CHOSEN POSSIBILITIES OF DEVELOPING SOCIAL COMPETENCES OF ADULTS WITH ATTENTION DEFICIT / HYPERACTIVITY DISORDER

[a]MARIANNA MÜLLER DE MORAIS, [b]PETRA JEDLIČKOVÁ

Constantine the Philosopher University in Nitra, Department of Pedagogy, Drážovska cesta 4, 949 74 Nitra, Slovakia
email: [a]mmdmorais@ukf.sk, [b]jedlickova@ukf.sk

Abstract: All people - children, adults and seniors - are able to develop their personalities. This raises many questions related to the development of social competences of people who have Attention Deficit / Hyperactivity Disorder also in their adulthood. Our target group is formed by adults who need to develop their social competences more intensively due to the consequences of their disorder so that they are able to live in their family, social or work environment in a more optimal and integrated way. Our study presents chosen possibilities of developing social competences of adults with ADHD by means of a training programme that is based on the cognitive-behavioural approach.

Key words: adult with ADHD, training of social competences, training programme, cognitive-behavioural approach;

1 Introduction

Even nowadays there has still been valid the general opinion that hyperactivity is related only to children and therefore it is a problem only in younger or older school age. Many people also think that symptoms of Attention Deficit / Hyperactivity Disorder will "naturally disappear" with maturing of the central nervous system. However, almost half of people with the ADHD syndrome still have this disorder in their adulthood and for this reason they have problems to study, work, entertain themselves, enter into contact, and keep their friendships and partnerships.
We do not have many data about adult individuals who were diagnosed with ADHD. There are usually accessible only the statistics from the psychiatric institutions, anti-alcoholic facilities or prisons. This fact does not contribute to the positive perception of this target group. However, it is important to emphasize here the fact that these statistics describe only such cases of children with the given disorder whose development to the adulthood was going in a wrong and devious way (Žáčková, H., Jucovičová, D., 2017b). At this time we already know that many negative symptoms of the ADHD syndrome can be alleviated or even completely eliminated with purposeful training, practising and applying of several approaches. On the other side, many positive qualities can be developed and used for learning strategies of newer, more acceptable ways of behaviour. For this reason, one of the aims of our article is to point out the fact that this can be carried out by means of our training of social competences that is later specified and described in more details.

2 ADHD in adulthood

ADHD, Attention Deficit/Hyperactivity Disorder, belongs to such disorders whose symptoms change with the course of time. Some people will "lose" this disorder when they grow up but in 35%-60% of individuals these symptoms are still present in their adulthood. Their hyperactivity is ceasing to count (it is rather perceived as a feeling of inner inquietude or subjective need to do something all the time). There still remain problems with attention, concentration, distraction, irritability, impulsiveness (in adults, they can lead to attacks of anger, manifold addictions, irresponsible or unpredictable acting), emotional lability, low frustration tolerance and immaturity. This tumultuousness in behavior is more evident in adults than in children with ADHD. People with the syndrome of hyperactivity also have a higher tendency to behave in antisocial and self-destructive way. ADHD has significantly different forms in adults when compared to children. The hyperactivity in children is usually reflected in incessant physical doing of something, whereas in adults it is more about their hyperactive mind that never sleeps and thinks all the time. This kind of mind is making people feel exhausted, causing them also many other smaller or bigger problems (Pugnerová, M., Kvintová, J., 2016; Paclt, I. a kol., 2013; Paclt, I., 2002; Masopust, J., Mohr, P., Anders, M., 2014).

Despite their excellent cognitive abilities, this attention disorder can be the reason of unfinished study and lower financial evaluation of adults with ADHD, and therefore many of them feel ashamed and socially disadvantaged. In this target group we can also meet with problems of self-presentation and self-confidence. They are at higher risk of having a distorted relationship between a parent and a child, and for this reason their children have more psychopathological problems than their peers. Adult individuals with ADHD create and form functional compensation mechanisms such as practising sport or choosing an action type of job, writing a diary, or they try manifold meditation techniques. Unfortunately, these mechanisms can be dysfunctional as well. Postponing unpleasant tasks to later time or taking drugs to alleviate symptoms of their disorder can be included into this type of mechanisms (Masopust, J., Mohr, P., Anders, M., 2014).

