Palacký University in Olomouc

Faculty of Physical Culture

Department of Adapted Physical Activity

THE DETERMINANTS OF PARTICIPATION IN PHYSICAL ACTIVITIES AFTER THE WAR TRAUMA IN THE NATIONAL SITTING VOLLEYBALL TEAM OF BOSNIA AND HERZEGOVINA

Master Thesis

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Abstract:

The purpose of this thesis was to examine the determinants that affect the reentry to physical activities after the war trauma in Bosnian and Hercegovinan national sitting volleyball team. I have analysed the effect of determinants on influance to sport activities and in relation to these determinants, I found out the approximate time period required for reentry to physical activities after trauma. This determinants are psycho-social. Using semi-structured interview I gained and evaluated data from 9 subjects, selected from Bosnian and Herzegovinian national sitting volleyball team, aged between 26 and 55 years. Major determinants, that had an effect on the return to physical activities, are discussed later. Amongst the determinants, I found the main as family, former friends, new friends with similar disabilities, hospitalization, rehabilitation center, economic situation, access to a vehicle, sport environment and influence of the intact society. The approximate time requires to return to physical activity with my selected sample is specified in the summary of this thesis.

Keywords: physical disability, paralympic sport, sitting volleyball, volleyball, sport/physical activity participation after trauma, coping with extreme stress, amputation, family.

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Abstrakt:

Cílem této diplomové práce bylo zjistit determinanty které ovliv uji návrat hrá národního týmu Bosny a Hercegoviny ve volejbalu vsed do fyzické aktivity po valé nem traumatu. Analyzoval jsem vliv determinany na znovu navráceni do pohybových aktivit. Hlavní byly psychosociálního rázu. V souvislosti s t mito determinaty jsem zjistil pr m rnou dobu návratu do sportovní aktivity. P i použití semistrukturovaného rozhovoru jsem získal a zpracoval údaje od 9 respondent , ve v ku 26 až 55 let, vybraných z národního týmu Bosny a Hercegoviny ve volejbalu vsed . Hlavní determinanty, které ovlivnily návrat do sportovní aktivity bosenských hrá , jsou popsány dále. Mezi determinanty se ve v tšin p ípad objevovaly: rodina, sta í p átele, noví kamarádi s podobnými potížemi, hospitalizace, rehabilitace, finan ní situace, p ístup k automobilu, sportovní prost edí a vliv spole nosti. Pr m rná doba znovunavrácení do pohybových aktivit je specifický vysv tlená v záv ru mé diplomové práce.

Kli ová slova: t lesné postižení, paralympijský sport**,** volleyball, sitting volleyball, zvládání stresových situací, amputace, rodina.

Souhlasím s p j ováním diplomové práce v rámci knihovních služeb.

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I would also like to thank to players who participated in interviews and all others who contributed on any way in making of this thesis. Special thanks go to my loved ones,who supported me during my studies.

Olomouc ....

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1. INTRODUCION

The fact is, that the humanity of every society is reflected in the care of their disabled citizens, in ensuring normal life and working conditions and anything else which is necessary in order to have a normal life. Sometimes, in life struggle, the most militant people happened to be "tricked" for whatever reason. This unequal battle is showing us that the human being is an "open space ", and that it is existence is actually an endurance fight which has to be continued. From this arises the realization that this defeat should be accepted as a natural thing which should be accepted as soon as possible. The time should not be wasted on unimportant things in life, in opposite should be concentrated on figuring out things that will bring us further in life and close to that what we want and what is best for us. It is very important to find the way to express our ego. One of the best ways maybe is sport, because sport is not just a privilege for people without disabilities, but at the same time this specific area of human activities reinforces self-confidence, optimism and faith. It gives us opportunity to contribute to progress in various areas of life as well as in sport. The proof for this hypothesis is sitting volleyball, and so this work is intended for those who want to take a different ways of dealing with this kind of sport. I have chosen this topic because I believe that there is no one in Bosnia and Herzegovina who wrote about this topic. I am also very proud to contribute in this way at least to the popularity of the sports and demonstrate some of the problems related to people with disabilities in Bosnia and Herzegovina. A very large number of people with disabilities is not aware of violation of their rights such as lack of access to information, education, employment or health services, represents also violation of their basic human rights.

According to the recommendations of the ombudsmens for Human Rights, the Parliamentary Assembly of Bosnia and Herzegovina and the Council of Ministers should, without any delays, begin to create conditions that:

- Provides equal opportunities in exercising the rights of persons with disabilities, regardless of their place of residence or domicile in the entire territory;
- Adopts a framework law and other by-laws that will comprehensively and efficiently regulate the sensitive area of disability protection (in Bosnia and Herzegovina must be ensured the harmonized practice in the application of law and defining the scope of public authorities in the entities, districts, cantons, municipality, city, as well as work with disabled persons);
- Establishes a unified methodology in the approach to the existential issues of disabled persons, as well as to develop a uniform records (database), which would have included all the relevant information about disabled (categories, the percentage of physical disability, gender, type of associated fees, etc.);
- (State) achieves better coordination, exchange of information and experience between all authorities, as well as associations of disabled persons;
- Adopts a law on occupational safety of Bosnia and Herzegovina, whose adoption would significantly contribute to the higher level of workers and the overall security of the working environment.

According to the research data which was supported by, Lifelong Learning Program of the European Commission in Federation of Bosnia and Herzegovina there are currently 3,901 people unemployed, 1060 woman and 2841 man (Blatnik, Selimovi & Mujezinovi , 2013).

