, thoughtful, accepting and know about ADHD and have the ability to satisfactorily identify the needs of students with ADHD are most likely to select and apply appropriate approaches to students with ADHD. These approaches should be based, according to participants' reports, on the following eight principles: first, open communication between important others and students with ADHD about the manifestations

and determinants of ADHD; second, establishing clear and firm rules of conduct; third, establishing an individual motivation system for each ADHD student; fourth, respecting different learning styles and paces; fifth, the use of special education aids and equipment; sixth, using the strengths and talents of the ADHD student to benefit his/her social inclusion and school performance; seventh, using varied, playful, cooperative, interactive and practice-oriented teaching methods; and eighth, peer tutoring.

3.3 A comparison between the lived experiences of students with ADHD, parents of children with ADHD and teachers of pupils with ADHD

In the lived experiences of students with ADHD, parents of children with ADHD, and teachers of students with ADHD, the following similar factors were identified as supporting school functioning and inclusion of students with ADHD: (a) warm, empathetic and accepting personality of the teachers, (b) the in-school and out-of-school friendships of students with ADHD with peers and classmates, (c) important others (parents, teachers, helping professionals, classmates) theoretical knowledge of ADHD and the knowledge and skill to use educational and upbringing approaches and methods to meet the special educational and other needs of students with ADHD.

Students with ADHD considered the warm and empathetic personalities of teachers and important others and the coping strategies of students with ADHD as key factors. Consistent with the report of students with ADHD, maintaining quality relationships with warm, empathetic and accepting teachers, parents, helping professionals and peers was a motivating force for those ADHD students to cope with the demands of school.

Parents of students with ADHD emphasized the importance of the factor of adaptive coping strategies of parents of children with ADHD, cooperation between parents, teachers and helping professionals, and the secure attachment of children with ADHD to important others. These factors were important to parents of children with ADHD as they intensively sought ways to manage the challenging task of raising and educating their children with ADHD.

Teachers of students with ADHD considered the key factors were the ability of important others and students with ADHD to sufficiently recognise and meet the special educational needs of students with ADHD. This factor was crucial for teachers of students with ADHD because they were aware of how recognition of the special educational needs

of students with ADHD can be distorted by a variety of unconscious and conscious preconceptions and biases of important others toward children with ADHD. Most teachers were also aware of how adequate recognition of the special educational needs of students with ADHD can facilitate the work of teachers and improve the in-school and out-of-school well-being of students with ADHD.

4 Discussion

The discussion section provides three main parts. The first part provides a comparison of the results of the analyses of the lived experience of students with ADHD with theoretical and empirical evidence. The second part provides a comparison of the results of the analyses of the lived experience of parents of students with ADHD with theoretical and empirical evidence. And the third part provides a comparison of the results of the analyses of the lived experience of teachers of students with ADHD with theoretical and empirical evidence.

4.1 Comparing the results of a thematic analysis of the lived experiences of students with ADHD with theoretical and empirical evidence.

The aim of this part of the present study was to explore factors that ADHD students perceived as supportive for their school functioning and inclusion. The following main supportive factors were identified: parenting style respecting the difficulties and needs of ADHD children, openness and warmth of teacher's personality, teachers' practical interventions tailored to ADHD students, ADHD students' friendships with peers, and ADHD students' ways to manage the manifestations of ADHD at school.

Most participants children with ADHD experienced an upbringing in which parents responded well to their educational difficulties and needs. This finding is in accordance with Barkley (2013) and Reffner (2020), who, just like our participants children with ADHD, pointed out that parents should teach their ADHD children how to plan the school day, follow a daily routine, and promote ADHD children's special talents and involve those talents in enriching activities, especially in areas of interest. Barkley (2013) and Reffner (2020) further emphasized the importance of parental provision of consistency. This consistency means that both parents have the same attitudes, demands and methods when raising a child with ADHD over the long term, even if the setting change and immediate results do not occur. Compared to the study by Barkley (2013) and Reffner (2020), our participants children with ADHD were especially grateful for a parents' consistency in effort to help rather than a specific type of help. A possible explanation for this participants children with ADHDs' preference is that parental consistency in effort to help shapes children with ADHD's sense of relational parental availability and closeness with parents, which is a greater benefit than the positive outcomes of specific type of parental help.

And probably for this reason, most of the participants children with ADHD reported that parental consistent help with managing ADHD students' educational difficulties was associated with secure family relationships and climate, which increased ADHD children's so called "inner sense of security". This inner sense of security was an important source of ADHD students' capacity of courage to manage school demands. This is consistent with social referencing theory Feinman (1982), Walden (1991), which emphasizes that a parent's positive affective response to a particular environment is a message to the child about the safety of that environment, which that child can then explore without fear. Also, a study by Schofield & Beek (2005) suggested that parents can generally develop a child's sense of inner security by promoting his or her reflective function, self-esteem and autonomy, and fostering trust in parental availability. Schofield & Beek (2005), Zilberstein & Messer (2010) pointed out that a child's inner sense of security is supported by the experience of long-term caregivers' care and stable family relationships. A possible explanation for the adaptive parenting styles of most of our participants children with ADHDs' parents may be the parents' higher education, secure attachment and the absence of ADHD, which is also suggested by some other studies (Dallos & Smart, 2011; Nahas et al., 2017).

In accordance with social referencing theory (Feinman, 1982; Walden, 1991), some participants children with ADHD also reported that teachers' accepting and kind affective responses helped students with ADHD develop prosocial behaviour and motivation for school engagement. Those participants children with ADHD suggested that teachers' positive affective responses stemmed from the teachers' naturally open and warm settings of personality. This finding is supported also by past research (Park & Hwang, 2013; Todorovic et al., 2011). Todorovic et al. (2011) found that the teacher's personality dimension of openness was positively related to the teacher's positive attitudes towards students with special educational needs. Park and Hwang (2013) suggested that teachers' empathy was positively associated with educational interventions in ADHD by increasing the understanding of the specific difficulties of ADHD children. One of our participants children with ADHD also reported that not only the warmth of the teacher but also a firm and consistent approach was important for his good school performance. This participant's report can be explained by the tendency of ADHD students to react uncontrollably to their internal and external impulses, and therefore the need of those students to have a consistent and firm correction of school behaviour from teachers.

Our participants children with ADHD also suggested several practical interventions for teachers of ADHD students. However, it is important to note that our ADHD children

participants differed in their manifestation of ADHD. Therefore, teachers should have an individual approach to each student with ADHD that respects their specific educational needs. Teachers also should check the correct understanding of the curriculum and test questions. ADHD students were also found to be benefited by teaching that included games, practical examples and interesting curiosities from practice. This is in line with Martinussen et al. (2011), who suggested that teachers should organise and structure materials and goal-setting, enhance the clarity of instructions and provide various instructional supports and high rates of feedback. Some participants children with ADHD wanted their teachers to emphasise which parts of the lecture are essential, so that ADHD students could devote the capacity of their attention to those important parts. This recommendation of the participants children with ADHD may be difficult to implement in practice, however, because it may lead students without ADHD to ignore all parts of the lecture that the teacher does not declare to be important. Furthermore, it could also demotivate other students in the class to listen to the 'unimportant' parts of the lecture.

Our participants children with ADHD also recommended that teachers should use the interests and talents of ADHD students to increase self-esteem, self-confidence and efficiency of the ADHD students' learning process. These recommendations can be implemented, e.g., by the teacher inviting a student with ADHD to prepare a demonstration or lecture for his/her classmates about his/her interests and hobbies.

In accordance with some participants children with ADHDs' reports, extracurricular and school friendships were an important factor that facilitated the feelings of inclusion of students with ADHD in the classroom. In extracurricular friendships, some students with ADHD made corrective relational experiences. They learned that they were not alone with their difficulties and that it was possible to establish relationships with peers based on sharing similar interests and lifestyle. This corrective experience gave those participants children with ADHD the courage to also establish relationships with their classmates. Our findings that extracurricular and school friendships supported inclusion in the classroom of students with ADHD is in line with Becker et al. (2013), Mikami (2010), who suggested that high-quality friendships between ADHD students and peers may mitigate peer rejection and other long-term social problems associated with ADHD symptomatology.

A few of our participants children with ADHD reported that even secure friendships with peers from online computer games was an influence that supported their abilities to make friends at school. Nevertheless, the benefit of this factor is disputable, because ADHD

students are at higher risk of developing video game addiction in general (Mathews et al., 2019).

In line with the participants children with ADHDs' reports, some classroom relationships were improved, but some also declined when they explained their manifestations to their classmates. The findings on improving relationships between ADHD students and classmates due to the explanation of ADHD is completely in line with Krtkova et al. (2022), and the finding on the declining quality of those relationships with O'Driscoll et al. (2012). O'Driscoll et al. (2012) found that classmates with knowledge of ADHD had a more negative attitude towards ADHD students than towards students with depression. Although Krtkova et al. (2022) suggested improving relationship classmates-student with ADHD due to the explanation of ADHD, those authors emphasised that their finding was based on the report of parents of children with ADHD. Krtkova et al. (2022) also emphasised, that parents wanted experienced and skilled teachers, and not children with ADHD, to explain the manifestations of ADHD to classmates. Thus, a possible explanation for an ambivalent effect of ADHD explanations on the relationship classmates-student with ADHD is that the ADHD explanation was made by students with ADHD in an inept or awkward manner.

Interestingly, only a few participants children with ADHD reported that they were able to realise the disruptive manifestations of ADHD in school and tried to partially manage those ADHD manifestations. These ADHD students were also not afraid to ask for the help of teachers at times when they felt overwhelmed by ADHD symptoms. This is in line with Givon & Court (2010), who found that some students with ADHD use adaptive coping strategies of determination and reconciliation. Students with ADHD using the coping strategy of determination were able to perceive the disability as a condition that can be changed and in spite of which personal competencies can be developed. Students adopting the coping strategy of reconciliation knew their limits but learned to manage them. They also tried to regulate their emotions and actively sought help.

An explanation for the low use of adaptive strategies by our participants children with ADHD may be the impaired attention related to ADHD. Impaired attention may make it difficult to use awareness and knowledge of adaptive strategies more consistently, frequently and in relevant situations. A possible explanation for the adaptive coping of ADHD manifestations in some of our participants children with ADHD may be their higher self-perceptions of competence and intellectual functioning, which is also suggested by Dvorsky & Langberg (2016), Mitchell et al. (2021). More research is needed in this field.

4.2 Comparing the results of a thematic analysis of the lived experiences of parents of students with ADHD with theoretical and empirical evidence.

The aim of this part of the present study was to assess which factors parents of ADHD students perceived as supportive for the school functioning and school inclusion of their children with ADHD. Our findings suggest that the following had a major influence: a kind personality of the teachers; secure attachment of the ADHD students to important others; knowledge of the ADHD determinants among parents, teachers and other helping professionals; school success of students with ADHD perceived as a part of a teacher's professional identity; cooperation between school leaders, parents, teachers, psychologists and psychiatrists; and practical pedagogical approaches and interventions tailored to meet the SEN of ADHD students.

Some participants parents of children with ADHD reported that the empathetic and kind personality of teachers and secure attachment between ADHD students and teachers, classmates, and parents led to a higher motivation of the ADHD students to study and to maintain stable and positive relationships. This is in accordance with past studies (Becker et al., 2013; Bergin & Bergin, 2009; Feder et al., 2017; Gumustas & Yulaf, 2019) that found associations between secure attachment with important others and better social functioning of ADHD children. Importantly, as other studies emphasise, this secure attachment must be quite strong to have a positive effect, because children with ADHD tend to form unstable and hostile relationships (Rampp et al., 2020).

Furthermore, participants parents of children with ADHD considered knowledge of ADHD determinants as the most important factor, because it allows the teachers to recognise that a student with ADHD is not misbehaving intentionally or to distinguish the behavioural symptoms of ADHD from behaviour that is age-appropriate. This may allow teachers to better regulate their negative emotions and to reach a higher degree of tolerance of ADHD symptoms, with greater openness to acknowledge the positive qualities of ADHD students. This finding is in accordance with a recent study by Wienen et al. (2019), where teachers reported that ADHD classification in students helped teachers to have higher empathy for ADHD students. Nevertheless, even this classification should be used moderately, as shown in the study by Wienen et al. (2019), who pointed to its negative side, i.e., that this

classification burdened ADHD students with a label for many years (see also Iudici et al. 2014).

According to our participants parents of children with ADHD, the teachers should also realise that even small successes in educating ADHD student represent their own big success and confirms their professional competence and teaching skills. In our study, the parents reported that neither the teacher nor the parent should have exaggerated expectations about the school results of ADHD students. This suggestion is in agreement with the study by Weyandt et al. (2013) in which ADHD students were found to have poorer academic performance because of inattention and impulsivity; psychological distress, including obsessive-compulsive symptomatology, depression, anxiety, hostility; and impaired social functioning. However, some of our participants parents of children with ADHD emphasised that ADHD students have many positive qualities and talents that, if not overlooked, can help these students with school inclusion. This notification is in line with Sedgwick et al. (2019), who consider divergent-thinking, non-conformity, hyper-focus, adventurousness, self-acceptance and sublimation of excessive energy as the positive aspects of ADHD students (see also Sherman et al., 2006).

Some of our participants parents of children with ADHD thought that relationships between classmates and an ADHD student could be improved by a teacher's explanation of the determinants of ADHD and its symptoms to all students in the class. This finding is in contrast with the recommendation of the study by O'Driscoll et al. (2012), which found that if peers know about ADHD of their classmates, they perceive them more negatively than classmates with depression.

Furthermore, participants parents of children with ADHD suggested that teachers should resolve conflicts with students with ADHD outside the classroom and use the positive qualities of an ADHD student to make the student popular with classmates. The effectiveness of the practical application of these parental recommendations is, however, debatable. Positive discrimination of students with ADHD in the classroom may elicit the impression of 'unfairness' in other students' eyes and may trigger negative emotions, such as envy or jealousy, targeted towards a 'protected' ADHD student. A sensitive and balanced approach of the teacher is needed regarding this issue (see Capodieci, Rivetti, and Cornoldi 2019).