When talking about their work relationships and obligations, hyperactive people are often perceived as "irresponsible" ones because they tend to leave their work unfinished, they come to work late, they do not meet deadlines, they forget important facts, and they do not respect authority of their bosses or used work strategies. Their work abilities are reduced and they have lower working potential. They prefer independent work. Since they are not able to satisfy their needs, they often burn out or change jobs. On the other side, these hyperactive people can be very hard-working and they often become workaholics. Their high working speed can be inconvenient for their colleagues and this fact does not contribute to their good and positive relationships at work. Adults with Attention Deficit/Hyperactivity disorder can make friends easily, but they have a reduced ability to keep these relationships. Their impulsiveness, emotional lability or changes in mood are very often the reason for impulsive breaking up of their friendships. This difficulty to maintain longer relationships is later also manifested in their partnerships. Some personal characteristic features of hyperactive individuals put the stability of their relationships at risk (Žáčková, H., Jucovičová, D., 2017a)

The diagnostic and statistical manual of psychological disorders DSM-5 from the year 2013 brought some changes in the diagnostics of ADHD in the adulthood (in individuals above the age of 17). This manual does not define the subtypes of this disorder like DSM-4, but it describes the forms of ADHD. This approach is better in observing the occurrence of specific symptoms and their changes during particular developmental periods. Based on the number of symptoms, the manual differentiates a light, medium and difficult form of ADHD in its three forms:

1. Combined form (ADHD – C)
2. Form with the prevalence of hyperactivity and impulsiveness (ADHD – HI)
3. Form with the prevalence of attention deficit (ADHD – I or ADD) (Kvašná, L., 2015).

ADHD (Attention-Deficit/Hyperactivity Disorder) - the abbreviation denoting the equivalent of hyperkinetic disorder in MKCH 10, is commonly used in our context as well. DSM-5 divides 18 symptoms into two main groups - attention deficit and hyperactivity/impulsiveness. A very significant change can be seen in the age criterion of the occurrence of these symptoms. In DSM-IV the starting point was set before the child is seven years old, but in DSM-5 it is before the twelfth year of life. There is specified the need for the presence of six or more symptoms out of nine defined symptoms in order to confirm the diagnosis. For adults aged 17 + only five symptoms are required. This disorder can be diagnosed in the adulthood as well. The codes for specification enable to code the combined disorder, disorder with

the prevalent attention deficit and disorder with the predominant hyperactivity/impulsiveness. In case there was diagnosed ADHD in the past and currently there still remain some symptoms leading to distortions in functioning, but the diagnostic criteria are not fulfilled, we code the specification of "partial remission". (http://www.tdahytu.es/manual-para-diagnosticar-el-tdah-dsm-5/; Pečeňák, J., 2014).

Diagnostic criteria of ADHD according to DSM 5:
A. A persistent pattern of INATTENTION (1) and/or HYPERACTIVITY-IMPULSIVITY(2) that interferes with functioning or development. Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: *Note:* The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

1. Inattention
a) Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
b) Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
c) Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
e) Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
g) Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
h) Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i) Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2. Hyperactivity and impulsivity
a) Often fidgets with or taps hands or feet or squirms in seat.
b) Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
c) Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
d) Often unable to play or engage in leisure activities quietly.
e) Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
f) Often talks excessively.
g) Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
h) Often has difficulty waiting his or her turn (e.g., while waiting in line).
i) Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g.,at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal). (Masopust, J., Mohr, P., Anders, M., 2014).

In the course of the last 25 years the research has been aimed at the study of social competences of individuals diagnosed with Attention Deficit/Hyperactivity Disorder. Experts found out differences at the level of social competences in particular forms of ADHD that are mentioned above. Adults with ADHD-C show their negative and positive emotions in more intensive ways, they are more competitive and therefore they want to be evaluated as the best ones. They also desire to receive positive evaluation and feedback. On the contrary, individuals with ADHD-I are more passive, shy, their social inclusion is problematic and therefore they are often at the periphery of the social group. People evaluate them less positively, but they are also less actively rejected when compared to the first form of ADHD. However, in all three forms of this diagnosis our target group has the biggest problems with the social adaptation. The research dealing with describing social competences of people with ADHD divides these problems into four areas: *socio-cognitive deficit* (overestimation of oneself, absence of adequate self-perception, desire to be in the centre of attention and to be above the group), *limited social communication* (it seems to be problematic in relation to the environment), *limited emotional regulation* (reduced emotional competences: comprehension, expression and regulation of emotions, a lower level of understanding social situations), and *deficit of behavioural expressions* in social interactions (more chaotic, negative and unstable ways of behaviour in relationships, reduced ability to identify and accept the rules, destructive and negative attitudes) (Kvašná, L., 2015).