I also would like to highlight the problem of land mines in Bosnia and Herzegovina. According to the research of BHMAC (Bosnia and Herzegovina Mine Centre), Bosnia and Herzegovina is the most landmine contaminated country in Europe and among the worst impacted countries in the world. An area with a size of 1820 square kilometers, around 3.6% of the total territory, is filled with land mines. The estimated data are suggesting that there are still more than 1,000,000 landmines and UXO (Unexploded Ordnances) to be found in the ground. Almost 5,000 people in this country have been killed or injured by landmines, including 1520 since the end of the war in 1995.

The main aim of this thesis was to find out determinates which influence the reentry of participants to physical activity after war trauma at Bosnian and Herzegovinian national sitting volleyball team.

Regarding to general information about the time between trauma and new sports participation and special situation in BiH the intention of the project was:

- To formulate time spent to re-entry to physical activities after trauma.
- To compare the data with former results in country with different conditions (Czech Republic).

The relevance of this study is to introduce the sitting volleyball, as one of the sports for disabled people to the wider population in Bosnia and Herzegovina. I hope that the information from this study will help others to get to know better this population of people and why they participate in sport.

2. LITERATURE REVIEW

2.1. Disability and physical disability

Disability is any physical or mental condition that limits a person's movements, senses or activities. Various terms have been used to describe individuals with disabilities over the years. Currently, the preferred terminology is one in which the person is mentioned first, as in''person with disability'' or ''individual with physical impairment (DePauw & Gavron, 2005). According to the United Nations Convention on the Rights of Persons with Disabilities, "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others". Disabilities can be permanent, temporary, or episodic. They can affect people from birth, or be acquired later in life through injury or illness. A range of international documents have highlighted that disability is a human rights issue, including the World Programme of Action Concerning Disabled People (1982), the Convention on the Rights of the Child (1989), and the Standard Rules on the Equalisation of Opportunities for People with Disabilities (1993). More than 40 nations adopted disability discrimination legislation during the 1990s (Quinn at al, 2002). The CRPD (The Convention on the Rights of Persons with Disability) entered into force in 2008. At its core, the Convention ensures that persons with disabilities enjoy the same human rights as everyone else, and are able to lead their lives as citizens who are given the same opportunities to grow and contribute to society as those without disabilities. It marks a paradigm shift from seeing persons with disabilities as objects of charity and pity to holders of rights. The extent to which these impairments disable someone is dependent upon the level of attitudinal and environmental barriers encountered in society. Examples of these can be seen everywhere from stairs into

buildings, reading materials in inaccessible formats, and prevailing negative attitudes towards persons with disabilities. The more barriers, the less likely persons with disabilities are able to participate in society (www.social.un.org).

Education for all youth is critical for realizing their full potential. Yet, UNESCO estimates that 98% of children with disabilities in developing countries do not attend school and 99% of girls with disabilities are illiterate. By the time they enter adolescence, many youth with disabilities run a high risk of being illiterate, leading to restricted opportunities for further education, employment, and income generation. Some families do not feel that youth with disabilities should receive an education, often believing that young people with disabilities are incapable of learning (Groce, 2004). As a result, a disproportionate number of persons with disabilities in developing nations live in extreme poverty (www.un.org). Poverty itself cannot be addressed without confronting both the causes of disability and the social and economic exclusion of persons with disabilities. The World Bank estimates that approximately 600 million people, or 10% of the world's population, have a disability and that 80% of these people live in developing nations. If families of persons with disabilities are included, at least 25 % of the world is directly affected by disability. Disability is both a cause and a consequence of poverty.

Disability is complex, dynamic, multidimensional, and contested. Over recent decades, the disabled people's movement (Charlton, 1998) – together with 4 World report on disability numerous researchers from the social and health sciences (Barnes,1991) – have identified the role of social and physical barriers in disability. According to the World Health Organization (WHO. 2003) experience and scientific evidence show that regular participation in appropriate physical activity and sport provides people of both sexes and all ages and conditions, including persons with disabilities, with a wide range of physical, social and mental health benefits. Physical activity and sport support strategies to improve diet and discourage the use of tobacco,

alcohol and drugs. As well, physical activity and sport help reduce violence, enhance functional capacity, and promote social interaction and integration.

The vision we have of the person with physical disabilities has varied over the years, some years ago, we saw that people were relegated to their homes, unable to socialize, much less to have job options; this condition are improving daily, and governments are becoming more aware of implementing policies to make cities more friendly places to the person living with a disability. Individuals with disabilities have always been present in society but for various reasons they become more visible in the 21st century than in previos centuries (DePauw & Gavron,1995). We found people with disabilities who occupy important positions in politics, prominent businessmen, musicians, athletes, artists, etc. There are several reasons of physical disabilities: congenital, hereditary chromosomal, accidents or degenerative diseases, neuromuscular, or metabolic infectious among others.

2.1.2. International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health (ICF) has been developed by the World Health Organization (WHO) for use in describing functioning and disability. In May 2001, the World Health Assembly endorsed the ICF. The ICF is now recognised as a reference member of the World Health Organization family of International Classifications, and complementary to the International Classification of Diseases and Related Health Problems (ICD).

2.1.3. Components of the ICF

The ICF defines functioning and disability as multi-dimensional concepts, relating to:

- The body functions and structures of people.
- The activities people do and the life areas in which they participate, and the factors in their environment that affect these experiences.

For each of these components, the ICF provides a hierarchy of classifications and codes. In the ICF, a person's functioning or disability is conceived as a dynamic interaction between health conditions and environmental and personal factors.