Most of our participants parents of children with ADHD would like both teachers and helping professionals to have good ADHD knowledge and mutual collaboration. However, only some participants parents of children with ADHD reported having personal experience with such quality of professional help. This finding is in accordance with

Blatchford et al. (2012), Greenway & Edwards; Murtani et al. (2020), who reported that many teachers and other professionals still lack sufficient knowledge, understanding and education for work with ADHD students or have insufficient motivation to complete training for working with ADHD students (Toye et al., 2019).

4.2.1 Coping strategies of parents of children with ADHD

Furthermore, our findings suggest factors supporting adaptive coping strategies of parents of children with ADHD (These adaptive strategies of parents of children with ADHD support school functioning and inclusion of students with ADHD). These factors were as follows: parents' emotional intelligence, long-term experience with ADHD children, teachers and other professionals' recommendations. Factors associated with maladaptive coping strategies were the efforts of parents to manage everything only by their own forces, ADHD of parents and inexperience in raising ADHD children. We also identified nine types of parents' coping strategies that were both adaptive and maladaptive.

The participants parents of children with ADHD provided interesting insights into life with ADHD children. Most of them reported skilfully their powerful ambivalent emotions and the empathy to themselves and to their ADHD children. Strong emotions led parents to understanding that something nonstandard happened which would be a challenge for seeking a new type of adaptive coping strategy. This is generally in accordance with Stephan (2012), who pointed out to strength of 'existential emotions' that have the power to completely change the way of life. Our finding is also in line with Finzi-Dottan et al. (2011). These authors concluded that parents' sense of competence, parenthood as a challenge and threat mediates association between emotional intelligence and social support on the one hand, and stress-related growth on the other.

However, most of our participants also reported they avoided solving children's problematic behaviours and their distress at the beginning of parenthood because they didn't want to admit that their child had a disorder. Therefore, they tried to solve everything only with their own forces. The lack of experience in raising ADHD children also contributed to the parents' overload. This is in accordance with Craig et al. (2020), who pointed out that parents of ADHD children use more avoidance-focused coping strategies than parents of typical children.

Furthermore, our findings suggest that parents of children with ADHD experience more helplessness in the upbringing of ADHD children and use more maladaptive coping

strategies than other participants. A similar conclusion was reached by Babinski et al. (2016), Park et al. (2017) suggested that greater parental ADHD symptoms were associated with less positive and more harsh and lax parenting behaviours and parent– children with ADHD conflicts and internalizing problems.

Nevertheless, most of our participants parents of children with ADHD reported that with more long-term experience, they gradually realized that their children were not behaving in a standard way and began to seek more adaptive coping strategies. In some cases, these strategies were recommended to parents by teachers and other professionals. This is slightly in contrast to the findings of recent studies (Blatchford et al., 2012; Greenway & Edwards; Mulholland et al., 2015; Murtani et al., 2020) which showed that many teachers and other professionals still lack sufficient knowledge, understanding and education for work with ADHD or insufficient motivation to complete trainings for working with ADHD children (Toye et al., 2019). (Degroote et al., 2021) also pointed to the phenomenon that teachers are often indecisive about whether ADHD was indeed at the base of a specific child's hyperactivity, impulsivity and inattention.

Our participants parents of children with ADHD reported predominantly on adaptive coping strategies. A possible explanation for this may be the higher level of cognitive intelligence, which may be associated with the high incidence of participants' higher education. This is consistent with the study by Kholodnaya & Aleksapol'sky (2010), who found out that adaptive coping strategies were used more by persons with a higher cognitive intelligence. Probably due to this factor, our participants parents of children with ADHD reported using adaptive coping strategy focused on problem-solving, testing alternative solutions, the authoritative approach of upbringing, searching for professional help, emotional regulation, rest, cognitive restructuring, gaining knowledge about ADHD, and a sense of humour.

Coping's strategy of authoritarian upbringing based on clear and firm rules, brought parents and ADHD children a distinction between desirable and undesirable behaviour and the certainty of order. This is in line with McKee et al. (2004), who examined the effect of a parent training program on parents of ADHD children. These authors concluded that parents' maladaptive and less adaptive coping styles were associated with lax and overly reactive discipline. However, our findings point to the danger of over-authoritarian upbringing, which can go unnoticed into the physical and mental abuse of ADHD children, as also suggested by the study of Ghanizadeh et al. (2014). The coping strategy of emotional regulation may have similar pitfalls. Catharsis of strong parental emotions in a safe

environment (such as in psychotherapy) can have a relieving effect, but spilling those emotions on ADHD children can significantly reduce the well-being of the whole family.

Participants parents of children with ADHD considered cognitive re-framing to be one of the most effective coping strategies. The positive effect on the parents' well-being was especially due to the re-framing of ADHD from the disorder to a source of positive potential. This is consistent with Sedgwick et al. (2019), who consider non-conformity, adventurousness, divergent-thinking, hyper-focus, self-acceptance and sublimation of excessive energy, as a positive aspect of ADHD. Sherman et al. (2006) even recommended that we should look at ADHD children not through the perspective of disorder, but through the perspective of "exceptionality" and 'geniality'. These authors refer to the possibility that ADHD had geniuses, such as Mozart or Einstein.

Although some of our participants parents of children with ADHD were able to view ADHD as a source of exceptionality, they not lose sight of the fact that ADHD is also a disorder. This attitude towards ADHD may have the advantage that parents perceive their children more positively and help to develop children's specific talents, but at the same time do not deny children's disabilities and specific educational needs. This is consistent with recent labeling theory (Iudici et al., 2014) which suggests that labeling ADHD can remove the excessive guilt from ADHD children and parents and so increase their well-being. Nevertheless, excessive apology for children' disruptive behaviour in ADHD label can lead to giving up the effort to work and manage this behaviour and setting too low demands on parents and ADHD children, which does not support their personal growth.

Our participants parents of children with ADHD tried to avoid the same negative consequences when using a coping strategy of sense of humour. On the one hand, they were able to alleviate the burdensome emotions with fun. On the other hand, they were relieved only to the extent that they did not ignore the serious consequences of ADHD that needed to be addressed. This motivated the participants to find information about ADHD and apply a coping strategy focused on solving the problem and testing alternative solutions.

4.3 Comparing the results of a thematic analysis of the lived experiences of teachers of students with ADHD with theoretical and empirical evidence.

This section of the discussion is divided into two parts. The first section provides a discussion regarding the quality of the relationship teacher-student with ADHD. The second

section provides a discussion of other factors that teachers of students with ADHD found to be supportive of school inclusion and functioning for students with ADHD.

4.3.1 Quality of the relationship teacher-student with ADHD

Teachers of students with ADHD considered the quality of the teacher-student with ADHD relationship to be an important factor supporting school inclusion and the functioning of students with ADHD. Therefore, the aim of this part of the present study was to assess the teachers' perceptions of quality of their relationship with ADHD students and to gain insight into the factors that influence the quality of this relationship. We found that teachers often perceive ambivalent emotions to their ADHD students. Furthermore, our findings suggest that the quality of the teacher-ADHD student relationship is mainly influenced by the students´ behaviour, teachers' beliefs and knowledge of ADHD, special abilities and talents of ADHD students, teachers' respect to special educational needs and teachers' motivation and resilience.

4.3.1.1 Positive, negative and ambivalent teachers´emotions

Although most participants teachers of children with ADHD in our study reported positive emotions in relation to students with ADHD, the strength of the negative emotions was tangible, which is in line with the findings of other authors (Ewe, 2019; Zendarski et al., 2020). Ewe (2019, Zendarski et al. (2020) suggested poorer quality of the relationship between a teacher and a student with ADHD than between a teacher and a student without ADHD. There are several possible explanations to these findings. First, the participants teachers of children with ADHDs' negative emotions, such as anxiety, helplessness, anger, fatigue, and exhaustion, were found to be their responses to unpredictability, hyperactivity, inattention, motor restlessness, and resistance to authority in students with ADHD, which is in line with other studies (Greene et al., 2002; Masse et al., 2015). These experiences might result in higher levels of stress in teachers, as described e.g. by Greene et al. (2002), who reported that teachers of ADHD students experienced a three times higher level of stress compared to other teachers. In our study, some participants teachers of children with ADHD explained this situation by the long-term accumulation of stressful situations with ADHD students, suggesting that at some point these experiences may form an internal generalized negative attitude toward these students. Negative emotions may gradually overshadow the

positive experience, and the teacher creates a strong association between the negative emotions and the idea of working with students with ADHD. Second, some factors contributing to the negative emotions of the teachers towards ADHD students may in fact lie on the side of the teachers. These factors may involve e.g. teacher's burnout syndrome (Corbin et al., 2019; Hoglund et al., 2015) or the insecure attachment style of the teacher (Morris-Rothschild & Brassard, 2006; Sher-Censor et al., 2019). Third, other factors may be of a more practical nature, e.g. the unanswered need for regular teachers' supervision (Hoque et al., 2020; Mogg, 2020), the lack of cooperation between school management and parents (Feranska, 2018), the lack of extra educational support for ADHD students (de Boer & Kuijper), too many students in the classroom or teachers' lack of understanding or misinformation of the symptoms of ADHD (te Meerman et al., 2017).

Nevertheless, in our study, the participants teachers of children with ADHD described their relationship to ADHD students also in positive terms, such as joy, compassion, and love. These testimonies described how the teachers enjoyed the liveliness, creativity, authenticity, sense of humour and artistic talent of the students with ADHD. This is consistent with Sedgwick et al. (2019), who consider divergent-thinking, non-conformity, hyper-focus, adventurousness, self-acceptance and sublimation of excessive energy, as positive aspects of students with ADHD. These authors also pointed out that while the excessive amount of uncoordinated energy hidden in hyperactivity can be disruptive for an ADHD student and classmates during the learning process in the classroom, this energy can turn into a liveliness leading to productive ends when sublimed into the activity that ADHD students love. The close relationship and the teachers´ positive emotions towards students with ADHD can be explained by the hypothesis that some of our participants looked at the students with ADHD not through the perspective of disorder, but through the perspective of "exceptionality". This point of view is in line with Krtkova et al. (2022), Sherman et al., (2006). Sherman et al. (2006) considered the manifestations of ADHD to be the characteristics of geniuses such as Mozart or Einstein and emphasized the need for a new, more positive view of ADHD.

Altogether, our findings suggest that teachers are not only experiencing either positive or negative emotions towards their ADHD students, but that they often simultaneously experience a mixture of these emotions. These findings are in accordance with Anderson et al. (2017), who further pointed out that teachers also reported ambivalent beliefs and behaviours towards ADHD students and connected it with the teachers´ insufficient knowledge about ADHD. Another possible explanation of this ambivalence

might also be contextual factors that may increase or decrease ADHD symptoms. On the one hand, teachers might feel positive emotions towards ADHD students when there are mostly positive contextual factors at work, such as adult supportive attitudes towards ADHD students, strong intellectual functioning or positive self-perceptions of competence of students with ADHD (Dvorsky & Langberg, 2016; Mitchell et al., 2021). On the other hand, negative contextual factors, such as poor parenting (Haack et al., 2016) or intellectual disabilities of students with ADHD (Hastings et al., 2005) may strengthen the teachers´ negative emotions towards these students. In general, our findings of ambivalent and often mixed emotions of teachers support the theory of conflict and closeness (Mason et al., 2017; Pianta & Stuhlman, 2004). In line with this theory, we observed that both strong negative emotions, such as anxiety and anger are associated with conflict, and strong positive emotions, such as joy and satisfaction are associated with the closeness in the teacher-student relationship. Thus, a problematic behaviour of ADHD students might increase the conflict and decrease the closeness in the relationship (and vice versa).

The findings of the present study also point out that despite the presence of ambivalent emotions in the relationship of the teacher and ADHD student, the core of this relationship often consists of a strong social bond which may reduce or increase the quality of the relationship. If negative emotions take control over a teacher's behaviour, a strong social bond can lead to a vicious circle of mutual accusation, hatred, aggression, and bullying, because the teacher may begin to perceive a student with ADHD as bad and intentionally harmful. This may also later lead to school failure, peer rejection, exclusion, loneliness and low self-esteem of students with ADHD (Ewe, 2019). In contrast, if the teacher enables a free passing of their positive emotions and is able to regulate negative emotions, a strong bond can lead to a deeper empathy and understanding and can help the student to manage the symptoms of ADHD and school demands. This is in line with Bergin & Bergin (2009) who suggested the associations between a secure and insecure attachment of teachers and school success and the social competence of students with ADHD.

4.3.1.2 Teachers' beliefs about ADHD and their consequences for the quality of the relationship with ADHD students

Our findings also suggest that the teachers' attitudes towards ADHD students are often burdened by the teachers' beliefs that some of those students justified their selfish and oppositional behaviour and the inability to learn by suffering from ADHD. In such cases, some participants teachers of children with ADHD were hesitant about whether the ADHD

students' behaviour was due to ADHD or poor parenting. At the same time, the teachers who understood ADHD better were also more tolerant towards their ADHD students. Thus, the participants teachers of children with ADHD considered this distinction to be important because it determines the degree of closeness and conflict in the relationship teacher-ADHD student. Our finding of a conflict between two opposing views of the causes of behaviour in ADHD students is consistent with recent labelling theory (Dauman et al., 2019; Iudici et al., 2014). Dauman et al. (2019), Iudici et al. (2014) suggested that ADHD label can remove the excessive guilt from students with ADHD, their parents and teachers, which may pave the way for building better relationships. However, excessive perception of causes of disruptive students' behaviour in neurodevelopmental determinants of ADHD can lead to giving up the effort to manage that behaviour. Thus, too low demands may be required on ADHD students, which does not support their personal growth.

