

EFFECTS OF A 53-HOUR ADAPTIVE SWIMMING AND DIVING PROGRAMME USING THE IDA METHOD IN TWO INDIVIDUALS WITH ABLEPHARON-MACROSTOMIA SYNDROME: A TWO-PARTICIPANT CASE SERIES

Ana Golez, MD, PhD*

General Hospital Celje, 3000 Celje, Slovenia.

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*Corresponding Author: Ana Golez

General Hospital Celje, 3000 Celje, Slovenia.

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ABSTRACT

Background: Ablepharon-macrostomia syndrome (AMS) is an exceptionally rare congenital disorder associated with variable craniofacial, ocular, auricular, cutaneous and systemic abnormalities. Information concerning rehabilitation, adaptive physical activity, swimming and diving in individuals with AMS is extremely limited. Aquatic environments may facilitate movement through buoyancy and provide multidirectional resistance during active movement. **Objective:** To describe the characteristics of an intensive adaptive swimming and diving programme using the IDA method and clinically observed functional changes in two individuals with AMS. **Materials and Methods:** Two individuals with AMS participated in 53 hours of individually adapted swimming and diving activities delivered over 24 days. The programme included aquatic adaptation, buoyancy-assisted movement, postural-control activities, propulsion, swimming, SCUBA diving, breath-hold diving and progressive modification of physical assistance. Diving exposure was characterized using recorded depth and breath-hold data. **Results:** Both participants completed the programme. Participant 1 participated in SCUBA and breath-hold diving, reaching a maximum SCUBA depth of 9.9 m and a maximum breath-hold depth of 6.0 m. The mean recorded diving depth was 2.43 m and the longest recorded breath-hold was 1 min 26 s. Participant 2 participated exclusively in SCUBA diving, reaching a maximum depth of 1.5 m, with a reported mean depth of 1.35 m. Clinically observed changes included greater active aquatic movement, functional physical capacity, postural control, participation and reduced direct assistance during selected activities. **Conclusion:** The 53-hour individually adapted programme was associated with positive functional observations in two individuals with AMS. Causal conclusions cannot be drawn because of the very small sample, descriptive design and possible contribution of concurrent rehabilitation, learning and familiarization. The detailed diving data demonstrate the individualized nature of the intervention and provide a basis for future research.

KEYWORDS: Ablepharon-macrostomia syndrome; adaptive swimming; adaptive diving; SCUBA; aquatic rehabilitation; IDA method.

INTRODUCTION

Ablepharon-macrostomia syndrome (AMS) is an exceptionally rare congenital disorder characterized by a variable combination of craniofacial, ocular, auricular, cutaneous and other systemic abnormalities. Reported manifestations include severe abnormalities of eyelid development, macrostomia, auricular abnormalities, altered skin development, sparse hair and other congenital anomalies.^[1-4]

The clinical phenotype is heterogeneous, and affected individuals may require multidisciplinary medical, surgical, developmental and rehabilitative management. Molecular investigations have identified recurrent pathogenic variants in the basic domain of the **TWIST2** gene in individuals with AMS and related Barber-Say syndrome, providing an important genetic basis for these phenotypes.^[5]

Although the genetic and clinical characteristics of AMS have been increasingly described, substantially less information is available concerning rehabilitation, physical activity, adaptive sport and participation.

This gap is clinically relevant because rehabilitation extends beyond the management of individual impairments and includes activity, independence and participation. Individuals with rare congenital disorders may experience considerable barriers to participation in conventional physical activities and recreational sports.

Aquatic environments may provide specific opportunities for movement. Buoyancy reduces effective gravitational loading and can facilitate body positioning, floating and movement in individuals who experience difficulty with antigravity activity on land. At the same time, water resistance provides resistance during voluntary movement and permits multidirectional movement.

Aquatic interventions have been investigated in several populations with disabilities. Reviews have reported potential benefits for selected motor and functional outcomes, although the available evidence remains heterogeneous with respect to diagnoses, intervention protocols, outcome measures and methodological quality.^[6-8]

Findings from populations such as children with cerebral palsy cannot, however, be directly extrapolated to individuals with AMS.

The IDA method

The present intervention incorporated the **IDA method**, an adaptive aquatic and diving approach developed by IAHD Adriatic in Slovenia.