Body functions are the physiological functions of body systems (including psychological functions). Body structures are anatomical parts of the body, such as organs, limbs and their components. (ICF, WHO, 2001). Impairments are problems in body function and structure, such as significant deviation or loss. Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation. Activity limitations are difficulties an individual may have in performing activities. Participation restrictions are problems an individual may experience in involvement in life situations. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

2.1.4. Classification system of volleyball for disabled

Classification system is not ended to detect the eligibility of the athlete to compete in the sitting and standing volleyball as well as to allocate the athlete into the appropriate class. The WOVD Classification system in the general terms complies with the IPC classification rules.The purpose of WOVD Classification system is to minimize the impact that eligible impairment type shave on the outcome of the competition. The WOVD system of Classification aims to place athletes intoclasses according to how much their impairment impact on the specific core

determinants of successin sitting and standing volleyball. As an outcome, the according International Classification Status is given to an athlete during the WOVD sanctioned events. WOVD International Classifiers are in charge of the application of the current Classification rules. The eligible impairment types in WOVD sitting and standing volleyballare: amputations, impaired muscle power, restricted joint movements, in stability of the joints, impaired balance and coordination. The conditionsare normally of the opedicor neurological nature. The current WOVD Classification system usest terms listed in International Classification of Functioning, Disability and Health (ICF, agreed by the World Health Assembly in 2001) as a framework for the unified and standardized Classification (Vute, 2009).

2.1.5.Sitting volleyball classification

Classification in sitting volleyball is currently based on three tiers. In the most basic from these tiers are defined as; disabled, minimally disabled, and able bodied. As this are the terms usedby the atlets, coaches, managers, and classifiers within the sport, any political correctness issues are omitted for the sake of the sport specific classification (Kwok, 2012). Although the United nations changed its terminology in the ''Rights of the Disabled People' to' Rights for Person with disabilities' there are many views that state the reason why the players can play in this sport at classification event, is because they have some type of disability that impedes on their ability to play other form of volleyball (Kwok, 2012). Coincinding with the reason for people with disabilities playing disabled sports, the common practice among the disability community in Sitting Volleyball has coined up three short and simple to understand acronymus. In short, players are often referred to as abbreviated terms; D (disabled), MD (minimally disabled), and AB (able bodied), (Kwok, 2012).

- At any time on court, a team may have a maximum of 1 MD player.

- At any time, a team may have a maximum of 2 MD players on the team.

This is a technical regulation which is in power for the Paralympic Games, World Championships and Zonal Championships. That regulation can be accordingly 22 changed at the discretion of the other (not mentioned above) tournament's organizers in consultation with the Zonal Manager. In the last case, the changed formula is to be without the changes in the actual Classification of the players. Eligible for competition are those players with a minimal disability as defined inthese rules and in the Clarifications for the Minimal Disability here below (Vute, 2009).

2.1.6.Most frequent disabilities in the volleyball

Sitting volleyball can be generally suggested as a safe tool for promoting health and physical working capacity for persons with locomotor disabilities (Mustafins, Landõr, Vetral & Scibrja, 2008). Most players who take part inWOVD official competitions are classified as amputee, cerebralpalsy, poliomyelitis (polio) and les autres (shorter limbs, muscle dystrophy, congenital dysfunctions, etc.). Sitting volleyball seems to be a favorable choice for amputee athletes, especially for those with lowerlimb amputations.

Amputee:

The term ampute erefers to those individuals who have at least one major joint in a limb missing (elbow, knee, wrist, ankle) or, in cases where the amputation is through the ankle or the wrist, no functional movement remaining in those joints. Amputations are either congenital or acquired. Congenital amputations occuras a result of a failure of the fetus to develop in first thre emonths of gestation. Acquired amputation can be result of a disease, trauma or tumor (Vute, 2009).

Amputees are by farmostre presented in volleyball for the disabled. There for teachers and coaches should pay attention to the following specifics:

- a missing limb can cause a distortion in body image
- skin care around the stump area can be a problem
- the center of gravity may be affected which in turn affects balance and spine problems there may a problems associated with thermoregulation for the amputee.

Because the amount of body surface for respiration is reduced, the bodymay overheat on particularly hot or humid environment (Vute, 2009).

Minimal disability of upper extremities

- amputation of two first fingers on both hands
- amputation of seven or more fingers on both hands
- amputation of one hand between metacarpal – phalange joint and wrist

Minimal disability of lower extremities

- amputation in lisfranc joint on the foot

It is the joint between metatarsal bones (the long bones that lead up to the toes) and tarsal bones (bones in the arch).

- amputation in chopart joint on one foot

It is the tarsal articulation between talus and navicular bone medially and calcaneus and navicular bones laterally (Vute, 2009).

Cerebral palsy (CP):

Cerebral Palsy (CP) is characterized by nonspecific damage to areas of the brain controlling muscular tone and spinal reflexes. Some 61% of competitors with CP are affected primarily by spasticity, 17% by athetosis (alternating bouts of hyper and hypo-tonus), and 10% by other

disabilities, although many CP athletes have both spasm and athetoid movements (Shepard, 1990).

Cerebral palsy is a disorder of movement and posture appearing in early years of life. It is caused by damage to, or lack of development in small part of the brain controlling movement and posture (Vute, 2009). The term Cerebral palcy covers a wide range of types and severity of disability. Some people are somildly affected that there may be no obvious disability, while others may be affected very seriously. The damage of an area of the brain affects the control and coordination of muscle tone, reflexes, posture and movement (Vute, 2009).

Minimal disability:

- minimal diplegia (the lower extremities are affected with little to no upper-body spasticity)
- minimal hemiplegia (one side of the body being affected)
- monoplegia (paralysis of a single limb, usually an arm)
- minimum impairment of the cerebellum (in complete coordination), (Vute, 2009).