4.3.1.3 Teachers´ suggestions how to improve the quality of the teacher-ADHD student relationship

Our participants teachers of children with ADHD also provided suggestions how to improve the quality of the teacher-ADHD student relationship. This improvement was associated with teacher-student cooperation, viewing the teacher as a positive role model, joint efforts by the teacher and student to find a more adaptive behaviour to ADHD symptoms, open communication about the student's needs, long-term mutual experience, and using special abilities of students with ADHD for a better learning process. These findings are in accordance with Curtis et al. (2006) who pointed out several categories of special educational needs of students with ADHD, namely a need to receive frequent feedback on undesirable behaviour, to set goals for desirable behaviour, to record the rate of achievement, to reward for strengths and positive behaviours and to be provided with a clear system of evaluation and conduct in the classroom. Merrick (2020) emphasized that open communication in the form of listening to students with ADHD is a suitable way how to get feedback and valuable information about the students' specific educational needs.

4.3.2 Hierarchy of factors supporting school inclusion and functioning of students with ADHD from teachers' perspectives

The purpose of this part of the present study was to explore other factors that teachers of students with ADHD perceived as supportive for the school functioning and inclusion of

students with ADHD and whether it is possible to find hierarchies and interactions between those factors. The following factors were identified as key factors: personality of important others and students with ADHD, ability of important others to sufficiently recognise and meet the school needs of students with ADHD, approaches and methods for upbringing and educating students with ADHD.

Some participants teachers of children with ADHD reported that empathetic, thoughtful and accepting personalities of important others are a favourable prerequisite for the ability of those important others to satisfactorily recognise and meet the needs of students with ADHD through approaches that respect the determinants of ADHD and the individuality of each ADHD student. This is in accordance with findings of empirical studies that suggested there are associations between teachers' empathy and an increased understanding of children with ADHD and appropriate educational interventions Park & Hwang (2013), between teachers' and parents' knowledge of ADHD and a more positive emotional, cognitive and behavioural attitude towards children with ADHD (Amiri et al., 2016; Ghanizadeh et al., 2006), and between mentalisation training of important others and an increased ability to self-regulation and compassion for children with ADHD (Conway et al., 2019). In comparison to these studies, our participants teachers of children with ADHD emphasised that school inclusion and the functioning of students with ADHD is most supported when important others are able to set a balance between recognising and meeting their own needs and the needs of students with ADHD. This balance provides ADHD students with, on the one hand, a sufficient inner sense of security, and on the other hand, slight discomfort. This inner state leads students with ADHD to try to manage the demands of school partly on their own and partly in cooperation with important others. In contrast to this desirable state of affairs, participants teachers of children with ADHD warned against important others over-empathising, recognising and meeting the needs of students with ADHD. Excessive care of important others may cause anxiety and lack of independence in students with ADHD, as is also suggested by Gere et al. (2012), Meyer et al. (2022).

A few participants teachers of children with ADHD reported that a key factor for school inclusion and the functioning of students with ADHD is important if others can recognise that their interpretation of the behaviour of students with ADHD is inadequately distorted by the unconscious projection of past negative life experiences. The cognitive-emotional-behavioural charge of those past experiences tends to be unconsciously projected into the interpretation of ADHD students' behaviour, because it was formed in response to types of behaviours that resembled behaviours manifested by students with ADHD. For this

reason, negative projections are very difficult for important others to recognise and control. This finding is in agreement with the theory of mentalisation, which assumes that recognition of the needs of others is predominantly based on preconscious, subjective and imaginative mental activity (Diamond & Kernberg, 2011; Fonagy et al., 2019). The preconscious nature of this mental activity implies the possibility of influence of various unconscious projections in interpreting the behaviour of others. Participants teachers of children with ADHDs' reports about the unconscious, distorted interpretation of ADHD students' behaviour is also consistent with studies that pointed out that helping professionals' attitudes toward students with ADHD are often laden with negative personal biases (Dudova & Kocourkova, 2013; Fadus et al., 2020). In contrast to the study by Dudova & Kocourkova (2013), Fadus et al., (2020), a few participants teachers of children with ADHD were of the opinion that some biases may partially hide correct interpretations of reality (e.g., the negative influence of poor parenting style on increased rates of ADHD students' disruptive behaviour). Nevertheless, participants teachers of children with ADHD emphasised that the perspective of bias often completely occupies the interpretation of the behaviour of students with ADHD and is therefore inappropriate.

Participants teachers of children with ADHD further reported that the degree of inappropriate occupation of the interpretation of ADHD by one absolutized perspective can be reduced if important others seek to consciously reflect on the life experiences that shape their attitudes toward students with ADHD (in e.g., psychotherapy, self-experience training or supervision). Through this reflection, important others create a 'map of experience', on the basis of which they try to estimate as realistically as possible the extent to which different conditions contribute to manifestations of ADHD. This participants teachers of children with ADHDs' view of ADHD considering multiple conditions of ADHD is consistent with the conditional approach to ADHD, which considers the neurodevelopmental, environmental, social, cultural and other conditions of ADHD (Furman, 2005).

Furthermore, participants teachers of children with ADHD reported that purging the interpretation of ADHD students' behaviours from inappropriate projections can contribute to important others being able to recognise positive aspects in the characteristics and behaviours of students with ADHD and use those aspects to promote school inclusion and the functioning of those students. This is consistent with studies by Leroux & Levitt-Perlman (2000), Sedgwick et al. (2019), which pointed to the non-conformity, nondivergent-thinking, creativity, hyper-focus, adventurousness, energetic, artistic and musical talents of children with ADHD as aspects that can help those children with inclusion into a community and

performing well in school. However, participants teachers of children with ADHD cautioned that even important others' perceptions of the positive aspects of students with ADHD may not benefit students with ADHD, if important others tend give too much preference to the positive aspects of students with ADHD and completely ignore addressing the negative manifestations of ADHD. In this matter, it is suitable to advise important others to be cautious and to use an approach that takes into account both sides of the coin.

Participants teachers of children with ADHD also outlined educational and upbringing approaches that important others should follow to support school inclusion and the functioning of students with ADHD. These approaches are as follows: open communication between important others and students with ADHD; clear rules of conduct; respect for the different motivation, working style and pace of students with ADHD; using the strengths and talents of students with ADHD for social inclusion and school performance; the use of special aids and equipment; interactive and cooperative teaching methods; and the use of peer tutoring. This is in accordance with Krtkova et al. (2022); Krtkova et al. (2023). Compared to the studies by Krtkova et al. (2022), Krtkova et al. (2023) (where the participants were parents of students with ADHD and students with ADHD), which were more concerned with providing an enumeration of approaches that support school inclusion and functioning for students with ADHD, our participants teachers of children with ADHD were concerned with finding an adequate level of application of those approaches. A possible explanation for this difference is that our participants teachers of children with ADHD were teachers who have to consider the extent to which it is possible to accommodate students with ADHD without being perceived by other students in the classroom as overly favouring ADHD students. Another possible explanation is the teachers' experience that a workable approach needs to be dosed differently for each student with ADHD.

4.4 Limitations

Limitations of the part of the present study that explores the lived experience of students with ADHD is in the self-report of ADHD student from the cultural environment of the Czech Republic, which can be affected by current mood bias, social desirability, fabrication, ADHD and related comorbidities. Participants' willingness to participate in research may also be a bias, because willingness to participate in research can be associated with recognising similar supporting factors. Furthermore, participants' ADHD could make it

difficult for participants to concentrate and understand the questions in interviews correctly. However, the researchers were trained to interview students with ADHD. Another limitation may be the predominant college education of the participants' parents, the very limited age range of participants, the lack of information regarding socio-metric status of participants, the small number of participants (impossibility to generalize the findings), small number of ADHD girls in the sample, and relatively old data (data collected in 2018-2019).

Limitations of the part of the present study that explores the lived experience of parents of children with ADHD is that our data are based on the self-report of participants from the cultural environment of the Czech Republic, which can also be distorted by many other factors, e.g., social desirability, fabrication or current mood bias. Further bias may be caused by the participants' willingness to participate in research, as we can assume that those who wish to participate are more inclined to perceive similar helping factors. Another limitation is that most of the participants were women between the ages of 30 and 50 and they were reporting mostly about their sons with ADHD. Therefore, we do not have enough data from the fathers of students with ADHD and parental experiences with girls with ADHD.

Limitations of the part of the present study that explores the lived experience of teachers of students with ADHD. Considering the weaknesses, the social desirability effect was present in the participants' testimonies, for example when some participants tried to portray themselves in a good light. The reluctance of self-disclosure in these participants may have impoverished our final findings about the teacher-student with ADHD relationship. It is also possible that these participants tended to respond in a socially desirable way because they were recruited through snowball methods by members of the advisory panel who had the participants in professional care at the time. Thus, though the participants were ensured about the anonymity of the research and the data protection, on a less reflected level they may still have been afraid that the interviewer would reveal something that could ruin their relationship with the members of the advisory panel. Another bias on the side of the advisory board could be that the members have already been working with some participants, so it was easier for them to recommend them for research. Thus, another weakness of the snowball method could be that the participants who were recruited using this method came from a narrow subgroup. However, this weakness was minimized by the fact that the vast majority of the participants were recruited through advertisements in periodicals available in all regions of the Czech Republic.

4.5 Implications

4.5.1 Practical implications emerging from findings based on the lived experience of students with ADHD

Some recent studies suggested how to improve behavioural training of parents and teachers of children with ADHD (van der Oord & Tripp, 2020) and how these programmes can be effective (Derakhshanpour et al., 2021). Based on the findings of the present study, it seems suitable that training programs for teachers and parents of children with ADHD should be led by special educators experienced in working with ADHD students. In the first part of the training, special educators would act out theatrical skits focused on relationship approaches and the skills of working with ADHD students. In the second part of workshop, the special educators would act out the ADHD students, and the teachers and parents would try to respond with the interventions they observed in the first part of the training. In the third part of the workshop, special educators would give feedback and rehearse with teachers and parents' skills that were not effectively applied. Similar types of training workshops can be effective in improving teachers' knowledge, attitudes and approaches to students with ADHD, as also suggested recent studies.

Furthermore, teachers and parents of ADHD students should seek to involve the ADHD students in a peer group where these students are accepted and valued and where their strengths, adaptive coping strategies and talents are developed (See Table 2 for more specific practical recommendations).

4.5.2 Practical implications emerging from findings based on the lived experience of parents of students with ADHD

Secure attachment has been found to be the most fundamental helping factor. It motivates students with ADHD to overcome unpleasant feelings, to manage their study, and to maintain healthy school relationships. Therefore, teacher training focused on developing secure attachment with a student, such as self-experiential development seminars and supervision, can be recommended.

Furthermore, teachers, classmates and students with ADHD should be informed about the determinants of ADHD symptoms. Therefore, information campaigns aiming to enhance teachers' awareness of ADHD are recommended. This may help to consolidate teachers' expectations of their ADHD students' school success. Facilitating the inclusion of

ADHD students could also happen when a teacher and other important persons perceive them not only through the ADHD label but also through a perspective that highlights their positive personality traits, talents and specific abilities.

It is also appropriate to support communication and cooperation between the teachers, parents, and professionals. Teacher-parent cooperation may include sharing information about proven working methods and approaches, the behaviour of ADHD students at school, school supplies and school responsibilities needed for the next day, or the current mental state of a student with ADHD and its consequences. The teacher and parent can thus better prepare for a certain type of behaviour of an ADHD student.

Furthermore, it can be beneficial for the student with ADHD to attend group psychotherapy, where he or she may improve social skills, self-knowledge, and self-reflection, which may lead to better school functioning.

4.5.3 Practical implications emerging from findings based on the lived experience of teachers of students with ADHD

Practical implications emerging from findings based on the lived experience of teachers of students with ADHD suggest several activities that can be used to improve the quality of the teacher-student with ADHD relationship (and thus well-being of the teachers and students with ADHD) and to eliminate the teachers' stress experienced in teaching ADHD students. These activities may involve the teachers´ education regarding ADHD and their own personal support.

The educational activities may involve refining the teachers´ beliefs and emotional attitudes regarding ADHD students through seminars introducing and explaining the various determinants of ADHD and the relevant methods of working with ADHD students. Teachers may also reduce the level of stress and increase the quality of the relationship with the ADHD students by being prepared for the disruptive behaviour of ADHD students. They should be taught to respond to such behaviour quickly but calmly and to monitor their emotions during the lessons. During emotionally-aroused situations, teachers should try to focus their attention on a possible solution of the problem rather than on their own feelings or on further stirring up negative emotions. Pre-prepared alternatives for solving critical situations in the classroom can also be helpful. Furthermore, teachers should reframe the expectations related to the ADHD students' school achievement. It cannot be in general expected that the quality and way of school work of students with ADHD can reach the quality of students without

ADHD. This means that sometimes even a small school achievement of students with ADHD can be proof of a very efficient work of teachers. If teachers are aware of this, it can protect them from stress, disillusion and disappointments that can arise from holding unrealistic expectations.

Teachers could acquire these skills by attending seminars that could take place one weekend a year at the regional level at selected schools. These seminars could be led by psychologists, teachers, psychotherapists, special pedagogues with many years of experience working with ADHD students and researchers who study ADHD. Those professionals should provide the teachers with theoretical knowledge of ADHD, but also skills on how to build a stable teacher-ADHD student relationship and what methods, approaches and interventions to use when working with those students. The seminar should include exercises in addressing the disruptive behaviour of ADHD students. Professionals in the field of ADHD could imitate the behaviour of ADHD students at school, and teachers should try to respond to this behaviour with skills acquired from the theoretical part of the seminar. At the end of each exercise, there should be a discussion on what the teachers did well and where their skills need to be improved. We are of the opinion that the costs of the seminars would pay off in various forms for the state and schools. The seminars would increase the well-being of teachers, ADHD students, classmates and thus could reduce the state's financial costs for professional health, psychological and social care.

Furthermore, teachers should be educated in line with European Union and national policies for the education of students with special educational needs (Ministry of Education 2020). These policies recommend the use of adapted textbooks, specific teaching materials, compensatory and rehabilitation equipment and tools, support and behaviour services, additional support staff and additional teaching in specific subjects.