According to descriptions published by IAHD Adriatic, the IDA method has been developed for people with disabilities and has been used in therapeutic, recreational and sport-diving contexts. The approach emphasizes adaptation of aquatic and diving activities to the functional characteristics and abilities of each individual.^[9-12]

The practical principles relevant to the present intervention include:

- individual adaptation of aquatic activities;
- use of buoyancy to facilitate movement;
- active rather than exclusively passive participation;
- multidirectional and three-dimensional movement;

- individualized physical assistance;
- progressive development of aquatic skills;
- adaptation of swimming and diving activities; and
- continuous attention to safety.

The IDA approach differs from conventional swimming instruction in that the participant is not required to conform to a standardized swimming technique. Instead, aquatic tasks can be modified according to functional ability, body position, level of assistance, movement pattern and safety requirements.

Buoyancy may facilitate movement by reducing the effective gravitational load on the body. Water resistance simultaneously provides resistance during active movement. The combination can create an environment in which participants can repeatedly practise movement while maintaining an appropriate level of physical support.

The diving component provides an additional three-dimensional activity environment. Underwater movement requires changes in body orientation, propulsion, breathing and spatial awareness. SCUBA diving permits breathing underwater, whereas breath-hold diving requires voluntary breath control.

It is important to distinguish descriptions of the IDA method from evidence concerning its efficacy. Available professional and organizational material documents the development and practical application of the method, whereas peer-reviewed evidence specifically evaluating the effectiveness of IDA remains limited.^[9–12]

The objective of this case series was therefore not to establish treatment efficacy but to describe the characteristics of a **53-hour adaptive swimming and diving programme delivered over 24 days** and the clinically observed functional changes in two individuals with AMS.

MATERIALS AND METHODS

Study design

A descriptive two-participant case-series design was used.

The intervention consisted of **53 hours of adaptive swimming and diving delivered over 24 days**.

The primary purpose was to document the intervention and describe clinically observed changes in aquatic movement, functional physical capacity, postural control, aquatic independence and participation.

No inferential statistical analysis was undertaken because of the very small number of participants.

Participants

Two individuals with diagnosed ablepharon-macrostomia syndrome participated in the programme.

For confidentiality, the participants are identified throughout the manuscript as **Participant 1** and **Participant 2**.

Because AMS is exceptionally rare, potentially identifying demographic or clinical information should only be included where publication is compatible with the participants' informed consent.

The intervention was individually adapted according to functional ability, aquatic experience, participation and safety requirements.

Intervention duration and dose

The total intervention dose was:

- **53 hours of adaptive aquatic activity;**
- delivered over **24 days;**
- incorporating swimming and diving activities; and
- using principles of the IDA method.

The intervention was intensive and should not be interpreted as equivalent to a conventional weekly aquatic therapy programme.

DESCRIPTION OF THE INTERVENTION**Aquatic adaptation**

The programme included progressive adaptation to the aquatic environment.

Activities included immersion, orientation, floating, supported body positioning and transitions between body positions.

The degree of physical assistance was individually adjusted.

The objective was active and safe participation rather than achievement of a standardized swimming technique.

Buoyancy-assisted movement

Buoyancy was used to reduce effective gravitational loading and facilitate movement.

Participants were encouraged to initiate and control movement actively whenever possible.

Physical support was provided when required for safety or successful completion of an activity.

Postural control

The programme incorporated activities requiring participants to maintain and modify body position.

These included floating, changes in orientation, turning, propulsion and underwater movement.

External support was progressively modified according to individual performance.

Swimming and propulsion

Swimming activities were individually adapted.

The intervention included propulsion, coordinated limb movements, directional changes, body-position control and sustained movement through water.

The emphasis was on functional aquatic movement rather than competitive swimming performance.

Diving

Diving was individualized according to participant ability and safety requirements.

Both SCUBA and breath-hold diving were included in the overall programme, although the diving modality differed between participants.

Participant 1 participated in both SCUBA and breath-hold diving.

Participant 2 participated exclusively in SCUBA diving.

DIVING EXPOSURE

The diving component was characterized using recorded depth and breath-hold data.

The **minimum operational water depth of the programme was 1.4 m**. This value refers to the water/pool depth available for the programme and is therefore distinguished from the mean depth recorded during individual diving activities.