3 Emotional disorders and additional disorders in behaviour

People with ADHD suffer from distortions in the emotional area and their display belongs to the most serious symptoms of this disorder because they significantly influence their quality of life and, at the same time they can contribute or be the reason of failures in their interpersonal relationships. Therefore it is important for the given target group to participate in manifold trainings focused on the development of their social skills and competences.

In their childhood and also adulthood we can observe weakened emotional areas and our training could be effective for their development and also for the elimination of unsuitable ways of behaviour resulting from these deficit. We describe our training in the following part of our article. We deal mainly with these additional disorders: *emotional lability* (changes in mood), *increased affectivity* (strong emotional reactions of verbal and physical character), *low frustration tolerance* (inadequate reactions to weak impulses), *unrealistic self-perception and decreased self-confidence* (they are not self-confident, they underestimate themselves and compensate these feelings with attracting attention of other people), *lowered or weakened ability of empathy, increased egocentrism, weakened auto-regulation, neurotic expressions* (Žáčková, H., Jucovičová, D., 2017a; Žáčková, H., Jucovičová, D., 2014). Therefore the above mentioned problems are not related only to the period of childhood, but they influence the quality of life of adults with ADHD and their behaviour in family, partnerships, friendships and work relationships. It is not possible to eliminate the symptoms of the given syndrome completely, but these people need to learn how to live and cope with this syndrome.

However, it is possible to influence many symptoms accompanying ADHD by means of therapeutic guiding focused on self-knowing and solving or eliminating of mainly negative impacts on everyday life, or by means of training of social competences that is a subject of our article. Our training can be part of the therapeutic guiding where the clients are lead to the understanding of themselves, their own behaviour, reactions and their gradual controlling. In addition to learning how to control themselves and create a system in their life, they also learn to understand interpersonal relationships, they improve their ability of empathy, general social communication, and orientation in social situations, etc. They also acquire better skills in planning, time management, finishing of their tasks, and they learn to be responsible for their work and decisions. Furthermore, they learn to make use of the so called compensation mechanisms as well (Žáčková, H., Jucovičová, D., 2017a).

There are many therapeutic approaches and the most effective one seems to be the cognitive-behavioural therapy (KBT). For this reason we focus on this approach in our article. On its basis we created also our training programme with the aim to develop mainly the social competences of adult people with ADHD. The basis of the mentioned type of therapy is practising adequate behaviour and oppression (alleviation or elimination) of the negative behaviour. By means of manifold techniques such as modelling of situations, role playing, self-instruction (hyperactive people control their reactions of impulsiveness, distraction or increased emotionality) the target group learns the way of adaptive behaviour. The training of social competences seems to be very effective in forming our emotions. The inability to understand, name, process or guide the emotional experience of target group does not have to be related to wrong or problematic education but to the weakening and differences in the central nervous system.

The level of emotional experiencing can be depicted with the following pyramid:

(Žáčková, H., Jucovičová, D., 2017a).

In order to reach the stability of the pyramid it is necessary so that its particular levels are stable, including the lowest levels. We often meet with the fact that people with ADHD begin and finish at the first level - at the level of *OVERLOADING* with emotions , and therefore they are not able to handle and control their behaviour. In general, they have a tendency to be affective or to have strong and sudden emotional reactions of inadequate intensity. Their outburst is very fast and their course is very tumultuous. Overloading with emotions is a normal phenomenon but it is important not to stay in this stage, but to rise up to the top of the pyramid. This process is possible also by means of our training which helps people with ADHD to be aware of their own feelings, to name and describe their emotions, to be able to control them, and to show their empathy to other people in their surroundings (Žáčková, H., Jucovičová, D., 2014).