The second set of activities may be represented by the teachers' psychotherapy, behaviour or supervision, where the teachers may foster their own secure attachment. A secure attachment of the teachers may increase the sense of security and safety of the teachers, which increases resilience in stressful situations in the classroom and thus opens up the teachers' capacity for a closer and warmer relationship with students with ADHD. Through supervision, the teachers may also refine their motivation for working with ADHD students. This professional support may help teachers to serve as positive role models for ADHD students and to focus on positive skills, traits and talents of students with ADHD.

Future research could focus on a more detailed exploration of the factors that determine the teachers' ambivalent emotions and the factors that help them to regulate these

emotions. Specifically, it can focus on the relationship between the teachers' ambivalent emotions and contextual factors such as the self-esteem and sense of competence of students with ADHD and teachers.

Some recent studies have suggested that the training of important others should be provided to improve their knowledge and attitudes towards students with ADHD (Cueli et al., 2023; van der Oord & Tripp, 2020). In light of this empirical evidence and the results of the present study, it seems appropriate for important others of students with ADHD to attend seminars and workshops (on working with students with ADHD), supervision and self-experience training. Self-experience training and supervision should focus primarily on recognising and mitigating the influence of unconscious projections of negative past experiences into important others' interpretation of the behaviour of students with ADHD. In self-experience training and supervision, important others should also focus on a more conscious reflection of all experiences that help in realistically estimating the needs of students with ADHD. This personal and professional development should also ensure that important others learn to balance recognising and meeting their own needs and the needs of students with ADHD.

5 Conclusion

The following factors were identified from the lived experiences of students with ADHD as supporting school functioning and inclusion for students with ADHD: parenting style respecting the difficulties and needs of ADHD children, openness and warmth of teacher's personality, teachers' practical interventions tailored to ADHD students, ADHD students' friendships with peers, and ADHD students' ways to manage the manifestations of ADHD at school. According to the participants students with ADHD, the most influential supportive factors for school inclusion and functioning of students with ADHD were the warm personality of teachers and friendship with classmates. Warm relationships with those important others motivated students with ADHD to cope with school demands.

The following factors were identified from the lived experiences of parents of students with ADHD as supporting school functioning and inclusion for students with ADHD: a kind personality of the teachers, secure attachment of the ADHD students to important others, knowledge of the ADHD determinants among parents, adaptive coping strategies of parents of children with ADHD, knowledge of the ADHD determinants among teachers and other helping professionals, school success of students with ADHD perceived

as a part of a teacher's professional identity, cooperation between school leaders, parents, teachers, psychologists and psychiatrists, and practical pedagogical approaches and interventions tailored to meet the SEN of ADHD students. According to the participants parents of students with ADHD, the most influential supportive factor for school inclusion and functioning of students with ADHD were secure attachment of the ADHD students to important others and practical pedagogical approaches and interventions tailored to meet the SEN of ADHD students.

The following factors were identified from the lived experiences of teachers of students with ADHD as supporting school functioning and inclusion for students with ADHD: accepting and empathetic personality of important others and students with ADHD, ability of important others to sufficiently recognise and meet the school needs of students with ADHD, quality relationship teacher-student with ADHD, approaches and methods for upbringing and educating students with ADHD. According to the participants of teachers of students with ADHD, the most influential supportive factors for school inclusion and functioning of students with ADHD were the ability of important others to sufficiently recognise and meet the school needs of students with ADHD and quality relationship teacher-student with ADHD.

The following main implications can be drawn from the findings: (a) promote the development of important others and students with ADHD secure attachment and adaptive coping strategies through psychotherapy, counselling, supervision, (b) promoting in important others and students with ADHD familiarity with current medical and conditional models of ADHD and knowledge of educational and pedagogical approaches that respect the SEN of students with ADHD, (c) development of important others ability to recognize and meet the SEN of students with ADHD. From the findings, we proposed a workshop structure for teachers to refine their theoretical knowledge of ADHD as well as, through practical training, their skills to recognise the SEN of students with ADHD and educational approaches and interventions that respect the SEN of students with ADHD.

Annotation

An increasing number of recent studies in the field of special needs education have recognised the importance of factors supporting school inclusion and functioning of students with attention-deficit/hyperactivity disorder (ADHD). Recent studies have also highlighted the need for further in-depth investigation of the factors supporting school inclusion and functioning of students with ADHD from the lived experience of a clinical sample of students with ADHD, parents and teachers of students with ADHD. Therefore, the goal of the present study was to explore the factors that ADHD students, their parents, and teachers perceived as supportive for their school functioning. The sample consisted of 20 students with ADHD, 20 parents of children with ADHD, and 15 teachers of student with ADHD. Thematic analysis of the interviews with ADHD students revealed the following supportive factors for effective functioning and inclusion of ADHD students at school: parenting style respecting the special needs of ADHD students, close friendship of ADHD students with their peers, openness and warmth of the teachers, practical teachers' and parents' interventions tailored to the strengths of ADHD students and ADHD students' own effort to manage ADHD manifestations at school. Thematic analysis of the interviews with parents of students with ADHD suggested the following factors supporting school inclusion and functioning of ADHD students: adaptive coping strategies of parents of students with ADHD, the teachers' knowledge of ADHD symptoms, the use of educational methods respecting the determination of ADHD, special school aids and equipment, and the help of various professionals and psychotherapy. Thematic analysis of the interviews with teachers of students with ADHD indicated the following main factors supporting school inclusion and functioning of ADHD students: the quality of the relationship teacher-student with ADHD, empathetic and accepting personality of the teacher, the ability of important others (parents of student with ADHD, teachers, peers, other helping professionals) and students with ADHD to recognize the special educational needs of students with ADHD, and educational approaches and methods that respect the special educational needs of students with ADHD. Practical implications emerging from the results of the present study involve important others training focused on the development of knowledge about ADHD and secure attachment of important others and students with ADHD, and training the ability of important others and students with ADHD to recognize the special educational needs of students with ADHD. Based on these implications, we designed a workshop for teachers and other helping professionals.

Title: Factors supporting school inclusion and functioning of students with ADHD: thematic analysis of lived experiences of students with ADHD, parents and teachers of students with ADHD

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Anotace

Stále větší počet empirických studií v oblasti speciálního vzdělávání naznačuje důležitost faktorů podporujících školní inkluzi a fungování žáků s poruchou pozornosti a hyperaktivity (ADHD). Nedávné studie také zdůraznily potřebu dalšího hloubkového zkoumání faktorů podporujících školní inkluzi a fungování žáků s ADHD na základě žité zkušeností klinického vzorku žáků s ADHD, rodičů a učitelů žáků s ADHD. Cílem této studie proto bylo prozkoumat faktory, které studenti s ADHD, jejich rodiče a učitelé vnímají jako podpůrné pro školní fungování student s ADHD. Vzorek tvořilo 20 žáků s ADHD, 20 rodičů dětí s ADHD a 15 učitelů žáků s ADHD. Tematická analýza rozhovorů s žáky s ADHD odhalila následující faktory podporující školní fungování a inkluzi žáků s ADHD: styl výchovy respektující speciální potřeby žáků s ADHD, blízká přátelství žáků s ADHD s jejich vrstevníky, otevřenost a vřelost učitelů, praktické intervence učitelů a rodičů přizpůsobené silným stránkám žáků s ADHD a vlastní snaha žáků s ADHD zvládat projevy ADHD ve škole. Tematická analýza rozhovorů s rodiči žáků s ADHD naznačila následující faktory podporující školní inkluzi a fungování žáků s ADHD: adaptivní copingové strategie rodičů žáků s ADHD, znalost učitelů o projevech ADHD, využívání vzdělávacích metod respektujících determinanty ADHD, speciální školní pomůcky a vybavení a pomoc různých odborníků a psychoterapie. Tematická analýza rozhovorů s učiteli žáků s ADHD poukázala na tyto hlavní faktory podporující školní inkluzi a fungování žáků s ADHD: kvalita vztahu učitel - žák s ADHD, empatická a akceptující osobnost učitele, schopnost důležitých druhých (rodiče žáka s ADHD, učitelé, vrstevníci, další pomáhající odborníci) a žáků s ADHD

rozpoznávat speciální vzdělávací potřeby žáků s ADHD a vzdělávací přístupy a metody respektující speciální vzdělávací potřeby žáků s ADHD. Praktické implikace vyplývající z výsledků této studie zahrnují tréninky důležitých druhých zaměřené na rozvoj znalostí o ADHD, tréninky zaměřené na rozvoj bezpečné vztahové vazby důležitých druhých a studentů s ADHD, trénink schopnosti důležitých druhých a studentů s ADHD rozpoznat speciální vzdělávací potřeby studentů s ADHD. Na základě těchto důsledků jsme navrhli workshop pro učitele a další pomáhající profesionály.

Resume

Title of work

Factors supporting school inclusion and functioning of students with ADHD: thematic analysis of lived experiences of students with ADHD, parents and teachers of students with ADHD

Structure of the present study

The structure of the present study is as follows: (a) theoretical part, (b) methodology, (c) results, (d) discussion, (e) limitations (f) implications, (g) conclusion.

Introduction

A growing body of current empirical studies in the field of education addresses the difficulties associated with ADHD. These studies often focus on the negative manifestations of ADHD and how those manifestations complicate school and other life of children with ADHD, parents of children with ADHD, teachers, and peers. A smaller number of empirical evidence addresses factors that support school inclusion and the functioning of students with ADHD. This empirical deficiency has become a challenge that the present study seeks to address by exploring the lived experiences of students with ADHD, parents of students with ADHD, and teachers of students with ADHD in the Czech Republic with factors that support school inclusion and functioning of students with ADHD.

The theoretical part

The theoretical section of the present study deals with the historical development of the concept of ADHD, current theoretical approaches to ADHD, and theories that may provide a theoretical background for the results of the analysis of the lived experiences of participants concerning factors that support school inclusion and functioning of students with ADHD.

Methods

The goal of the present study

The research goals established by the research questions focused on understanding the lived experiences of students with ADHD, parents of children with ADHD, and teachers of students with ADHD with factors that support school inclusion and functioning of students with ADHD. Furthermore, the present study aimed to explore similarities and differences in the lived experiences of the participants.

Methods of data analysis

The lived experience of participants with factors supporting school inclusion and the functioning of students with ADHD was gained through semi-structured interviews. Given the nature of the data, interpretive phenomenological analysis and thematic analysis were chosen for data analysis. These qualitative methods can lead to the identification of valuable results and insights for practice and future research.

Results

In the lived experiences of students with ADHD, parents of children with ADHD, and teachers of students with ADHD, the following factors were identified as supporting school functioning and inclusion of students with ADHD.

Students with ADHD considered the warm and empathetic personalities of teachers and important others and the coping strategies of students with ADHD as key factors. Consistent with the report of students with ADHD, maintaining quality relationships with warm, empathetic and accepting teachers, parents, helping professionals and peers was a motivating force for those ADHD students to cope with the demands of school.

Parents of students with ADHD emphasized the importance of the factor of adaptive coping strategies of parents of children with ADHD, cooperation between parents, teachers and helping professionals, and the secure attachment of children with ADHD to important others. These factors were important to parents of children with ADHD as they intensively sought ways to manage the challenging task of raising and educating their children with ADHD.

Teachers of students with ADHD considered the key factors were the ability of important others and students with ADHD to sufficiently recognise and meet the special educational needs of students with ADHD. This factor was crucial for teachers of students with ADHD because they were aware of how recognition of the special educational needs of students with ADHD can be distorted by a variety of unconscious and conscious preconceptions and biases of important others toward children with ADHD. Most teachers were also aware of how adequate recognition of the special educational needs of students with ADHD can facilitate the work of teachers and improve the in-school and out-of-school well-being of students with ADHD.

Discussion

The discussion focuses on comparing our findings with recent empirical and theoretical evidence in the area of school inclusion and the special educational needs of students with ADHD. The following main implications can be drawn from the findings: (a) promote the

development of important others and students with ADHD secure attachment and adaptive coping strategies through psychotherapy, counselling, and supervision, (b) promoting important others and students with ADHD familiarity with current medical and conditional models of ADHD and knowledge of educational and pedagogical approaches that respect the SEN of students with ADHD, (c) development of important others ability to recognize and meet the SEN of students with ADHD. From the findings, we proposed a workshop structure for teachers to refine their theoretical knowledge of ADHD as well as, through practical training, their skills to recognise the SEN of students with ADHD and educational approaches and interventions that respect the SEN of students with ADHD.

Resume

Název

Faktory podporující školní inkluzi a fungování žáků s ADHD: tematická analýza žitých zkušeností žáků s ADHD, rodičů a učitelů žáků s ADHD

Struktura dizertační práce

Struktura dizertační práce je následující: (a) teoretická část, (b) metodologie, (c) výsledky, (d) diskuse, (e) limity, (f) závěr.

Úvod

Stále více empirických studií v oblasti vzdělávání se zabývá obtížemi spojenými s ADHD. Tyto výzkumy se často zaměřují na negativní projevy ADHD a take na to, jak projevy ADHD ovlivňují život dětí s ADHD ve škole i mimo ni, ale také život jejich rodičů, učitelů a vrstevníků. Poměrně málo empirických studií se zabývá faktory, které podporují školní inkluzi a fungování žáků s ADHD. Tato mezera v hlubší exploraci faktorů podporujících školní inkluzi a fungování studentů s ADHD se stala výzvou, na kterou se zaměřuje tato dizertační práce. Cílem této diseratční práce je tedy zkoumání žitých zkušeností žáků s ADHD, rodičů žáků s ADHD a učitelů žáků s ADHD v České republice s faktory, které podporují školní inkluzi a fungování žáků s ADHD.

Teoretická část

Teoretická část této dizertační práce se zabývá historickým vývojem konceptu ADHD, současnými teoretickými přístupy k ADHD a teoriemi, které mohou poskytnout teoretické zázemí pro výsledky našich analýz žitých zkušeností participantů s ohledem na faktory, které podporují školní začlenění a fungování žáků s ADHD.