Poliomyelitis:

Poliomyelitis is the virus infection which starts as an acute infection last in gup to six weeks. A severe attack causes varying amounts of damage to the part of the brain and spinal cord responsible for the control of voluntary movement. This results in paralysis of muscles, which no long erreceives any nerve impulses. The degree of paralysis varies from one pers onto another. Some maybe on the wheelchair, others maybe affected in only one limb. The reisn of cure or polio, but prevention by the vaccineis effective (Vute, 2009).

Les autres conditions:

The term les autres have been used to describe athletes with arange of conditions that result in locomotor disorders that have not fitted into traditional classification system of the established disability groups (Vute, 2009).

Les autres classification does not make specific provision for those with severe mental disability, or does it offer clearly defined handicaps for those individuals having cardiac, respiratory, abdominal, cutaneous, auditory, or visual problems without locomotor dicability (Biering-Sorensen, 1983). Whereas CP-ISRA is content with three broad categories of event (track, filed, and swimming), ISOD offers detailed functional descriptions for each of the 16 sports is currently recognizes (Shepard,1990).

Only two athletes with minimal disability per team are allowed to participateinthe official sitting volleyball competition, but only one of the seathletes can be on the courtat any time. Example of conditions not eligible for les autresare: Down syndrome or persons with severely reduced mental capacity, persons with heart, chest, abdominal, skin, earandeye diseases without locomotor disability (Vute, 2009).

2.1.7.Trauma

Amputation of a limb can take place immediately at the site of an accident or the extensive trauma can cause sufficient damage or death of tissue to require subsequent ablation. The aim in trauma management is to restore the limb to the best possible length with a good soft tissue covering (Engstrom & Van de Ven, 1999). To achieve this, the expertise, cooperation and rational decision making of orthopedic, plastic and vascular surgeons is necessary, with the consultant in prosthetic rehabilitation. This team must bear in mind priorities of surgical management from injury to successful prosthetic outcome. In an emergency setting, life may be

saved by loosing the limb, but once the patient has stablished, the decision concerning limb salvage and optimum level of amputation can be made. The psychological make-up of the patient and their goals and employment must be considered. The amputation can therefore take place immediately, or months or even years following the trauma, and this final decision should only be taken after extensive assessment and discursion between the patient, the surgeon and the rehabilitation team. Years of pain and lack of independence can possibly be avoided by seeking referral to the local prosthetic service for a pre-amputation consultation by members of multidisciplinary team. This will allow the patient to be given a realistic view of their future lifestyle as an amputee. Additionally, a small number of elective orthopedic procedures, such as joint replacement, occasionally suffer overwhelming infection and, although two-stage revision with interim intravenous antibiotics is the treatment of choice, amputation has to be considered in severe cases (Engstrom & Van de Ven, 1999).

2.1.7.1. Examples of trauma

Various types of trauma can lead to amputation, including:

- Compound fractures, particularly those involving skin and soft tissue loss – often in association with multiple injuries
- Blood vessel rupture
- Severe burns
- Stab, gunshot or blast injuries
- Compression injuries
- Cold trauma, i.e. frostbite.

The factors listed above may occur in combination; re-implantation and tissue transfer with microsurgery may often be necessary. Re-implantation is rarely successful in cases of adult

proximal upper limb or lower limb trauma. In young children, this technique may be successful and is valuable for treating forearm and hand trauma in adults (Engstrom & Van de Ven, 1999).

2.1.8. Situation in Bosnia and Herzegovin

Bosnia and Herzegovina (BiH) is committed to and applying the principles of multiparty democracy, pluralism, and market economics. At the same time, the functioning of the state in general, and of its democratically elected institutions in particular, is affected by the specifics of the country's constitutional set up. The 1995 Dayton Accords, which ended the war in BiH and paved the way to the country's stability, created a uniquely complex institutional structure and a fragmented policy-making apparatus. Bosnia and Herzegovina signed and ratified the UN Convention on the Rights of People with Disabilities in 2010, but has made little progress in implementing it. This decision determines that the Council of People with Disabilities of BiH shall have 20 members, representatives of state, entity and Br ko District of BiH institutions and representatives of associations of persons with disabilities. So far four sessions of the Council were held and covered by the media, with the aim of promoting the rights of persons with disabilities. (www.internationaldisabilityalliance.org)

People with disabilities represent one of the most vulnerable and hidden groups in the country. With no structured state system of social care or community-based services, they and their families have nowhere to turn for support. They are wrongly viewed as incapable of participating in everyday life and excluded from society and, worse, are often placed in institutions that are located in remote areas and further removed from society. This is not in the spirit of the Convention (www.usaid.gov).

In South East Europe, it is often the case that resources are used to make ramps or dropped kerbstones but without applying standards. These are subsequently not usable by people with

disabilities, a waste of resources and an example of insensitive planning. Ramps are very often far too steep and cannot be used by wheelchair users in Sarajevo, a ramp was built inside of a municipal building entranceway again too steep to be used. In Sarajevo, there are many public buildings with such electronic ramps that are also rarely use and often times inaccessible due to this infrequent use (Sestranetz & Adams, 2006). A member of the Association of Citizens with Cerebral Palsy and Muscular Dystrophy in Goražde reports:

"There are sidewalks adjusted for people with disabilities but we call them "deadly ramps" since they are too steep. They are simply building without planning for true accessibility." In addition to this, in many towns around the region, priority is given to cars rather than pedestrians. Almost as a rule, parked cars encroach upon the sidewalks reducing the space and obstructing the movement of normal pedestrians let alone people in wheelchairs, mobility scooters or those walking with a guide dog or white cane or those using walkers or other assistive devices that require more girth. In places where dropped kerbs exist, cars are often parked without consideration and negligibly so as to block the access to dropped kerbs this making them unusable. As a wheelchair user and member of IC Lotos Tuzla explains, " My problem in town, and not only mine but also for people who are not wheelchair users or not disabled at all, is that although paved sidewalks are indeed accessible owing to dropped kerbs, but are at the same time full of parked cars and I am forced to be part of the road traffic in my wheelchair which is very dangerous. But it is difficult to change as it is a cultural behavior." Different kinds of audible and visual signalization for people with sight or hearing impairments at traffic light or at cross walks rarely exist. Also, textured pathways for blind people on sidewalks and, in particular, on crossroads can be found only on few main streets in major cities. A blind member of IC-Lotos in Tuzla explains, "As to accessibility of information for blind persons, there should be markings in all public buildings in Braille letters, such as in elevators or in places, where it is necessary and

audible signalization should be provided such as at traffic lights and inter-sections. In the Tuzla canton in Bosnia and Herzegovina, the state only purchased low-floor buses after a strong lobbying campaign carried out by IC Lotos in 1999. The initiative began when the IC Lotos learned that the cantonal public transportation company was planning to purchase new buses. IC Lotos contacted the director of the company and began lobbying him to purchase low-floor buses. After strong lobbying, the public transportation company agreed to buy 8 used low-floor buses and all future purchases will be exclusively low floor buses. Six years later, Tuzla is the only town in Bosnia and Herzegovina in which citizens within the city and those living in the suburbs of the city can travel by low floor accessible buses (Sestrantez & Adams, 2006).

2.2. Psycho-social factors connected with trauma

Stress is simply a reaction to a stimulus that disturbs our physical or mental equilibrium. In other words, it's an omnipresent part of life. A stressful event can trigger the "fight-or-flight" response, causing hormones such as adrenaline and cortisol to surge through the body. A little bit of stress, known as "acute stress," can be exciting-it keeps us active and alert. But long-term, or "chronic stress," can have detrimental effects on health. You may not be able to control the stressors in your world, but you can alter your reaction to them (www.psychologytoday.com).

2.2.1. Family and stress

Although the concept of family stress has been utilized with considerable frequency in both clinical and research literature, it has continued to remain elusive and is frequently used without explicit definition. In many investigations, at least one of three aspects of "family stress" is identified, although consensus on definitions does not exist. Most commonly, stressors are defined as those life events or occurrences of sufficient magnitude to bring about change in the

family system (Hill, 1949). Stress is not seen as inherent in the event itself, but rather is conceptualized as a function of the response of the distressed family to the stressor and refers to the residue of tensions generated by the stressor which remain unmanaged (Hill, 1949). Stressors are most often defined as life events or circumstances of such force which is sufficient to bring changes into a family system (Hill, 1949). Stress is not viewed in the given event as a separate unit, but conceived rather as a function of the response of the affected family to the stressor, and relates to subsequent tensions which are activated by the stressor and which remain unresolved. Crisis relates to the level of inability or disorganization within the family, where inadequate resources are available (Hill, 1949).

Family stress may relate to family reactions to such events, which in many cases influence manifestations of the emotional state of the family members; interpersonal conflict or financial difficulty (Simmons at al. 1973). For example, stress is often defined and studied in the context of events such as prolonged war-induced separation, kidney transplants, or spinal cord injury (Simmons et al., 1973). A family struggling with other life changes, such as for example developmental transitions and connected role changes may lack the expressive and instrumental resources to cope with further changes. A "pile-up" of life crisis event occurs (Šterbova, 2007). McCubbin at al. (1980) present the Lipman-Blumen (1975) schema for understanding family crises, in which it is possible on the basis of certain criteria to classify stressors and the same time determine the extensiveness of the stress within the family system:

- Internality vers. externality,
- Pervasiveness vers. limitation,
- Sudden beginning vers. gradual beginning,
- Intensity vers. subtlety,
- Transience (temporary nature) vers. chronicity,

- Coincidence vers. expectation,
- Natural origin vers. artificial origin,

2.2.2. Coping with extreme stress (PTSD)

Whether or not people develop PTSD (post-traumatic stress disorder) depends on their subjective perception of the traumatic event as well as on the objective facts. For example, people who are threatened with a replica gun and believe that they are about to be shot, or people who only contract minor injuries during a road traffic accident but believe at the time that they are about to die, may develop PTSD. Furthermore, those at risk of PTSD include not only those who are directly affected by a horrific event, but also witnesses, perpetrators and those who help PTSD sufferers (vicarious traumatisation). People at risk of PTSD include: victims of violent crime (e.g. physical and sexual assaults, sexual abuse, bombings, riots) members of the armed forces, police, journalists and prison service, fire service, ambulance and emergency personnel, including those no longer in service victims of war, torture, state-sanctioned violence or terrorism, and refugees survivors of accidents and disasters women following traumatic child birth, individuals diagnosed with a life-threatening illness.War is not a singular traumatic event, but a sequence of extremly disruptive events to wich are added prolonged hardship. The concept of post-traumatic stress disorder (PTSD) is frequently used in connection with traumatic events, but may, in fact, be rather less useful for service planners than has often been assumed. An analysis of human responses to extreme and catastrophic experience reveal these to be much more diverse and varied than what is included in symptom criteria that comprise PTSD. A first consideration is that not all mental distress after traumatic events can be described in terms of PTSD. In other words, it is not necessarily the only expression of extreme distress manifest after traumatic events (Shalev &Yehuda, 1998). An exclusive emphasis on PTSD overlooks the

normal and healthy ways in which many victims adapt to extreme stress. As explained by cognitive theories, the general psychological and psychical processes that follow in the wake of trauma can be useful in helping to integrate traumatic experiences and should, in principle, not be regarded as pathological responses (Orner & Shnyder, 2003).