4 Developing social competences of adults with ADHD by means of a training programme

Currently the development of social competences has been at the centre of attention of many areas of social practice. Programmes aimed at developing social competences have become a part of lifelong education and psycho-therapeutic procedures. We understand training of social competences as a practical activity which support the process of (social and cognitive) learning based on interpersonal experience and emotional feelings. Its basic principle is the purposeful and organised development of social behaviour. The training is based on developing personal qualities of individuals, their social competences in the area of interpersonal perception, sensitivity, emotional self-expression, verbal and non-verbal communication, cooperation, assertiveness, effective solving of conflicts, auto-regulation of behavior, responsibility, etc.

The training of social competences can be carried out in the individual or group form. The individual form allows us to concentrate on the specific problems of the participant. This way is preferred when we work with a person with ADHD (and its health condition influenced with the given disorder requires it) or with a person who has problems with joining a group (Wilkinson, Canterová, 1982).

However, the group form has several advantages.The group creates a social situation which is already "a real situation". There are different types of people and this is a positive aspect in role playing and providing feedback. Members of the group represent different models and they can help others to realise that the model of the coach is not the only one 'correct' there. This form of learning is more effective when the models have features more similar to the observer / participant of the training (Bandura, Grusec, Menlove, 1967, in: Wilkinson, Canterová, 1982).

Though there are several reasons for having a group form of training, it could be more suitable for some types of clients to start with the individual form. These individual sessions take place simultaneously with the group training. In the practice the choice of the right form of training depends on the given situation and specific needs of clients. In both cases these training sessions should be beneficial mainly for the client (Wilkinson, Canterová, 1982)

The model of this group form of social training for adults with ADHD has a structured character and it is based on the cognitive behavioural approach (Liberman, Derisi, Muesser, 1989, Praško, Možný, Šlepecký et al., 2007, Wilkinson, Canterová, 1982 etc.). We also applied there our own longtime experience from carrying out trainings of social competences in different target groups.

The cognitive behavioural approach (see also Praško, Možný, Šlepecký et al, 2007) is based on the theory that the cause of psychological difficulties is found in wrong ways of thinking and behaving which are taught and kept by outer and inner factors. People are able to get rid of or re-learn these wrong ways of behaving, or they can learn newer, more suitable ways of behaviour which will enable them to adapt themselves to new situations more effectively and to solve their problems. Over the course of several decades, many behavioural methods have arisen (e.g. methods of creating new behaviour, methods of changing the existing behaviour - operational conditioning, etc.) as well as cognitive methods (e.g. cognitive re-structuralisation, self-briefing, etc.). They have a wide application not only in the therapeutic approach to the treatment of mental disorders but also some of them have been applied to the training of social competences and developing of social competences of the wider population. Social training as a model social situation is based on the assumption that there exists the process of cognitive and social learning in every group interaction. After completing the training, the acquired social competences and components of social behaviour can be applied to real life by means of transferring them from the model situation.

The aim of our designed training is to increase the social competence of adults with ADHD by means of developing social competences in the area of knowing themselves and others and in self-effectiveness *(the first part of the programme)*, in the area of interpersonal communication and self-confidence *(the second part)*. It can also help them to understand their emotions *(the third part)*, to solve conflicts and to cope with difficult situations

(the fourth part) and to be more creative *(the fifth part)*. Individual parts of the programme are mutually independent.

We recommend to carry out trainings in a form of small homogenous groups (according to the type and degree of disability). Each part requires 10 sessions. The sessions should be regular, taking place once a week. The length of these meetings depends on the health condition of the participants as well as on the specific needs resulting from ADHD. If it is possible, we recommend 60 minute sessions.

The traditional group session is divided into six parts. They can be adapted to the specific needs of the given group (Wilkinson, Canterová,1982, adapted by Hupková, 2010):

1. Warming up the group
After arriving, members of the group get acquainted with the new situation, establishing a feeling of safety and certainty within the group. Help them to understand any new conditions and start relaxing the group by means of some warm-up exercises. You can use the warm-up exercises as an introductory part of the training programme and a complement to other activities as well. Particular types of warm-up exercises can be created in order to practise different aspects of behaviour, which are trained during the sessions but are not related to specific situations, such as compared to role-play.