This distinction is important because Participant 2 had a reported mean recorded diving depth of 1.35 m.

Participant 1

Participant 1 participated in both SCUBA and breath-hold diving.

The maximum recorded SCUBA depth was **9.9 m**.

At this depth, the estimated absolute ambient pressure was approximately **1.98 bar**.

The reported mean recorded diving depth was **2.43 m**.

Participant 1 also participated in breath-hold diving.

The maximum recorded breath-hold depth was **6.0 m**, corresponding to an estimated absolute ambient pressure of approximately **1.59 bar**.

The longest recorded breath-hold was **1 min 26 s**.

Participant 2

Participant 2 participated exclusively in SCUBA diving.

The maximum recorded depth was **1.5 m**.

The reported mean recorded diving depth was **1.35 m**.

Participant 2 did not participate in breath-hold diving.

The considerably shallower diving exposure compared with Participant 1 reflects the individualized structure of the programme.

Table 1: Diving characteristics of the two participants.

Parameter	Participant 1	Participant 2
Minimum operational programme water depth	1.4 m	1.4 m
Diving modality	SCUBA + breath-hold	SCUBA only
Maximum SCUBA depth	9.9 m	1.5 m
Maximum breath-hold depth	6.0 m	Not performed
Mean recorded diving depth	2.43 m	1.35 m
Maximum breath-hold duration	1 min 26 s	Not performed
Estimated absolute pressure at maximum SCUBA depth	1.98 bar	approximately 1.15 bar
Estimated absolute pressure at maximum breath-hold depth	1.59 bar	Not applicable

Pressure values are estimated absolute ambient pressures calculated from depth and are presented to characterize the diving environment rather than as therapeutic outcomes.

SAFETY AND INDIVIDUALIZATION

The diving activities were individually adapted and conducted under appropriate supervision.

No common target depth was prescribed for both participants.

The maximum depth achieved by Participant 1 was considerably greater than that achieved by Participant 2. Participant 1 participated in both SCUBA and breath-hold activities, whereas Participant 2 remained within shallow-water SCUBA activity.

This difference demonstrates the individualized nature of the intervention.

Depth was not considered an outcome measure and was not interpreted as a marker of therapeutic effectiveness.

Similarly, the breath-hold duration of 1 min 26 s was recorded as a characteristic of Participant 1's participation and not as evidence of an intervention-related physiological improvement.

OPERATIONALIZATION OF THE IDA METHOD

Table 2: IDA-related principles applied in the present programme.

IDA-related principle	Application in the programme	Functional domain
Individual adaptation	Aquatic tasks individually modified according to ability	Activity and participation
Buoyancy-assisted movement	Floating and movement with reduced effective gravitational loading	Movement
Active participation	Voluntary propulsion and swimming	Functional physical capacity
Three-dimensional movement	Rotation, turning and underwater movement	Coordination
Progressive assistance	External support modified according to performance	Aquatic independence
Postural adaptation	Maintenance and modification of body position	Postural control
Adaptive diving	Individualized SCUBA and/or breath-hold activities	Aquatic participation
Safety adaptation	Individual supervision and task modification	Safe participation

This table describes how the principles of the IDA method were operationalized in the present programme. It is not intended to represent a formally validated taxonomy of the IDA method.

OUTCOME DOMAINS

Aquatic movement

Aquatic movement was evaluated descriptively according to the ability to perform floating, changes of body position, propulsion, swimming and underwater movement.

Functional physical capacity

Functional physical capacity referred to the participant's ability to initiate, sustain and repeat active aquatic movement.

No dynamometric or other quantitative muscle-strength assessment was performed.

Consequently, the study does not claim objectively measured improvement in muscle strength.

Postural control

Postural control referred to the ability to maintain and actively modify body position during floating, swimming, turning, propulsion and underwater activities.

Aquatic independence

Aquatic independence referred to the level of active participation and amount of direct physical assistance required during selected aquatic tasks.

It did not imply unsupervised swimming or diving.

Participation and confidence

Participation was evaluated descriptively through engagement in aquatic activities, willingness to perform progressively more complex tasks and observed confidence.

No validated quality-of-life instrument was administered.

RESULTS**Programme completion**

Both participants completed the 53-hour adaptive swimming and diving programme delivered over 24 days.