Metody

Cíle výzkumu

Výzkumné otázky se zaměřily na porozumění žitých zkušeností žáků s ADHD, rodičů dětí s ADHD a učitelů žáků s ADHD s faktory, které podporují školní začlenění a fungování žáků s ADHD. Dále bylo cílem této dizertační práce prozkoumat podobnosti a rozdílnosti v žitých zkušenostech paerticipantů.

Metody analýzy dat

Žité zkušenosti participantů s faktory podporujícími školní inkluzi a fungování žáků s ADHD byly získány prostřednictvím polostrukturovaných rozhovorů. Vzhledem k povaze dat byla pro jejich analýzu zvolena interpretativní fenomenologická analýza a tematická analýza. Tyto kvalitativní metody mohou vést k získání hodnotných výsledků a poznatků pro praxi a budoucí výzkum.

Výsledky

V žitých zkušenostech žáků s ADHD, rodičů dětí s ADHD a učitelů žáků s ADHD bylo identifikováno množství faktorů podporujících školní inkluzi a fungování žáků s ADHD.

Žáci s ADHD považovali za klíčový faktor vřelou a empatickou osobnost důležitých druhých (rodiče studentů s ADHD, učitelé, vrstevníci, pomáhající profesionálové). Dále, dle studentů s ADHD, byly důležité následující factory: adaptivní copingové strategie studentů s ADHD, kvalitní vztahy s vrstevníky, učiteli, rodiči a odborníky (díky nimž nacházeli studenti s ADHD motivaci a sílu pro zvládání školních nároků).

Rodiče žáků s ADHD zdůrazňovali důležitost faktoru adaptivních copingových strategií rodičů studentů s ADHD, spolupráci mezi rodiči, učiteli a pomáhajícími odborníky a bezpečnou vztahovou vazbu dětí s ADHD k důležitým druhým. Tyto faktory byly pro rodiče dětí s ADHD klíčové, protože tyto rodiče, dle jejich reportů, intenzivně hledali způsoby, jak zvládnout náročný úkol výchovy a vzdělávání svých dětí s ADHD.

Učitelé žáků s ADHD považovali za klíčový faktor schopnost důležitých druhých a žáků s ADHD rozpoznat a naplnit speciální vzdělávací potřeby žáků s ADHD. Tento faktor byl pro učitele žáků s ADHD esenciální, protože si tito učitelé byli vědomi toho, jak může být rozpoznání speciálních vzdělávacích potřeb žáků s ADHD zkresleno různými nevědomými i vědomými předsudky a přednastaveními. Většina učitelů si také uvědomovala, jak může adekvátní rozpoznání speciálních vzdělávacích potřeb žáků s ADHD usnadnit práci učitelů a zlepšit školní i mimoškolní kvalitu života žáků s ADHD.

Diskuse

Diskuse se zaměřuje na porovnání našich zjištění s empirickými a teoretickými poznatky v oblasti školní inkluze a speciálních vzdělávacích potřeb žáků s ADHD. Ze zjištění lze vyvodit tyto hlavní implikace: (a) podporovat rozvoj bezpečné vztahové vazby a adaptivních copingových strategií důležitých druhých a žáků s ADHD prostřednictvím psychoterapie, poradenství, supervize, (b) obeznámenost důležitých druhých se současnými poznatky o ADHD a znalost důležitých druhých o vzdělávacích a pedagogických přístupech, které respektují speciální vzděšlávací potřeby žáků s ADHD, (c) rozvoj schopnosti důležitých druhých rozpoznat a naplňovat speciální vzdělávací potřeby žáků s ADHD. Na základě zjištěných poznatků jsme navrhli strukturu workshopu pro učitele, který by jim umožnil: (a) zdokonalit teoretické znalosti o ADHD, (b) prostřednictvím praktického nácviku zdokonalit dovednost rozpoznávat speciální vzdělávací potřeby žáků s ADHD, (c) kultivovat vzdělávací a výchovné přístupy, metody a intervence respektující speciální vzdělávací potřeby žáků s ADHD.

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Supplements

1 Research information for participants

Institut sociálního zdraví
Univerzity Palackého

INFORMAČNÍ LIST PRO ÚČASTNÍKA ROZHOVORU

Modul: Zkušenosti dětí s ADHD, jejich rodičů a pedagogů

PODROBNĚJŠÍ INFORMACE A ČASTO KLADENÉ OTÁZKY

V následující části Vám zodpovíme otázky, které jsou členům našeho výzkumného týmu nejčastěji kladeny.

Co je cílem výzkumu?
Cílem výzkumného šetření je hlubší porozumění zkušenostem, které mají děti s ADHD, jejich rodiče a pedagogové. Prostřednictvím rozhovorů se snažíme zjistit, jak ADHD ovlivňuje život dětí a jejich rodin. Naším cílem je také zpřístupnit poznatky dalším lidem a napomoci zkvalitnění dětské zdravotní péče a vzdělávání v České republice. Na základě rozhovorů bude připravena webová stránka hovoryozdravi.cz, která bude sloužit dětem s ADHD, jejich rodinám, pedagogům, zdravotníkům nebo studentům jako zdroj informací a opory.

Jak výzkum probíhá?
Výzkum je realizován metodou DIPEx, která vznikla na Univerzitě v Oxfordu a postupně se rozšířila do mnoha zemí po celém světě. Je založena na rozhovorech mapujících subjektivní zkušenosti lidí s danou nemocí či poruchou. V rámci výzkumu budou realizovány rozhovory, které se zaměří na to, jak ADHD u dětí ovlivňuje život jedince. Rozhovory budeme realizovat nejen s dětmi s ADHD, ale také s rodiči dětí s ADHD a příslušnými pedagogy/asistenty pedagoga.

Jak bude rozhovor vypadat?
Nejprve se Vás zeptáme, zda souhlasíte s nahráváním rozhovoru na diktafon či kameru a pořízením fotografií. Pokud budete souhlasit s účastí na rozhovoru, stačí podepsat formuláře "Informovaný souhlas" a „Svolení k použití fotografií a obrazového/zvukového záznamu/písemného přepisu záznamu rozhovoru". Po podepsání obdržíte jejich kopie.
Rozhovor bude něco jako neformální konverzace, ve které budete mluvit o sobě svými vlastními slovy. Požádáme Vás, abyste mluvil/a o zkušenostech souvisejících s ADHD - budeme se ptát na Váš příběh, Vaše vlastní a osobní zkušenosti – ty dobré i ty špatné.
Stává se, že lidé někdy mají potřebu hovořit o svém příběhu nad rámec výzkumu, což však není v našich silách zachytit, a tak Vás v rozhovoru budeme stále „vracet" k tématu. Musíme Vás upozornit a jednoznačně předeslat, že tento výzkum není poradenstvím ani jinou formou psychologické či sociální intervence. Nicméně Vám můžeme poskytnout seznam užitečných kontaktů, budete-li si to přát.

Jak dlouho bude rozhovor trvat?
Délka rozhovoru se liší s ohledem na to, kolik toho máte na srdci – záleží pouze na Vás. Většina rozhovorů trvá minimálně hodinu, obvykle trvá rozhovor kolem dvou hodin. Rozhovor s dětmi trvá do 90 minut. Rozhovor je možné rozdělit i na dvě setkání. Rozhovor můžete také kdykoliv zastavit či přerušit, a to bez udání důvodu. Pokud se naší studie účastní i Vaše dítě, je možné realizovat rozhovor s dítětem a rodičem společně.

Co se stane po rozhovoru?
Rozhovor bude označen číselným kódem a přepsán. Tento přepis dostanete k dispozici a uvedete, zda můžeme použít veškeré jeho části nebo zda některé informace nemáme využívat k analýzám či publikaci na webové stránce. Výzkumník je vázán dohodou o mlčenlivosti (a tedy, že udrží v tajnosti vše, co zaznělo v rozhovoru). Digitální záznamy a přepisy rozhovorů, označené pouze číselným kódem, budou uchovávány na bezpečném místě v pracovišti OUSHI na Univerzitě Palackého v Olomouci. Společně s přepisem rozhovoru Vám zašleme také popis nejdůležitějších informací, které zazněly během rozhovoru, tzv. Váš příběh. Vámi schválený příběh později uveřejníme na webových stránkách hovoryozdravi.cz.

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Jak bude výzkumník používat záznam a přepis rozhovoru?

Podpisem formuláře "Svolení k použití fotografií a obrazového/zvukového záznamu/písemného přepisu záznamu rozhovoru" souhlasíte s tím, že Univerzita Palackého v Olomouci je oprávněna takové materiály užít v souladu s jejich účelem vyplývajícím z formuláře. Jeden exemplář podepsaného formuláře obdržíte i Vy. Všechna použitá data jsou přísně chráněna v rámci podmínek nařízení Evropského parlamentu a Rady EU 2016/679 ze dne 27. dubna 2016 o ochraně fyzických osob v souvislosti se zpracováním osobních údajů a o volném pohybu těchto údajů a o zrušení směrnice 95/46/ES. Výzkumné údaje v anonymizované podobě mohou být použity akademickými pracovníky pro výzkumné účely a následně publikovány (vždy jako souhrnná informace či anonymní ukázka) v odborných časopisech a knihách.

Musím se výzkumu zúčastnit?

Rozhodnutí, zda se chcete nebo nechcete zúčastnit, je zcela na Vás. Pokud se rozhodnete účastnit, máte kdykoliv možnost bez udání důvodu z výzkumu odstoupit. Nemusíte nikomu vysvětlovat, proč jste odstoupili. Chceme Vás ubezpečit, že rozhodování o tom, zda se zúčastníte výzkumu, neovlivní nikterak úroveň zdravotní péče o Vás.

Co se stane, když se zúčastním?

Budeme vás kontaktovat a domluvíme se na čase a místě rozhovoru, které Vám budou vyhovovat. Pokusíme se zodpovědět všechny otázky, které budete mít ohledně rozhovoru nebo projektu.

Kdo má dohled nad výzkumem?

Tato forma výzkumu vznikla na univerzitě v Oxfordu. Získání licence pro zahájení takového výzkumu v České republice bylo náročné, úroveň výzkumného pracoviště a také samotných výzkumníků je vždy pečlivě posuzována odborníky z oxfordské univerzity. Výzkum byl také projednán a schválen Etickou komisí Institutu sociálního zdraví Univerzity Palackého v Olomouci.

Jak je výzkum financován?

Tento výzkum je prováděn v rámci projektu *Inspirace v odlišnosti*, který získal podporu z operačního programu OPVVV v rámci výzvy pro podporu žáků se zdravotním postižením.

2 Participant data (students with ADHD)

Institut sociálního zdraví
Univerzity Palackého

Údaje o účastníkovi

Evidenční číslo rozhovoru:

ÚDAJE O ÚČASTNÍKOVI

Jméno .... Věk [W] .... Pohlaví [W] ....
Adresa ....
Telefonní č.. Datum narození ....
Emailová adresa ....
Vyplní výzkumník, pokud byl vyplněn vstupní formulář

Jméno a telefonní číslo zákonného zástupce (rodiče) ....
....
Preferované jméno pro webové stránky [W] ....
Žiji s matkou i otcem ANO – NE. Pokud ne, vysvětlete [W]..
....
....
Počet osob v domácnosti [W]..
Počet sourozenců a jejich věk a pohlaví [W]..
Zemřel ti někdo blízký?..
Země narození .... Etnická příslušnost/národnost ....
Vzdělání (škola) + ročník studia [W]...
Vyznání [W] ....
Zdravotní stav [W]...Datum stanovení diagnózy .... Věk ....

Účastník předběžně souhlasil se zveřejněním výše uvedených osobních dat na webové stránce a s uveřejněním rozhovoru v podobě video/audio/písemný přepis* ☐

Místo rozhovoru..(tj. doma/v práci/na klinice atd.)
Kontakt pro rozhovor ....(tj. praktický lékař/podpůrná skupina/odborný lékař atd.)
Výzkumník .... Datum rozhovoru .... Metoda nahrávání: audio/video*
Poznámky (co si účastník přeje/nepřeje a další)..
....
Vyplní výzkumník

Svým podpisem jakožto zákonný zástupce (rodič) účastníka stvrzuji, že výše uvedené údaje o účastníkovi jsou pravdivé a souhlasím s jejich zpracováním pro výzkumné účely a webové stránky DIPEx.

Zákonný zástupce účastníka projektu:

....
Jméno a příjmení (tiskacím) Podpis Místo Datum

[W] *tyto informace budou zveřejněny na weboých stránkách*

**nehodící se škrtněte, hodící se zakroužkujte*

hovoryozdravi.cz

DIPEx Internation 1

3 Informed consent (students with ADHD)

Evidenční číslo rozhovoru:

INFORMOVANÝ SOUHLAS

Souhlas účastníka výzkumného projektu spořízením fotografií, zvukového a obrazového záznamu a se zpracováním osobních a citlivých údajů

Subjekt realizující výzkumný projekt (studii):

Univerzita Palackého v Olomouci, Cyrilometodějská teologická fakulta, Institut sociálního zdraví (OUSHI)
Křížkovského 511/8, 771 47 Olomouc
IČ: 61989592
Kontaktní osoba: PhDr. Lucie Klůzová Kráčmarová, Ph.D., Univerzitní 22, 771 11 Olomouc,
lucie.kluzova@oushi.upol.cz

Jméno výzkumníka

Osoba, která provedla poučení účastníka výzkumného projektu a jeho zákonného zástupce

Účastník výzkumného projektu (studie):

Jméno a příjmení

Datum narození

Adresa
(dále též jako „účastník výzkumu“)

Zákonný zástupce (rodič) účastníka výzkumu:

Jméno a příjmení

Datum narození

Adresa
(dále též jako „zákonný zástupce účastníka výzkumu“)

Výzkumný projekt (studie): Inspirace v odlišnosti - Výzva č. 02_16_037 pro Podporu žáků se zdravotním postižením I (Implementace APIV) v prioritní ose 3 O**P** (dále jen “výzkumný projekt”)
Období realizace výzkumného projektu: 2018-2020
Hlavní řešitel výzkumného projektu: prof. Ing., Mgr. et Mgr. Peter Tavel, Ph.D.