2. Instruction
Every session should be based on a certain topic (social competence) which can be related to nonverbal or verbal behaviour. The first step of training social competences to be achieved is letting the participants feel the need or desire to acquire the given social competence and understand its benefit. The task of the coach is to describe the given behaviour in detail and to explain its importance. The coach will explain to the participants why it is necessary to use this competence in the social interaction, what advantages are connected with its acquisition, and disadvantages we may meet if we do not know or do not use these expressions of behaviour. It is possible to create the need or desire to acquire social competences by means of a dialogue or discussion about the advantages of using them, or by using a film or video recording. It is very important that the coach gives clear and understandable instructions presented on basis of examples which should be similar to the situations the participants experience and should be expressed in a language which the participants understand without any problem and make sense to them. The instructions are not only given to inform participants about the social behaviour, but should also provide the basis for any subsequent training and role-play. The participants should be aware of what they are supposed to do during the role-play before taking part in them.

3. Modelling
The essence of modelling is the performance of a social competence by means of a living or symbolic model. It is subsequently followed by specific training of the given social competence. The training of the social competence starts in such a way that two volunteers are asked to perform the usage of the given social competence. Feedback is very important in this step. In this way useful information can be provided to the participants about their behaviour, what they are doing correct or incorrect, and what they lack the most so that they can improve and correct their behaviour. After practising there should follow a discussion where we can analyse their behaviour, look for the best ways for using the social competence, or some alternative options. Modelling and practising the behaviour of participants necessarily needs guiding and controlling by the coach of the training, mainly by means of verbal instruction and feedback on social learning.

4. Role-playing
The main component of training social competences is the training of behaving. After the instructions and performed behaviour (competence), participants play out short scenes which simulate real situations from their lives. The task of the coach is mainly to deal with the preparation of a suitable environment for role-playing. When everything is ready, the coach should explain to the other participants which type of specific behaviour will be practised. In this way, the participants can concentrate better on the practised behaviour during the scene, and provide feedback later.

5. Strengthening
When all participants have received information about a certain social competence by means of instructions and models and they have practised the given behaviour, their skills will be improved on the basis of strengthening. Strengthening can take the form of positive or negative feedback which will provide participants with information about their behaviour and reward (appraisal), or we can use another form of evaluating. The coach and other members of the group can provide feedback. If the feedback is provided by the participants of the training group, the coach should prepare them in advance to be positive so that their feedback is helpful for all the group. The process of providing feedback can have a significantly positive influence. It provides an opportunity to practise direct communication with others and it helps other members of the group to concentrate on the shared activity. It unifies them and also increases the possibility of learning to observe the behaviour that they were just learning. Concerning rewards, we can use verbal rewards (praise and encouragement) or non-verbal rewards (nodding in agreement, a tap on the back, some applause) or we can use other forms of reward (stars as rewards, etc.). The systematic use of feedback and rewards can shape the individual in the correct way and it increases the probability of repeated occurence.

6. Giving homework
By means of training, participants will have acquired social competences in the model situations. Therefore it is important so that they apply them in real life. Giving homework provides an opportunity to try newly acquired ways of behaviour in real situations and in this way they can transform the competences acquired during the training sessions into their own environment. It is useful to write down the setting of homework on paper or in an exercise book. We can ask the participants to record their performance and take notes of everything what was happening during the practise, and their success, feelings and difficulties with which they had to cope. Taking a note of homework enables them to monitor their own behaviour and also provides useful information to the coach who can subsequently give feedback to the participants in future sessions. Noting homework together with subsequent feedback can be a very powerful tool for improving behaviour.

The constellation of the group session can change according to the situational and individual needs of participants. The particular tasks, activities and breaks are included in the training, work according to the preceding analysis of the group situation, depending on the needs of the participants and the current symptomatology in our target group.

When creating the aforementioned programme, we applied several principles which are based on the principles of working with individuals with special needs and people with Attention Deficit/Hyperactivity Disorder belong to them (Jesenský 2000, modified by Jedličková, 2014, Müller de Morais, Jedličková, 2015). It is also necessary to respect these principles in the subsequent application of the programme in our target group.