2.2.3. Social enviroment

The environment can be thought of in terms of physical and social dimensions. The social environment includes the groups to which we belong, the neighborhoods in which we live, the organization of our workplaces, and the policies we create to order our lives. There have been recent reports in the literature that the social environment is associated with disease and mortality risks, independent of individual risk factors. These findings suggest that the social environment influences disease pathways. Yet much remains to be learned about the social environment, including how to understand, define, and measure it (Yen & Syme, 1999). Human social environments encompass the immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact (Barett & Casper 2001). Components of the social environment include built infrastructure; industrial and occupational structure; labor markets; social and economic processes; wealth; social, human, and health services; power relations; government; race relations; social inequality; cultural practices; the arts; religious institutions and practices; and beliefs about place and community. The social environment subsumes many aspects of the physical environment, given that contemporary landscapes, water resources, and other natural resources have been at least partially configured by human social processes (Barett & Casper 2001). Embedded within contemporary social environments are historical social and power relations that have been institutionalized over time. Social environments can be experienced at multiple scales, often simultaneously, including

households, kin networks, neighborhoods, towns and cities, and regions. Social environments are dynamic and change over time as the result of bot internal and external forces. There are relationships of dependency among the social environments of different local areas, because these areas are connected through larger regional, national, and international social and economic processes and power relations (Barnett & Casper, 2001).

2.3. Sport for person with physical disabilities

2.3.1. Disability sports

The original purpose of disability sports as rehabilitation through sports expanded step by step to sport for sport as such where athletes face both positive and negative consequences. Top sports is no longer reserved for able bodied athletes, although synonyms for top sports are physical power, strength, endurance, and grace. It includes athletes with various disabilities like physical, mental or sensory impairments. All the major disability Games incorporate some form of volleyball. In the Paralympic Games, the sport takes the form known as sitting volleyball. The court for sitting volleyball is slightly smaller than for the standing game, and the net is considerably lower –about the height of a tennis net. (International Paralympic Committee, 2003). Special Olympics has team and Unified Sport team competitions. Lower-skill-level athletes compete in the volleyball juggle, volleyball pass, and volleyball toss and hit skills competitions. The game for the Deaf is played exactly as it is in the traditional form of standing volleyball (DePauw & Gavron,2005).

As individuals with a disability have entered the sport world, various terms have evolved to represent their involvement as perceived by the able-bodied sport world. Among the more prevalent of these are “handicapped sports”, “sports for the disabled”, “adapted sport”, “disabled sport”, “wheelchair sport” and “Deaf sport”. These terms generally imply a sport context designed for individuals with disabilities, and specify, in some istances, the type of disability.

These terms do not adequately describe the border entity of sport in which athletes with disabilities can be found: sport for athletes with disabilities specificially and sport that includes both athletes with disabilities and athletes without disabilities (DePauw & Gavron, 2005). Disability sports might include sports that were designed for a selected disability group: goal ball for blind athletes, wheelchair basketball for athletes with physical impairments who use a wheelchair, or sitting volleyball for athletes with lower-limb impairments. Disability sport also includes those sports practised by able-bodied individuals (e.g., athletics, volleyball, swimming), that have been modified or adapted to include athletes with disabilities (e.g., wheelchair tennis, tandem cycling), as wellas those that require little or no modification to allow individuals with disabilities to participate (e.g., athletics, wrestling, swimming), (DePauw & Gavron 2005).

Teachers and coaches of volleyball for the disabled should develop programs to the needs of individual players and select activities which match the performance level of the players. Today's challenge facing teachers and coaches is to integrate young people with disabilities into existing programs in schools and clubs. The extent to which integration in the games programs is a practical possibility will vary with the nature of the game and the disability. Both sitting and standing volleyball are one of the opportunities that fulfil criteria for successful integration in sports. Nowadays sports activities are widely recognized as life needs for all. Challenging persons with disabilities to try out new activities like volleyball can be a great way to motivate them. The number of variations in volleyball is limited only by a leader's imagination and the participants' curiosity. Sitting volleyball for example is not nearly as difficult to present as many people think once the basic principles of the game are thoroughly understood. Sitting volleyball has influenced the development of the particular skills, increasing large and fine muscle development and control, allowing players to gain mental alertness, develop social awareness

and the need for fair play. Sitting volleyball requires moving on the floor by using hands and quick reactions for getting into position early enough to play effectively (Vute, 2009).

This requires sufficient practice of basic techniques, plenty of play time, and the development of hand-eye and body co-ordination. For sitting volleyball to be played successfully on the elementary level, basic skills must be established. Teachers and coaches ought to receive specialized training in educating this substantial portion of the population. If the principle of gradual inclusion of disabled persons is accepted, and if a coherent policy is applied, all teachers, irrespective of their specialization or the level at which they are qualified, should receive at least a basic training in teaching persons with disabilities. The significant role of adapted physical activities in education, re-education and leisure activities should be recognized, including psycho-motor ability, well-being, functional gesture, motor behavior and sports movements (Vute, 2009). Physical activities form a link between rehabilitation or education on the one hand, and leisure on the other. The comprehensive training of any future teacher or leader of volleyball for the disabled should include a sound knowledge of the adaptation of physical activities. Teachers and coaches should be capable to introducing activities for disabled or health-impaired adults. Awareness must be heightened of the need of educate and train competent staff to promote and improve the conditions in which adapted physical activities are taught, too (Vute, 2009).