Aquatic movement

Both participants demonstrated increased active participation in aquatic movement.

Activities included floating, changes of body position, propulsion, swimming and underwater movement.

The participants were able to engage in progressively more complex aquatic activities according to their individual abilities.

Functional physical capacity

Clinically observable changes included an increased ability to initiate and sustain active aquatic movement.

Both participants demonstrated greater active contribution during selected propulsion and swimming activities.

Because objective strength testing was not performed, these observations are interpreted as changes in **functional aquatic physical capacity** rather than objectively measured increases in muscle strength.

Postural control

Improved control of body position was clinically observed during selected aquatic activities.

Participants demonstrated greater ability to maintain or modify body orientation during floating, swimming, turning and underwater movement.

The magnitude of these changes could not be quantified because validated quantitative postural measures were not used.

Aquatic independence

During selected activities, both participants required less direct physical assistance than at the beginning of the programme.

This was particularly relevant during swimming, propulsion and underwater activities.

The change is interpreted as increased **supported aquatic independence** rather than complete independence.

Both participants continued to require appropriate supervision.

Participation

Both participants demonstrated active engagement throughout the programme.

They participated in progressively more challenging aquatic activities and demonstrated increased involvement in swimming and diving tasks.

Positive observations concerning confidence and willingness to participate were also documented.

DIVING RESULTS

Participant 1 demonstrated the greater diving exposure.

The maximum SCUBA depth was **9.9 m**, corresponding to an estimated absolute ambient pressure of approximately **1.98 bar**.

The maximum breath-hold depth was **6.0 m**, corresponding to an estimated absolute ambient pressure of approximately **1.59 bar**.

The longest recorded breath-hold was **1 min 26 s**.

The mean recorded diving depth was **2.43 m**.

Participant 2 participated exclusively in SCUBA diving.

The maximum recorded depth was **1.5 m**, while the reported mean recorded diving depth was **1.35 m**.

The differences between participants demonstrate that the diving intervention was individualized rather than standardized.

DISCUSSION

The present two-participant case series describes a 53-hour adaptive swimming and diving programme delivered over 24 days to two individuals with AMS.

The programme incorporated principles of the IDA method and included aquatic adaptation, buoyancy-assisted movement, swimming, propulsion, postural-control activities, SCUBA diving and, in one participant, breath-hold diving.

The principal observations were increased active aquatic movement, functional physical capacity, postural control, supported aquatic independence and participation.

Because AMS is exceptionally rare, even a small clinical description may provide useful information concerning the feasibility of adapted physical activity.

Aquatic environment and movement

The observations are compatible with the general rationale for aquatic rehabilitation.

Buoyancy reduces effective gravitational loading and may allow individuals to perform movements that are difficult on land.

At the same time, water resistance provides resistance during active movement.

The combination of support and resistance may facilitate repeated movement practice.

Previous aquatic rehabilitation research has demonstrated potential improvements in motor and functional outcomes in several populations with disabilities, although the available evidence is heterogeneous.^[6-8]

The present observations should therefore be regarded as hypothesis-generating rather than confirmatory.

IDA method

The IDA method provided the framework for individualizing the aquatic and diving activities.

Rather than requiring a standardized swimming technique, the intervention allowed tasks to be modified according to functional ability.

This included adjustment of:

- body position;
- physical assistance;
- movement direction;
- task complexity;
- duration;
- diving modality;
- depth; and
- underwater activity.

Such flexibility may be particularly relevant for individuals with rare congenital disorders because functional profiles may differ considerably between individuals with the same diagnosis.

However, the present study does not establish the efficacy of the IDA method.

The available IDA material primarily describes the development and practical application of the method,^[9–12] while the broader evidence concerning aquatic rehabilitation comes from other intervention models and diagnostic populations.^[6–8]

Diving exposure

A distinctive characteristic of the present programme was the inclusion of detailed diving exposure data.

Participant 1 reached a maximum SCUBA depth of 9.9 m and a maximum breath-hold depth of 6.0 m.

Participant 2 remained within shallow-water SCUBA activity, with a maximum recorded depth of 1.5 m.

The difference demonstrates that the programme did not require participants to achieve the same diving performance. Instead, the diving activities were individualized.