Vážená paní, vážený pane,
obracíme se na Vás se žádostí o spolupráci na výzkumném projektu, jehož cílem je zkoumání zkušeností dětí od 10 do 18 let s ADHD, jejich rodičů a pedagogů. Prostřednictvím informačního listu, který tvoří nedílnou součást tohoto Souhlasu účastníka výzkumného projektu s pořízením fotografií, zvukového a obrazového záznamu a se zpracováním osobních a citlivých údajů Vám byly představeny základní informace o výzkumu. Z účasti na výzkumu pro Vaše nezletilé dítě vyplývají určité výhody, ale i rizika, se kterými budete seznámeni níže.

1. **Udělení souhlasu s pořízením fotografií, zvukového a obrazového záznamu**

Uděluji, jakožto zákonný zástupce účastníka výzkumu, svolení podle ust. §§ 84 a 85 a ust. § 892 zákona č. 89/2012 Sb., občanský zákoník, ve znění pozdějších předpisů, k pořízení fotografií, zvukového a obrazového záznamu a jejich kopií týkající se účastníka výzkumu za účelem zkoumání, zpracování, analýzy a zveřejnění výstupů do souboru „zkušenosti se zdravím a nemocí“ a dále za účelem vědeckým, zejména k publikačním výstupům v rámci zahraničních a domácích vědeckých periodikách, záznamy (audio/video) budou využity v rámci webových stránek hovoryozdravi.cz a hovoryovzdelavani.cz za účelem online zpřístupnění odborné i široké veřejnosti po celém světě, to vždy po předchozím písemném souhlasu každého účastníka výzkumu. Výsledky výzkumného projektu budou subjektem realizujícím projekt dále použity na přenosných discích a jiných úložištích při vzdělávání akademických pracovníků, zdravotnických i nezdravotnických profesí.

verze 1.0. z 20.2.2018 | 1

2. Prohlášení zákonného zástupce účastníka výzkumu:

Současně prohlašuji, že jsem byl jakožto zákonný zástupce účastníka výzkumu seznámen se skutečností, že jednou dané svolení k pořízení fotografií, zvukového a obrazového záznamu účastníka výzkumu lze kdykoliv odvolat, a to na základě písemného vyrozumění adresovaného subjektu realizujícímu výzkumný projekt.

3. Informace o zpracování osobních údajů účastníka výzkumu v průběhu a po skončení výzkumného projektu

Veškerá práva a povinnosti při zpracování osobních údajů se řídí nařízením Evropského parlamentu a Rady EU 2016/679 ze dne 27. dubna 2016 o ochraně fyzických osob v souvislosti se zpracováním osobních údajů a o volném pohybu těchto údajů a o zrušení směrnice 95/46/ES (dále jen „nařízení“). Pro účely vedení evidence týkající se výzkumného projektu a pro účely týkající se evidence, vyhodnocení a použití výsledků projektu, budou subjektem realizujícím výzkumný projekt zpracovány následující osobní a citlivé údaje o účastníkovi výzkumu:

a) jméno a příjmení,
b) datum narození, věk,
c) pohlaví,
d) adresa, telefonní číslo, email
e) počet osob v domácnosti,
f) země narození,
g) etnická příslušnost/národnost,
h) informace o zdravotním stavu (diagnóza, věk při diagnostikování),
i) vzdělání (ročník a typ školy).

(dále jen „osobní a citlivé údaje“).

Poskytnutí osobních a citlivých údajů účastníkem výzkumu subjektu realizujícímu výzkumný projekt je dobrovolné. Pokud účastník výzkumu odmítne poskytnout subjektu realizujícímu výzkumný projekt uvedené osobní a citlivé údaje, nemůže se výzkumného projektu zúčastnit. Zpracováním osobních a citlivých údajů se rozumí shromažďování těchto osobních a citlivých údajů, ukládání na nosiče informací, jejich vyhledávání, používání, uchovávání, přepis záznamů obsahujících osobní a citlivé údaje do písemné podoby a případně reprodukce těchto písemných přepisů třetími osobami, třídění a likvidace. Subjekt realizující výzkumný projekt bude zpracovávat osobní a citlivé údaje pouze v souladu s účelem, k němuž byly shromážděny. Osobní a citlivé údaje budou subjektem realizujícím výzkumný projekt zpracovávány po dobu neurčitou.

Beru jako zákonný zástupce účastníka výzkumu na vědomí, že pozici pověřence pro ochranu osobních údajů u subjektu realizujícího výzkumný projekt vykonává kancléř Univerzity Palackého v Olomouci, přičemž jej lze kontaktovat na výše uvedené adrese sídla subjektu realizujícího výzkumný projekt.

Beru jako zákonný zástupce účastníka výzkumu na vědomí také následující poučení činěná ze strany subjektu realizujícího výzkumný projekt v souvislosti s výše popsaným zpracováním osobních údajů dle čl. 13 nařízení, popř. podle čl. 15 až 22, 34 a 77 nařízení:

- Účastník výzkumného projektu má dle čl. 15 nařízení právo získat od subjektu realizujícího výzkumný projekt potvrzení, zda osobní údaje, které se jej týkají, jsou či nejsou zpracovány, a pokud jsou zpracovány, má právo získat přístup k těmto osobním údajům a k souvisejícím informacím vymezeným čl. 15 odst. 1 písm. a) - h) nařízení;
- Účastník výzkumného projektu má za podmínek dle čl. 15 nařízení právo na bezúplatné poskytnutí jedné kopie zpracovávaných osobních údajů;
- Účastník výzkumného projektu má dle čl. 16 nařízení právo na opravu nepřesných osobních údajů, které se jej týkají, případně právo na doplnění neúplných osobních údajů;
- Účastník výzkumného projektu má dle čl. 17 nařízení právo na to, aby subjekt realizující výzkumný projekt bez zbytečného odkladu vymazal osobní údaje, které se jej týkají, a to za podmínek stanovených článkem 17 nařízení, tedy zejména pokud:

  a) osobní údaje již nejsou potřebné pro účely, pro které byly shromážděny nebo jinak zpracovány;
  b) je odvolán souhlas, na jehož základě byly údaje podle čl. 6 odst. 1 písm. a) nařízení nebo čl. 9 odst. 2 písm. a) nařízení zpracovány, a neexistuje žádný další právní důvod pro zpracování;
  c) jsou vzneseny námitky proti zpracování podle čl. 21 odst. 1 nařízení a neexistují žádné převažující oprávněné důvody pro zpracování nebo jsou vzneseny námitky proti zpracování podle čl. 21 odst. 2 nařízení;
  d) osobní údaje byly zpracovány protiprávně;

e) osobní údaje musí být vymazány ke splnění právní povinnosti stanovené v právu Evropské unie nebo členského státu, které se na správce osobních údajů (subjekt realizující výzkumný projekt) vztahuje;

f) osobní údaje byly shromážděny v souvislosti s nabídkou služeb informační společnosti podle čl. 8 odst. 1 nařízení;

- Účastník výzkumného projektu má za podmínek stanovených čl. 18 nařízení právo žádat, aby subjekt realizující výzkumný projekt omezil zpracování osobních údajů;
- Účastník výzkumného projektu má podmínek dle čl. 34 nařízení právo být informován o nastalém porušení zabezpečení osobních údajů, a to je-li pravděpodobné, že takový případ porušení zabezpečení osobních údajů bude mít za následek vysoké riziko pro práva a svobody fyzických osob;
- Účastník výzkumného projektu má v souladu s čl. 77 nařízení právo podat stížnost u některého dozorového úřadu, zejména v členském státě svého obvyklého bydliště, místa výkonu zaměstnání nebo místa, kde došlo k údajnému porušení, pokud se domnívá, že zpracováním jeho osobních údajů je porušeno nařízení.

Beru jako zákonný zástupce účastníka výzkumu na vědomí, že další informace o právech účastníka výzkumu ve vztahu ke zpracování osobních údajů obsahují čl. 15 až 22 a 34 nařízení.

Účastník výzkumu je oprávněn v souladu s čl. 7 nařízení kdykoli svůj souhlas odvolat, a to sdělením o odvolání souhlasu, adresovaným subjektu realizujícímu výzkumný projekt. Odvoláním souhlasu není dotčena zákonnost zpracování osobních údajů před odvoláním souhlasu.

Beru na vědomí, že osobní a citlivé údaje účastníka výzkumu bude Univerzita Palackého v Olomouci shromažďovat a dále zpracovávat prostřednictvím svých pověřených zaměstnanců.

4. Informace o způsobu využití výsledků výzkumného projektu:

Výsledky výzkumného projektu budou využity k vědeckým účelům, k publikačním výstupům v rámci zahraničních impaktovaných a domácích recenzovaných vědeckých periodikách, záznamy budou využity v rámci webových stránek DIPEx za účelem online zpřístupnění odborné i široké veřejnosti po celém světě, to vždy po předchozím písemném souhlasu každého účastníka výzkumu. Výsledky výzkumného projektu budou subjektem realizujícím projekt dále použity na přenosných discích a jiných úložištích při vzdělávání akademických pracovníků, zdravotnických i nezdravotnických profesí.

5. Prohlášení zákonného zástupce účastníka výzkumu:

	ano	ne
1. Potvrzuji, že jsem si přečetl/a tento informovaný souhlas týkající se výše uvedeného výzkumu, včetně všech jeho příloh, a porozuměl/a mu.	☐	☐
2. Prohlašuji, že jsem byl/a poučena o možnosti klást otázky a tyto mi byly uspokojivě zodpovězeny. Rovněž prohlašuji, že všem výše uvedeným skutečnostem a poskytnutým informacím rozumím a beru je na vědomí. Nemám žádné další otázky ani nejasnosti a vyslovuji svůj výslovný souhlas s účastí účastníka výzkumu na výzkumném projektu.	☐	☐
3. Prohlašuji, že jsem plně způsobilý/á k právním úkonům a jako takový/á prohlašuji, že jsem informován/a o skutečnosti, že účast účastníka výzkumu v projektu je dobrovolná a že účastník výzkumu je oprávněn kdykoliv z výzkumného projektu odstoupit.	☐	☐
4. Prohlašuji, že beru na vědomí informace obsažené v tomto informovaném souhlasu a souhlasím se zpracováním osobních a citlivých údajů účastníka výzkumu v rozsahu a způsobem a za účelem specifikovaným v tomto informovaném souhlasu.	☐	☐
5. Prohlašuji, že jsem účastníka výzkumu jakožto jeho zákonný zástupce seznámil/a s textem tohoto informovaného souhlasu, že jsem účastníka výzkumu poučila o jeho právech, která s tímto informovaným souhlasem, resp. se zpracováváním výše uvedených údajů, souvisejí.	☐	☐
6. Prohlašuji, že tento souhlas uděluji na základě předchozího podrobného projednání tohoto souhlasu s účastníkem výzkumu a po zvážení všech možných aspektů, že tento souhlas nepředstavuje svévolné zasahování do soukromého života účastníka výzkumu ani nepředstavuje nezákonný útok na čest a pověst účastníka výzkumu a že účastník výzkumu s udělením tohoto souhlasu souhlasí.	☐	☐

Tento souhlas je sepsán ve dvou vyhotoveních s povahou originálu, přičemž jedno vyhotovení obdrží prostřednictvím zákonného zástupce účastník výzkumu a jedno vyhotovení obdrží subjekt realizující výzkumný projekt.

Zákonný zástupce účastníka výzkumu:	Jméno a příjmení (tiskacím)	Podpis	Místo	Datum
Účastník výzkumu:	Jméno a příjmení (tiskacím)	Podpis	Místo	Datum
Výzkumník:	Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Přílohy: Informační list pro účastník, Údaje o účastníkovi

Evidenční číslo rozhovoru:

SVOLENÍ KPOUŽITÍ OBRAZOVÉHO/ZVUKOVÉHO/PÍSEMNÉHO PŘEPISU ZÁZNAMU ROZHOVORU

Subjekt realizující výzkumný projekt (studii):

Univerzita Palackého v Olomouci, Cyrilometodějská teologická fakulta, Institut sociálního zdraví (OUSHI)
Křížkovského 511/8, 771 47 Olomouc
IČ: 61989592
Kontaktní osoba: prof. Ing., Mgr. et Mgr. Peter Tavel, Ph.D., Univerzitní 22, 771 11 Olomouc, peter.tavel@oushi.upol.cz

Osoba, která provedla poučení účastníka výzkumného projektu (studie):

Účastník výzkumného projektu (studie):

Jméno a příjmení:

Datum narození:

Adresa:
(dále též jako „účastník výzkumu“)

Výzkumný projekt (studie): Inspirace v odlišnosti - Výzva č. 02_16_037 pro Podporu žáků se zdravotním postižením I (Implementace APIV) v prioritní ose 3 O**P** (dále jen “výzkumný projekt”)
Období realizace výzkumného projektu: 2018-2020
Hlavní řešitel výzkumného projektu: prof. Ing., Mgr. et Mgr. Peter Tavel, Ph.D.