2.3.2. Sport as agent of socialization

Persons with disabilities are generally excluded from education, employment and community life from a young age. Exclusion deprives them of opportunities to engage and develop relationships with others - opportunities essential to their social development and important determinants of health and well-being. As a result, persons with disabilities may have had very little experience

greeting people, carrying on conversations and interacting with others. Sport is well suited to helping persons with disabilities acquire social skills they may be lacking. It teaches individuals how to communicate effectively as well as the significance of teamwork and cooperation, goal-setting, self-discipline, respect for others, and the importance of rules. Sport also enables persons with disabilities to take risks and learn how to manage failure and success in a safe and supportive environment (Serrill & Rainbolt, 1986).

Coaches and teammates provide important role models and can help persons with disabilities to develop skills they can apply in other aspects of their lives, such as employment. Sport's universal popularity makes it ideal for fostering social interaction, even in remote areas. By bringing together people with similar disabilities, sport contributes to normalization enabling persons with disabilities to share their experiences and enjoy camaraderie with others who understand their challenges and capacities. Through this peer interaction, persons with disabilities develop a positive sense of self and group identity because they no longer feel set apart they are like everyone else (www.un.org).

2.3.3. History and development of volleyball for the disabled

Sir (Doctor) Ludwig Guttmann, one of the founding fathers of organized physical activities for people with a disability, emigrated with his family to England in March 1939 as a refugee from Nazi Germany. While he was doing research at Oxford University in early 1944 he was asked by the British Government to set up a Spinal Injury Center at Stoke Mandeville Hospital. Here he put into practice unique ideas of treatment and rehabilitation of spinal cord paralyzed patients. The idea was very well accepted in Netherlands. Often sport meetings between Dutch and English players had set the basis for foundation of Stoke Mandeville Games. The first sports club for the disabled was established in the Netherlands as late in 1953. Athletics and Sitzball

(German origin) were the primary sports. Soon it was found that Sitzball, which is played sitting down on the floor, was too passive, more mobile forms of sports were looked for. The Dutch Sport Committee in 1956 introduced a new game, “sitting volleyball', combining Sitzball and volleyball. Since this time sitting volleyball has grown universally as one of the most practiced sports in competition for the disabled. Since 1967, international competitions have occurred, but it was not until 1978 that sitting volleyball was included in the International Sports Organization for the Disabled (ISOD) program. The first official International Tournament - under the umbrella of the ISOD - took place in 1979 in the Netherlands. In 1980, it was accepted as a Paralympic Sport with the participation of seven teams.Since 1993 the top class championships have been organized for women as well, including the Paralympic from 2004 (Vute, 2009). In 2000, volleyball would be played based on rally point. The point-on-serve scoring method had served or not, they had a chance to score a point. It was also the last games where standing volleyball was accepted into the Paralymic programme (Kwok, 2012). In 2002, the world championships were held in two different locations. Men competed in Cairo (Egipt and the women in Kamnik (Slovenia). In an all European team final , Bosnia and Herzegovina pulled of a victory over the best finish a German team had managed to achive since the 1984 Paralymic games (Kwok, 2012). In Europe, Bosnia and Herzegovina continue to hold onto the European crown after beating Germans in their home country, for the 2005 European Championships, which were held in Levercusen, Germany (Kwok, 2012). A year leter in 2007, all four zones held qualification matches for the Beijing Games. This was the firs time in th e history of Sitting Volleyball that all zonal committees had running tournament in the same year. The European Zone held its traditional European Championships (Kwok, 2012). The African Zone, in a former guise, organised its first Pan Arab Games. In Asian Pacific zone, the womens qualification tournament took place and the American Zone had the help of the Parapan American Games to

coordinate a zonal tournament (Kwok, 2012). The year 2011 was a year of qualification for the European and American zones. Bosnia and Herzegovina had qualifed from the world championships, and the best finishing European team other then the Bosnians would qualify. Bosnia and Hercegovina regruped to take the next three sets and continued to dominate in European men's Sitting Volleyball. The London 2012 Games were a major step foward in the advancement of the Paralympics. The men's final was eventually won by Bosnia, who managet to win their second goal in three Paralympics after being 1 set and 18-16 behind (Kwok, 2012). Sitting volleyball is a sport in which the disabled and able bodied can play together at a high technical level and, as such, represents a good opportunity for co-operation and integration. During the past years world volleyball and sitting volleyball as well has gone through a strong developmental process, introducing new rules and new playing possibilities. Today sitting volleyball is a popular world-wide game, played in Africa, both Americas, Asia, Australia and Europe, with its own playing concept and identity (Vute, 2009).

2.3.4. The start of sitting volleyball in Bosnia and Herzegovina

In 1981 the group of people with physical disabilities came together with the idea to found teams of sitting volleyball in Bosnia. The inspiration for this movement was Fadil Avdihodzi . The section "UPORNI" (persistent) was established. The roll model and the major support for this establishment was Croatian team SDI "HRABRI" (brave), which contributed the most to the building of this kind of activities in Sarajevo. Both teams met in Sarajevo for the exhibitiongame and afterwords discussed the rules of sitting volleyball. The team "UPORNI" started the learning procedures. However, that was the easiest part. The team was facing many issues such as playing hall etc. With the help of Institute for Blind Children in Nedzari i in Sarajevo, which offered the own hall, this problem was resolved. At the beginning the results were just modest. The only

mover for the young players was the hard work and persistence. The team very soon received recognition for their hard work, which was the invitation to represent the country, at that time former Yugoslavia at Paraolympic Games. The invitations went to the players: Sefko Nuhanovi , Mirza Hrustemovi , Mehmed Coli , Obren Pej i . This was a stimulus for many other players to get better and work harder which resulted in Yugoslavian Championships in 1989, 1990, 1991. the following players participated in triple Championships: Amir Kukavica, Sead Laka a, Zvonko Rabi , Dževad Kamber, Drago Pantic, Jasmin Kljaji , Sabahudin Hrelji , Svetozar Zimonji i Muamer Zuberovi (Mahmutovi & Turkovi , 1999).