The depth data should not, however, be interpreted as measures of therapeutic success.

A deeper dive does not necessarily represent a greater rehabilitation effect.

The diving depth is best regarded as a characteristic describing the physical exposure associated with the intervention.

SCUBA and breath-hold diving

The two diving modalities have different physiological characteristics.

SCUBA permits breathing compressed gas underwater, whereas breath-hold diving requires voluntary cessation of breathing during the underwater phase.

In the present programme, only Participant 1 performed breath-hold diving.

The maximum recorded breath-hold duration was 1 min 26 s at a maximum recorded depth of 6 m.

This finding is reported descriptively and should not be interpreted as evidence of improved respiratory function or physiological adaptation because respiratory outcomes were not systematically measured.

Postural control

Underwater movement requires continuous adjustment of body orientation.

Floating, turning, propulsion and diving involve movement in multiple planes.

The observed changes in postural control may therefore reflect repeated task-specific practice in an environment requiring continuous postural adaptation.

Nevertheless, the absence of standardized quantitative postural measurements prevents determination of the magnitude of change.

Functional physical capacity

The participants demonstrated greater active participation in swimming and propulsion.

The combination of repeated movement and water resistance may have contributed to these observations.

However, the programme also involved intensive practice and familiarization with the aquatic environment.

Therefore, the observed changes cannot be attributed to a single physiological mechanism.

The term **functional physical capacity** is preferable to "muscle strength" because muscle strength was not objectively measured.

Aquatic independence

A reduction in direct physical assistance was observed during selected activities.

For individuals with severe functional limitations, the ability to perform a greater proportion of a meaningful activity can represent an important functional change.

The term **supported aquatic independence** is therefore used to describe increased active participation while recognizing that appropriate supervision remained necessary.

Participation

The intervention provided an opportunity for active physical and recreational participation.

Swimming and diving may combine physical activity with exploration, achievement, confidence and social engagement.

For individuals with exceptionally rare congenital disorders, participation in adapted recreational activities may have relevance beyond physical performance alone.

Nevertheless, the study did not use validated participation or quality-of-life measures, and no causal conclusion can therefore be made concerning quality of life.

CLINICAL IMPLICATIONS

The present case series suggests several practical considerations for adaptive aquatic programmes involving individuals with rare congenital disorders.

First, aquatic intervention should be individualized rather than based on a uniform protocol.

Second, buoyancy may provide opportunities for active movement when land-based movement is difficult.

Third, physical assistance can be progressively adjusted according to performance.

Fourth, swimming and diving can be integrated into a broader participation-oriented intervention.

Fifth, objective recording of intervention exposure—including total hours, maximum depth, mean depth, diving modality and breath-hold duration—can improve reproducibility.

The data also demonstrate that participants with the same rare diagnosis may require substantially different aquatic and diving programmes.

LIMITATIONS

The principal limitation is the very small sample size of two participants.

No control group was included.

The study was descriptive and did not include inferential statistical analysis.

Validated quantitative measures of strength, postural control, aquatic skills or quality of life were not systematically administered.

The intervention was intensive, consisting of 53 hours over 24 days, which limits generalization to programmes of lower intensity.

Familiarization and learning effects may have contributed to the observed changes.

Concurrent rehabilitation, physical activity and developmental factors may also have contributed.

Because multiple intervention components were delivered simultaneously, the relative contributions of swimming, SCUBA diving, breath-hold diving, buoyancy-assisted movement, postural activities and repeated practice cannot be separated.

Although maximum and mean diving depths were recorded, other potentially relevant exposure variables, such as the number of dives, duration of individual dives, total underwater time and exact task-specific assistance, were not systematically presented.

Finally, peer-reviewed evidence specifically evaluating the IDA method remains limited.

CONCLUSION

A 53-hour adaptive swimming and diving programme delivered over 24 days and incorporating the IDA method was associated with clinically observed improvements in aquatic movement, functional physical capacity, postural control, supported aquatic independence and participation in two individuals with ablepharon-macrostomia syndrome.

The intervention included individualized swimming and diving exposure. Participant 1 participated in both SCUBA and breath-hold diving, reaching a maximum SCUBA depth of 9.9 m and a maximum breath-hold depth of 6.0 m. Participant 2 participated exclusively in shallow-water SCUBA diving, reaching a maximum depth of 1.5 m.