1. Principle of purposeful proceeding and performing: it is important to consider all interventions and components which form the educational process. We must not forget about personal interests, motivation or participation of people with ADHD in solving the given task. Intentionally established situations must be guided and completed by spontaneously acted means.

2. *Principle of well-being, rationality, emotionality, adequateness and prevention against stress:* we must avoid overly high requirements and stress during the educational intervention. Activities should become gradually more complicated. It is also necessary to alternate work with relaxation and to establish a positive atmosphere. Educational

actuation should represent prevention against undesirable phenomena, mainly the arising and development of defectiveness.

3. Principle of respecting the needs of disabled people, plurality and comprehensiveness of the educational actuation: it is based on the fact that adults with specific educational needs already have a formed personality. They usually know or feel what they need and it is important to respect that.

4. Principle of activity and independence: represents the abilities and states where disabled people usually have a low performance score. It is connected with underestimation and depressive states resulting from an inability to accept their disability or distortion. It is possible to overcome these states and avoid the defectiveness with the help of suitable means.

5. Principle of applying re-educational and compensative methods, technical conditions and marketing of educational services: this is an adaptation and modification of conditions of education regarding the type and degree of disability and the use of compensation and rehabilitation aids.

6. Principle of dominance and complementarity of tasks, means and institutionalisation: During the educational intervention (depending on its character and tasks) different approaches, means and forms can be used. Some components will have a dominant position and this dominance influences the effectiveness of the chosen means. An important task of the coach of the training programme is to determine and regulate this dominance.

7. Principle of integration, partnership, support and solidarity: the basis of this principle is to support the integration of disabled people into a society of people without disabilities or similarly disabled people. It can help them to get rid of isolation, segregation and defectiveness.

8. Principle of humanity and respect of human dignity of disabled people.

9. Principle of union of educational, rehabilitative and social actuation: the education of adults with ADHD should be related to their rehabilitation or social intervention. Therefore the differences between the educational, rehabilitative and social actuation should not be big, but instead complement each other. Competent specialists should be able to cooperate mutually and coordinate their actuation in favour of supporting the personal development of disabled people.

10. Principle of subsidiarity and participation: this is a requirement to approach the educational actuation in ways that can be carried out wherever disabled people live. At the same time, this principle requires some adjustment of local conditions and adequate schooling of people who are in daily contact with disabled people.

The effectiveness and success of educational-rehabilitative programmes is influenced more by the psychosocial components than any existing disability or illness. In the target group of adults with ADHD, often we see apathy and resignation present, as well as a decrease of performance conditioned by the organic changes of the brain which reduce and complicate the effectiveness of the educational-rehabilitative actuation. However, it is possible to overcome this. We can achieve this by means of determining small and easily accessible aims. This way is the basis of activities with disabled seniors. The steady results form the most important motivation in the area of education, activation and rehabilitation of disabled adults and seniors (Vítková, 2006).

The coach of the training programme is supposed to be sensitive, empathic, tactful and tolerant of the target group At the same time the coach should try to have a positive and balanced attitude to seniors and be willing to help them to achieve any personal aims and solve any problems and difficulties.

5 Conclusion

Trainings aimed at a purposeful development of social competences have a very important position in the system of lifelong education. We are of the opinion that these trainings should become a part of the work with adults with different kinds of disorders or disability. It is necessary to develop more adaptable social competences of people with Attention Deficit/Hyperactivity Disorder in order to improve their quality of life and minimise the negative impact of their disorder. The ability to cope with a wide range of social situations in an effective way can provide a certain protection against stressful life events, tensions and conflicts. A social training can be an optimal intervention in this type of situations. Socially competent and self-confident people play an active role in their life, expressing their requirements in a suitable way and they achieve their aims. Trainings of social competences can support the development and cultivation of personality with ADHD and we can see positive results in social interactions, communication, adequate self-confidence, self-realization, and in solving of conflicts and problems with adaptation, etc.(Liberman, Derisi, Muesser, 1989, Praško, Možný, Šlepecký et al, 2007, Wilkinson and Canter, 2005).

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