Jméno výzkumníka: ……

Jakožto účastník výzkumu prohlašuji, že jsem podpisem dokumentu ze dne …………………………… (evidenční číslo rozhovoru ……………………………), nazvaného „Informovaný souhlas“, vyslovil/a svůj souhlas s pořízením obrazového a zvukového záznamu a se zpracováním osobních údajů, a to za podmínek a v rozsahu uvedených ve výše uvedeném Informovaném souhlasu. Jakožto účastník výzkumu beru na vědomí, že toto svolení k použití zvukového záznamu a písemného přepisu záznamu rozhovoru (dále jen „Svolení k použití“) navazuje na výše uvedený Informovaný souhlas a že informace, poučení a práva a povinnosti vyplývající z výše uvedeného Informovaného souhlasu plynou i ve vztahu k tomuto Svolení k použití.
Uděluji, jakožto účastník výzkumu, svolení podle ust. **§ 85 a ust. § 892 zákona č. 89/2012 Sb., občanský zákoník,** ve znění pozdějších předpisů, k použití **obrazového/zvukového/písemného přepisu záznamu rozhovoru v plném rozsahu (dále jen “souhlas”)**, vedeného pod výše uvedeným evidenčním číslem, pořízený dne …………………… za účelem:

- Zařazení obrazového/zvukového/písemného záznamu do souboru nahrávek (v souvislosti s daným výzkumným projektem) dostupného na webových stránkách DIPEx (hovoryozdravi.cz a hovoryovzdelavani.cz) v rozsahu uvedeném níže, přičemž si uvědomuji, že záznam bude přístupný uživatelům internetu po celém světě.
- Rozmnožování a nahrávky na přenosných discích pro vzdělávací potřeby zdravotnických i nezdravotnických profesí, které přicházejí do styku s předmětnou problematikou.

Současně prohlašuji, že jsem byl seznámen/a se skutečností, že jednou dané svolení k pořízení zvukového záznamu účastníka výzkumu lze kdykoliv odvolat, a to na základě písemného vyrozumění adresovaného subjektu realizujícímu výzkumný projekt.

Souhlasím s tím, aby byl **obrazový/zvukový záznam/písemný přepis** rozhovoru v plném rozsahu použit následujícím způsobem *(zaškrtněte políčka všeho, co platí)*:

ano	ne	
☐	☐	zpřístupnění video záznamu rozhovoru
☐	☐	zpřístupnění zvukového záznamu rozhovoru
☐	☐	zpřístupnění písemného přepisu rozhovoru
☐	☐	při vzdělávání osob zdravotnických i nezdravotnických profesí
☐	☐	pro vědecké účely

V případě nesouhlasu s uveřejněním audio nebo video záznamu: Přeji si, aby byl video/audio záznam zpracován následujícím způsobem *(výzkumník s ním probere možnosti úpravy zvuku zde):*

Prohlašuji, že jsem se seznámil/a s textem tohoto souhlasu, že jsem byl poučen o právech, která s tímto souhlasem souvisejí.

Tento souhlas je zpracován ve dvou vyhotoveních s povahou originálu, přičemž jedno vyhotovení obdrží účastník výzkumného projektu a jedno vyhotovení obdrží subjekt realizující výzkumný projekt.

Nahrávka byla zaznamenána jako (zaškrtněte všechna platná pole)

	ano	ne		ano	ne
Audio	☐	☐	Video	☐	☐

Účastník výzkumu:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Výzkumník:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Účastník výzkumu je oprávněn v souladu s čl. 7 nařízení kdykoli svůj souhlas odvolat, a to sdělením o odvolání souhlasu, adresovaným subjektu realizujícímu výzkumný projekt. Odvoláním souhlasu není dotčena zákonnost zpracování osobních údajů před odvoláním souhlasu.

Beru na vědomí, že osobní a citlivé údaje účastníka výzkumu bude Univerzita Palackého v Olomouci shromažďovat a dále zpracovávat prostřednictvím svých pověřených zaměstnanců.

4. **Informace o způsobu využití výsledků výzkumného projektu:**

Výsledky výzkumného projektu budou využity k vědeckým účelům, k publikačním výstupům v rámci zahraničních impaktovaných a domácích recenzovaných vědeckých periodikách, záznamy budou využity v rámci webových stránek DIPEx za účelem online zpřístupnění odborné i široké veřejnosti po celém světě, to vždy po předchozím písemném souhlasu každého účastníka výzkumu. Výsledky výzkumného projektu budou subjektem realizujícím projekt dále použity na přenosných discích a jiných úložištích při vzdělávání akademických pracovníků, zdravotnických i nezdravotnických profesí.

5. **Prohlášení účastníka výzkumu:**

	ano	ne
1. Potvrzuji, že jsem si přečetl/a tento informovaný souhlas týkající se výše uvedeného výzkumu, včetně všech jeho příloh, a porozuměl/a mu.	☐	☐
2. Prohlašuji, že jsem byl/a poučen/a o možnosti klást otázky a tyto mi byly uspokojivě zodpovězeny. Rovněž prohlašuji, že všem výše uvedeným skutečnostem a poskytnutým informacím rozumím a beru je na vědomí. Nemám žádné další otázky ani nejasnosti a vyslovuji svůj výslovný souhlas s účastí účastníka výzkumu na výzkumném projektu.	☐	☐
3. Prohlašuji, že jsem plně způsobilý/á k právním úkonům a jako takový/á prohlašuji, že jsem informován/a o skutečnosti, že účast účastníka výzkumu v projektu je dobrovolná a že účastník výzkumu je oprávněn kdykoliv z výzkumného projektu odstoupit.	☐	☐
4. Prohlašuji, že beru na vědomí informace obsažené v tomto informovaném souhlasu a souhlasím se zpracováním osobních a citlivých údajů účastníka výzkumu v rozsahu a způsobem a za účelem specifikovaným v tomto informovaném souhlasu.	☐	☐

Tento souhlas je sepsán ve dvou vyhotoveních s povahou originálu, přičemž jedno vyhotovení obdrží účastník výzkumu a jedno vyhotovení obdrží subjekt realizující výzkumný projekt.

Účastník výzkumu:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Výzkumník:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Přílohy: Informační list pro účastníka, Údaje o účastníkovi

Tento souhlas je sepsán ve dvou vyhotoveních s povahou originálu, přičemž jedno vyhotovení obdrží prostřednictvím zákonného zástupce účastník výzkumu a jedno vyhotovení obdrží subjekt realizující výzkumný projekt.

Zákonný zástupce účastníka výzkumu:	Jméno a příjmení (tiskacím)	Podpis	Místo	Datum
Účastník výzkumu:	Jméno a příjmení (tiskacím)	Podpis	Místo	Datum
Výzkumník:	Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Přílohy: Informační list pro účastník, Údaje o účastníkovi

4 Participant data (parents/teachers of children with ADHD)

Evidenční číslo rozhovoru:

ÚDAJE O ÚČASTNÍKOVI

Jméno.. Věk [W] .... Pohlaví [W] ....
Adresa ....
Telefonní č. .... Datum narození ....
Emailová adresa ....
Vyplní výzkumník, pokud byl vyplněn vstupní formulář

Jméno a tel. číslo přítele nebo příbuzného pro jinou možnost kontaktu ....
....
Preferované jméno pro webové stránky [W] .... Rodinný stav [W] ....
Počet dětí [W] ....Věk dětí .... Počet dětí s ADHD [W] .... Doba od zjištění diagnózy.............
Počet osob v domácnosti [W]..Země narození ....
Vzdělání ....Etnická příslušnost/národnost ....

Současné zaměstnání [W] ....
Výčet zaměstnání v průběhu života (zakroužkujte jedno pro Vás nejdůležitější z nich) ....
....
....

Zaškrtněte všechna odpovídající políčka týkající se Vašeho nejdůležitějšího (zakroužkovaného) zaměstnání:

- ☐ zaměstnanec
- ☐ OSVČ
- ☐ pracující sam nebo s partnery
- ☐ se zaměstnanci
- ☐ vedoucí pracovník

Účastník předběžně souhlasil se zveřejněním výše uvedených osobních dat na webové stránce a s uveřejněním rozhovoru v podobě video/audio/písemný přepis* ☐

Místo rozhovoru...(tj. doma/v práci/na klinice atd.)
Kontakt pro rozhovor ....(tj. praktický lékař/podpůrná skupina/odborný lékař atd.)
Výzkumník .... Datum rozhovoru .... Metoda nahrávání: audio/video*
Poznámky (co si účastník přeje/nepřeje a další)...
....
Vyplní výzkumník

Svým podpisem stvrzuji, že výše uvedené údaje o mojí osobě jsou pravdivé a souhlasím s jejich zpracováním pro výzkumné účely a webové stránky DIPEx.

Účastník projektu:...
Jméno a příjmení (tiskacím) | Podpis | Místo | Datum

[W]tyto údaje budou zveřejněny na webu DIPEx, ostatní slouží jen ke zpracování pro výzkumné účely *nehodící se škrtněte*

(4) Údaje o účastníkovi, DIPEx 2016/2017

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5 Informed consent (parents/teachers of students with ADHD)

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Evidenční číslo rozhovoru:

INFORMOVANÝ SOUHLAS

Souhlas účastníka výzkumného projektu spořízením fotografií, zvukového a obrazového záznamu a se zpracováním osobních a citlivých údajů

Subjekt realizující výzkumný projekt (studii):

Univerzita Palackého v Olomouci, Cyrilometodějská teologická fakulta, Institut sociálního zdraví (OUSHI)
Křížkovského 511/8, 771 47 Olomouc
IČ: 61989592
Kontaktní osoba: PhDr. Lucie Klůzová Kráčmarová, Ph.D., Univerzitní 22, 771 11 Olomouc,
lucie.kluzova@oushi.upol.cz

Jméno výzkumníka

Osoba, která provedla poučení účastníka výzkumného projektu (studie)

Účastník výzkumného projektu (studie):

Jméno a příjmení

Datum narození

Adresa
(dále též jako „účastník výzkumu")

Výzkumný projekt (studie): Inspirace v odlišnosti - Výzva č. 02_16_037 pro Podporu žáků se zdravotním postižením I (Implementace APIV) v prioritní ose 3 O**P** (dále jen "výzkumný projekt")
Období realizace výzkumného projektu: 2018-2020
Hlavní řešitel výzkumného projektu: prof. Ing., Mgr. et Mgr. Peter Tavel, Ph.D.

Vážená paní, vážený pane,
obracíme se na Vás se žádostí o spolupráci na výzkumném projektu, jehož cílem je zkoumání zkušeností dětí od 10 do 18 let s ADHD, jejich rodičů a pedagogů. Prostřednictvím informačního listu, který tvoří nedílnou součást tohoto Souhlasu účastníka výzkumného projektu s pořízením fotografií, zvukového a obrazového záznamu a se zpracováním osobních a citlivých údajů Vám byly představeny základní informace o výzkumu. Z účasti na výzkumu pro Vás vyplývají určité výhody, ale i rizika, se kterými budete seznámeni níže.

1. **Udělení souhlasu s pořízením fotografií, zvukového a obrazového záznamu**

Uděluji svolení podle ust. §§ 84 a 85 a ust. § 892 zákona č. 89/2012 Sb., občanský zákoník, ve znění pozdějších předpisů, k pořízení fotografií, zvukového a obrazového záznamu a jejich kopií týkající se účastníka výzkumu za účelem zkoumání, zpracování, analýzy a zveřejnění výstupů do souboru „zkušeností se zdravím a nemocí" a dále za účelem vědeckým, zejména k publikačním výstupům v rámci zahraničních a domácích vědeckých periodikách, záznamy (audio/video) budou využity v rámci webových stránek hovoryozdravi.cz a hovoryovzdelavani.cz za účelem online zpřístupnění odborné i široké veřejnosti po celém světě, to vždy po předchozím písemném souhlasu každého účastníka výzkumu. Výsledky výzkumného projektu budou subjektem realizujícím projekt dále použity na přenosných discích a jiných úložištích při vzdělávání akademických pracovníků, zdravotnických i nezdravotnických profesí.

2. **Prohlášení účastníka výzkumu:**

Současně prohlašuji, že jsem byl seznámen se skutečností, že jednou dané svolení k pořízení fotografií, zvukového a obrazového záznamu účastníka výzkumu lze kdykoliv odvolat, a to na základě písemného vyrozumění adresovaného subjektu realizujícímu výzkumný projekt.

3. **Informace o zpracování osobních údajů účastníka výzkumu v průběhu a po skončení výzkumného projektu**

Veškerá práva a povinnosti při zpracování osobních údajů se řídí nařízením Evropského parlamentu a Rady EU 2016/679 ze dne 27. dubna 2016 o ochraně fyzických osob v souvislosti se zpracováním osobních údajů a o volném pohybu těchto údajů a o zrušení směrnice 95/46/ES (dále jen „nařízení"). Pro účely vedení evidence týkající se výzkumného projektu a pro účely týkající se evidence, vyhodnocení a použití výsledků projektu, budou subjektem realizujícím výzkumný projekt zpracovány následující osobní a citlivé údaje o účastníkovi výzkumu:

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a) jméno a příjmení,
b) datum narození, věk,
c) pohlaví,
d) adresa, telefonní číslo, email
e) počet osob v domácnosti,
f) země narození,
g) etnická příslušnost/národnost,
h) informace o zdravotním stavu (diagnóza, věk při diagnostikování),
i) vzdělání (ročník a typ školy).

(dále jen „osobní a citlivé údaje“).

Poskytnutí osobních a citlivých údajů účastníkem výzkumu subjektu realizujícímu výzkumný projekt je dobrovolné. Pokud účastník výzkumu odmítne poskytnout subjektu realizujícímu výzkumný projekt uvedené osobní a citlivé údaje, nemůže se výzkumného projektu zúčastnit. Zpracováním osobních a citlivých údajů se rozumí shromažďování těchto osobních a citlivých údajů, ukládání na nosiče informací, jejich vyhledávání, používání, uchovávání, přepis záznamů obsahujících osobní a citlivé údaje do písemné podoby a případně reprodukce těchto písemných přepisů třetími osobami, třídění a likvidace. Subjekt realizující výzkumný projekt bude zpracovávat osobní a citlivé údaje pouze v souladu s účelem, k němuž byly shromážděny. Osobní a citlivé údaje budou subjektem realizujícím výzkumný projekt zpracovávány po dobu neurčitou.

Beru jako účastník výzkumu na vědomí, že pozici pověřence pro ochranu osobních údajů u subjektu realizujícího výzkumný projekt vykonává kancléř Univerzity Palackého v Olomouci, přičemž jej lze kontaktovat na výše uvedené adrese sídla subjektu realizujícího výzkumný projekt.