These differences demonstrate the individualized nature of the intervention.

The findings cannot establish a causal therapeutic effect of the IDA method because of the small sample, absence of a control group, descriptive assessment, possible learning and familiarization effects, and concurrent activities.

Nevertheless, the case series demonstrates the feasibility of intensive individualized aquatic and diving activity in individuals with an exceptionally rare congenital disorder.

Future research should use prospective designs, validated functional outcome measures and standardized recording of aquatic and diving exposure. Multicentre collaboration would be particularly valuable because of the rarity of AMS.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

ETHICAL CONSIDERATIONS

Written informed consent for participation and publication was obtained from the participants' legal representatives. Because ablepharon-macrostomia syndrome is an exceptionally rare disorder, identifying clinical information should be limited to information for which publication consent has been obtained.

DATA AVAILABILITY

Individual-level participant data are not publicly available because the exceptionally small number of participants and rarity of the diagnosis may create a risk of identification. Additional information may be made available by the corresponding author where ethically and legally appropriate.

AI-ASSISTED WRITING STATEMENT

An artificial intelligence language model was used during manuscript preparation to assist with English-language editing, organization and refinement. The author independently reviewed the manuscript and takes full responsibility for the accuracy, interpretation and integrity of the final manuscript.

REFERENCES

1. De Maria B, Mazzanti L, Roche N, Hennekam RCM. Barber-Say syndrome and Ablepharon-Macrostomia syndrome: an overview. *Am J Med Genet A.*, 2016; 170(8): 1989–2001. doi:10.1002/ajmg.a.37757.
2. Kallish S, McDonald-McGinn DM, van Haelst MM, Bartlett SP, Katowitz JA, Zackai EH. Ablepharon-Macrostomia syndrome—extension of the phenotype. *Am J Med Genet A.*, 2011; 155A(12): 3060–3062. doi:10.1002/ajmg.a.34287.
3. Stevens CA, Sargent LA. Ablepharon-macrostomia syndrome. *Am J Med Genet*, 2002; 107(1): 30–37. doi:10.1002/ajmg.10123.
4. Schanze D, Harakalova M, Stevens CA, et al. Ablepharon macrostomia syndrome: a distinct genetic entity clinically related to the group of FRAS-FREM complex disorders. *Am J Med Genet A.*, 2013; 161A(12): 3012–3017. doi:10.1002/ajmg.a.36119.

5. Marchegiani S, Davis T, Tessadori F, et al. Recurrent mutations in the basic domain of TWIST2 cause Ablepharon Macrostomia and Barber-Say syndromes. *Am J Hum Genet*, 2015; 97(1): 99–110. doi:10.1016/j.ajhg.2015.05.017.
6. Ogonowska-Słodownik A, Jakobowicz O, Alexander L, Marinho-Buzelli AR, Devion C, Morgulec-Adamowicz N. Aquatic therapy in children and adolescents with disabilities: a scoping review. *Children*, 2024; 11(11): 1404. doi:10.3390/children11111404.
7. Roostaei M, Baharlouei H, Azadi H, Fragala-Pinkham MA. Effects of aquatic intervention on gross motor skills in children with cerebral palsy: a systematic review. *Phys Occup Ther Pediatr*, 2017; 37(5): 496–515. doi:10.1080/01942638.2016.1247938.
8. Rohn S, Novak Pavlic M, Rosenbaum P. Exploring the use of Halliwick aquatic therapy in the rehabilitation of children with disabilities: a scoping review. *Child Care Health Dev*, 2021; 47(6): 733–743. doi:10.1111/cch.12887.
9. IAHD Adriatic. Pilot project: therapeutic scuba diving for mentally challenged pupils in primary schools with an adaptive program, 2017.
10. IAHD Adriatic. First international diving camp for people with disabilities in Serbia: Kikinda 2017. 2017.
11. IAHD Adriatic. First International Conference on Diving for Persons with Disabilities in Taiwan: presentation of the IDA method in therapeutic and recreational scuba diving, 2017.
12. IAHD Adriatic. International working weekend in Serbia: IDA method in practice and sport diving for persons with disabilities, 2017.
13. Hoffmann TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ*. 2014;348. doi:10.1136/bmj.g1687.