Beru jako účastník výzkumu na vědomí také následující poučení činěná ze strany subjektu realizujícího výzkumný projekt v souvislosti s výše popsaným zpracováním osobních údajů dle čl. 13 nařízení, popř. podle čl. 15 až 22, 34 a 77 nařízení:

- Účastník výzkumného projektu má dle čl. 15 nařízení právo získat od subjektu realizujícího výzkumný projekt potvrzení, zda osobní údaje, které se jej týkají, jsou či nejsou zpracovány, a pokud jsou zpracovány, má právo získat přístup k těmto osobním údajům a k souvisejícím informacím vymezeným čl. 15 odst. 1 písm. a) - h) nařízení;
- Účastník výzkumného projektu má za podmínek dle čl. 15 nařízení právo na bezúplatné poskytnutí jedné kopie zpracovávaných osobních údajů;
- Účastník výzkumného projektu má dle čl. 16 nařízení právo na opravu nepřesných osobních údajů, které se jej týkají, případně právo na doplnění neúplných osobních údajů;
- Účastník výzkumného projektu má dle čl. 17 nařízení právo na to, aby subjekt realizující výzkumný projekt bez zbytečného odkladu vymazal osobní údaje, které se jej týkají, a to za podmínek stanovených článkem 17 nařízení, tedy zejména pokud:

  a) osobní údaje již nejsou potřebné pro účely, pro které byly shromážděny nebo jinak zpracovány;
  b) je odvolán souhlas, na jehož základě byly údaje podle čl. 6 odst. 1 písm. a) nařízení nebo čl. 9 odst. 2 písm. a) nařízení zpracovány, a neexistuje žádný další právní důvod pro zpracování;
  c) jsou vzneseny námitky proti zpracování podle čl. 21 odst. 1 nařízení a neexistují žádné převažující oprávněné důvody pro zpracování nebo jsou vzneseny námitky proti zpracování podle čl. 21 odst. 2 nařízení;
  d) osobní údaje byly zpracovány protiprávně;
  e) osobní údaje musí být vymazány ke splnění právní povinnosti stanovené v právu Evropské unie nebo členského státu, které se na správce osobních údajů (subjekt realizující výzkumný projekt) vztahuje;
  f) osobní údaje byly shromážděny v souvislosti s nabídkou služeb informační společnosti podle čl. 8 odst. 1 nařízení;

- Účastník výzkumného projektu má za podmínek stanovených čl. 18 nařízení právo žádat, aby subjekt realizující výzkumný projekt omezil zpracování osobních údajů;
- Účastník výzkumného projektu má podmínek dle čl. 34 nařízení právo být informován o nastalém porušení zabezpečení osobních údajů, a to je-li pravděpodobné, že takový případ porušení zabezpečení osobních údajů bude mít za následek vysoké riziko pro práva a svobody fyzických osob;
- Účastník výzkumného projektu má v souladu s čl. 77 nařízení právo podat stížnost u některého dozorového úřadu, zejména v členském státě svého obvyklého bydliště, místa výkonu zaměstnání nebo místa, kde došlo k údajnému porušení, pokud se domnívá, že zpracováním jeho osobních údajů je porušeno nařízení.

Beru jako účastník výzkumu na vědomí, že další informace o právech účastníka výzkumu ve vztahu ke zpracování osobních údajů obsahují čl. 15 až 22 a 34 nařízení.

Účastník výzkumu je oprávněn v souladu s čl. 7 nařízení kdykoli svůj souhlas odvolat, a to sdělením o odvolání souhlasu, adresovaným subjektu realizujícímu výzkumný projekt. Odvoláním souhlasu není dotčena zákonnost zpracování osobních údajů před odvoláním souhlasu.

Beru na vědomí, že osobní a citlivé údaje účastníka výzkumu bude Univerzita Palackého v Olomouci shromažďovat a dále zpracovávat prostřednictvím svých pověřených zaměstnanců.

4. Informace o způsobu využití výsledků výzkumného projektu:

Výsledky výzkumného projektu budou využity k vědeckým účelům, k publikačním výstupům v rámci zahraničních impaktovaných a domácích recenzovaných vědeckých periodikách, záznamy budou využity v rámci webových stránek DIPEx za účelem online zpřístupnění odborné i široké veřejnosti po celém světě, to vždy po předchozím písemném souhlasu každého účastníka výzkumu. Výsledky výzkumného projektu budou subjektem realizujícím projekt dále použity na přenosných discích a jiných úložištích při vzdělávání akademických pracovníků, zdravotnických i nezdravotnických profesí.

5. Prohlášení účastníka výzkumu:

	ano	ne
1. Potvrzuji, že jsem si přečetl/a tento informovaný souhlas týkající se výše uvedeného výzkumu, včetně všech jeho příloh, a porozuměl/a mu.	☐	☐
2. Prohlašuji, že jsem byl/a poučen/a o možnosti klást otázky a tyto mi byly uspokojivě zodpovězeny. Rovněž prohlašuji, že všem výše uvedeným skutečnostem a poskytnutým informacím rozumím a beru je na vědomí. Nemám žádné další otázky ani nejasnosti a vyslovuji svůj výslovný souhlas s účastí účastníka výzkumu na výzkumném projektu.	☐	☐
3. Prohlašuji, že jsem plně způsobilý/á k právním úkonům a jako takový/á prohlašuji, že jsem informován/a o skutečnosti, že účast účastníka výzkumu v projektu je dobrovolná a že účastník výzkumu je oprávněn kdykoliv z výzkumného projektu odstoupit.	☐	☐
4. Prohlašuji, že beru na vědomí informace obsažené v tomto informovaném souhlasu a souhlasím se zpracováním osobních a citlivých údajů účastníka výzkumu v rozsahu a způsobem a za účelem specifikovaným v tomto informovaném souhlasu.	☐	☐

Tento souhlas je sepsán ve dvou vyhotoveních s povahou originálu, přičemž jedno vyhotovení obdrží účastník výzkumu a jedno vyhotovení obdrží subjekt realizující výzkumný projekt.

Účastník výzkumu:

Jméno a příjmení (tiskacím) Podpis Místo Datum

Výzkumník:

Jméno a příjmení (tiskacím) Podpis Místo Datum

Přílohy: Informační list pro účastníka, Údaje o účastníkovi

Evidenční číslo rozhovoru:

SVOLENÍ KPOUŽITÍ OBRAZOVÉHO/ZVUKOVÉHO/PÍSEMNÉHO PŘEPISU ZÁZNAMU ROZHOVORU

Subjekt realizující výzkumný projekt (studii):

Univerzita Palackého v Olomouci, Cyrilometodějská teologická fakulta, Institut sociálního zdraví (OUSHI)
Křížkovského 511/8, 771 47 Olomouc
IČ: 61989592
Kontaktní osoba: prof. Ing., Mgr. et Mgr. Peter Tavel, Ph.D., Univerzitní 22, 771 11 Olomouc, peter.tavel@oushi.upol.cz

Osoba, která provedla poučení účastníka výzkumného projektu (studie):

Účastník výzkumného projektu (studie):

Jméno a příjmení:

Datum narození:

Adresa:
(dále též jako „účastník výzkumu“)

Výzkumný projekt (studie): Inspirace v odlišnosti - Výzva č. 02_16_037 pro Podporu žáků se zdravotním postižením I (Implementace APIV) v prioritní ose 3 O**P** (dále jen “výzkumný projekt”)
Období realizace výzkumného projektu: 2018-2020
Hlavní řešitel výzkumného projektu: prof. Ing., Mgr. et Mgr. Peter Tavel, Ph.D.

Jméno výzkumníka: ………

Jakožto účastník výzkumu prohlašuji, že jsem podpisem dokumentu ze dne ……………………………. (evidenční číslo rozhovoru ……………………………), nazvaného „Informovaný souhlas“, vyslovil/a svůj souhlas s pořízením obrazového a zvukového záznamu a se zpracováním osobních údajů, a to za podmínek a v rozsahu uvedených ve výše uvedeném Informovaném souhlasu. Jakožto účastník výzkumu beru na vědomí, že toto svolení k použití zvukového záznamu a písemného přepisu záznamu rozhovoru (dále jen „Svolení k použití“) navazuje na výše uvedený Informovaný souhlas a že informace, poučení a práva a povinnosti vyplývající z výše uvedeného Informovaného souhlasu plynou i ve vztahu k tomuto Svolení k použití.
Uděluji, jakožto účastník výzkumu, svolení podle ust. **§ 85 a ust. § 892 zákona č. 89/2012 Sb., občanský zákoník,** ve znění pozdějších předpisů, k použití **obrazového/zvukového/písemného přepisu záznamu rozhovoru v plném rozsahu (dále jen “souhlas”)**, vedeného pod výše uvedeným evidenčním číslem, pořízený dne …………………… za účelem:

- Zařazení obrazového/zvukového/písemného záznamu do souboru nahrávek (v souvislosti s daným výzkumným projektem) dostupného na webových stránkách DIPEx (hovoryozdravi.cz a hovoryovzdelavani.cz) v rozsahu uvedeném níže, přičemž si uvědomuji, že záznam bude přístupný uživatelům internetu po celém světě.
- Rozmnožování a nahrávky na přenosných discích pro vzdělávací potřeby zdravotnických i nezdravotnických profesí, které přicházejí do styku s předmětnou problematikou.

Současně prohlašuji, že jsem byl seznámen/a se skutečností, že jednou dané svolení k pořízení zvukového záznamu účastníka výzkumu lze kdykoliv odvolat, a to na základě písemného vyrozumění adresovaného subjektu realizujícímu výzkumný projekt.

Souhlasím s tím, aby byl **obrazový/zvukový záznam/písemný přepis** rozhovoru v plném rozsahu použit následujícím způsobem *(zaškrtněte políčka všeho, co platí)*:

ano	ne	
☐	☐	zpřístupnění video záznamu rozhovoru
☐	☐	zpřístupnění zvukového záznamu rozhovoru
☐	☐	zpřístupnění písemného přepisu rozhovoru
☐	☐	při vzdělávání osob zdravotnických i nezdravotnických profesí
☐	☐	pro vědecké účely

V případě nesouhlasu s uveřejněním audio nebo video záznamu: Přeji si, aby byl video/audio záznam zpracován následujícím způsobem *(výzkumník s ním probere možnosti úpravy zvuku zde):*

Prohlašuji, že jsem se seznámil/a s textem tohoto souhlasu, že jsem byl poučen o právech, která s tímto souhlasem souvisejí.

Tento souhlas je zpracován ve dvou vyhotoveních s povahou originálu, přičemž jedno vyhotovení obdrží účastník výzkumného projektu a jedno vyhotovení obdrží subjekt realizující výzkumný projekt.

Nahrávka byla zaznamenána jako (zaškrtněte všechna platná pole)

	ano	ne		ano	ne
Audio	☐	☐	Video	☐	☐

Účastník výzkumu:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

Výzkumník:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

6 Participant data (teachers of children with ADHD)

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Evidenční číslo rozhovoru:

ÚDAJE O ÚČASTNÍKOVI-PEDAGOG

Jméno   Věk [W]   Pohlaví [W]

Adresa   Kraj

Telefonní č.   Datum narození

Země narození

Emailová adresa

Vyplní výzkumník, pokud byl vyplněn vstupní formulář

Jméno a tel. číslo přítele nebo příbuzného pro jinou možnost kontaktu

Preferované jméno pro webové stránky [W]   Rodinný stav [W]

Počet dětí [W]   Věk dětí   Počet dětí s ADHD [W] .... Doba od zjištění diagnózy

Počet osob v domácnosti [W]

Vzdělání   Etnická příslušnost/národnost

Vy a ADHD* mám/nemám/nemám diagnostikováno/nevím

Informace o dítěti/dětech s ADHD a Vašem zájmu o toto téma:

S kolik dětmi s ADHD máte zkušenost:

Aktivně se v tématu ADHD* vzdělávám/nevzdělávám/jiné:

Pokud se vzděláváte, jakým způsobem:

Do šíření osvěty o ADHD se aktivně* zapojuji/nezapojuji/jiné:

Pokud se zapojujete, jakým způsobem:

Současné zaměstnání [W]

Výčet zaměstnání v průběhu života (zakroužkujte jedno pro Vás nejdůležitější z nich)

Zaškrtněte všechna odpovídající políčka týkající se Vašeho nejdůležitějšího (zakroužkovaného) zaměstnání:

☐ zaměstnanec   ☐ pracující sam nebo s partnery   ☐ vedoucí pracovník
☐ OSVČ   ☐ se zaměstnanci

1

[W]*tyto údaje budou zveřejněny na webu DIPEx, ostatní slouží jen ke zpracování pro výzkumné účely*   **nehodící se škrtněte*

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hovoryozdravi.cz MINISTERSTVO ŠKOLSTVÍ, MLÁDEŽE A TĚLOVÝCHOVY Institut sociálního zdraví Univerzity Palackého

Účastník předběžně souhlasil se zveřejněním výše uvedených osobních dat na webové stránce a s uveřejněním rozhovoru v podobě video/audio/písemný přepis* ☐

Místo rozhovoru		(tj. doma/v práci/na klinice atd.)
Kontakt pro rozhovor		(tj. praktický lékař/podpůrná skupina/odborný lékař atd.)
Výzkumník	Datum rozhovoru	Metoda nahrávání: audio/video*
Poznámky (co si účastník přeje/nepřeje a další)		
		Vyplní výzkumník

Svým podpisem stvrzuji, že výše uvedené údaje o mojí osobě jsou pravdivé a souhlasím s jejich zpracováním pro výzkumné účely a webové stránky DIPEx.

Účastník projektu:

Jméno a příjmení (tiskacím)	Podpis	Místo	Datum

2

W*tyto údaje budou zveřejněny na webu DIPEx, ostatní slouží jen ke zpracování pro výzkumné účely* **nehodící se škrtněte*

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