In 1991 Champions Cup held in Holland, they came 7th place. Members of this team in conjunction with ex national selection have achieved extraordinary results. They won bronze medal in Paraolympic games in Arthem, silver medal on World Championship and bronze in Euro Championship in Cristiansand and in Sarajevo 1987. Amongs successes maybe counted 4th place in Los Angeles and Seul Paralympic games.

Until the beginning of the war, BiH tried to establish and run sitting volleyball on the wider area, which was successful. Within the framework of ex Yugoslavia in BiH, they played in the Republic league tournament under the principle that the winner went on to play in State Championship. During the war in 1992 all activities were stopped. In 1993 the late Bedrudin Kameri -Bedro who was coach of Sarajevo team collected members for the ''Preporod'' tournament where they played an exhibition match. Using the initiative of Mirza Hrustemovi , players who played before war and people with disabilities from war, formed SDI ''SPID''. Mirza Hrustemovi was elected as the president of SDI ''SPID''.He intensively started working with his contacts to form clubs in other towns. Internationally he achieved contacts with Republic of Croatia and Republic of Slovenia. In 1994 was first championship in sitting volleyball in BiH. Participants of championship were: SDI SPID, RVI Zenica, Zenica 2 and

Tuzla. First state champion in sitting volleyball was SDI SPID. In contacts with SDI Hrabri from Zagreb and through them they were able to sign for first qualification for European Championship for clubs and national teams. In 1994 Bosnia and Herzegovina participated in qualification for European Championship in sitting volleyball in group with: Yugoslavia, United Kingdom, Croatian and Austria. Bosnia and Herzegovina in 1995 qualified on European Championship in Ljubljana, Republic of Slovenia and achieved 11th place. From Sarajevo wars path over mounting of Igman they went to European Championship in Republic of Slovenia. In 1995 with instructions from European association of sitting volleyball they established ASO BiH (Association of sitting volleyball of Bosnia and Herzegovina). Thanks to Dutchman Savico Tubanten, the Secretary of the European Association of sitting volleyball we were received as ASO BiH in European (ECVD) and World Association of sitting volleyball (WOVD) 1995. In 1996 on qualification for European Championship which was held in Ravanama in Republic of Slovenia they qualified for European Championship 1997 in Tallinn (Estonia) where they won bronze medal. Traveling to Tallin by bus, one way was 3400 km, and this didn't stop the boys to achieve a good result and as a reward for good results, decision was made that the European Championship 1999 would be held in Sarajevo. In 1998 on World Championship they won bronze medal which allowed them automatic qualification to the Paralympics games in Sydney (Mahmutovi & Turkovi , 1999). Representation continued winning series when they won their first gold medal, in front of their fans, at the European Championship in Sarajevoin 1999 (Proti , 2010). Bosnia and Hecezegovina compete as an independant contry since 1995 and they have not missed an opportunity to win a medal on any important competitionsince 1997 year.

- 1997 EC Tallin, Estonia bronze medal
- 1998 WC Teheran, Iran – bronze medal
- 1999 Bosnia and Herzegovina EC – gold medal

- 2000 Paralympics Sydney – silver medal
- 2001 EC Hungary – gold medal
- 2002WC Egypt – goldmedal
- 2003. EC Finland – gold medal
- 2004. Paralympics Athena – gold medal
- 2005. EC Germany – gold medal
- 2006.WC Holland – goldmedal
- 2007. EC Hungary – goldmedal
- 2008. Paralympics Beijing – silver medal
- 2009. EC Poland – gold medal
- 2010.WC Oklahoma, USA – silvermedal
- 2011. EC Rotterdam, Holland – gold medal
- 2012. Paralympics, London UK – gold medal
- 2013. EC Poland – Elblag - gold medal
- 2014. WC Poland – Elblag - gold medal

(AssociationofSitting Volleyball ofBosnia and Herzegovina, 2014)

2.3.5. Standing Volleyball

Standing volleyball is played strictly according to FIVB standard international rules by amputees, deaf, mentally impaired, spinal cord-injured and cerebral palsy athletes on an integrated basis. Athletes with amputations may play with or without their prostheses. Advances in both upper and lower extremity prosthesis design have made it easier for single below-the-elbow, single above-the-knee, and below-the-knee amputees to play with their prostheses.

Depending on the sense of balance, some bove-the-knee amputees will choose to play without a prosthesis, hopping on a single leg (Paciorek & Jones 2001).

2.3.6. Sitting Volleyball

Sitting volleyball is played with six players per team on a smaller court with a lowered net. This version of the game enables double leg amputees and individuals with spinal cord-injuries, polio, and various other lower extremity disabilities play volleyball. The seated game makes the game considerably faster-paced than standing version. Sitting volleyball is an excellent activity for physical education classes and to foster inclusion of individuals with and without disabilities (Paciorek & Jones 2001).

Some differences from the standing game include the following:

- The size of sitting court is reduced to 10m x 6m, compared to the standing volleyball size of 18m x 9m.
- The height of the net is lowered to 1.15 m for men and 1.05 m for women.
- The player cannot lift up when carrying out an attack - hit, and some part of the body from the buttocks to the shoulders must remain in contact with the floor at all times.
- The use of prosthetic or orthopedic devices is not allowed.
- Front row players may not block an opponent s service.

2.4. Methods of questioning

2.4.1. Interview

In situations where you won't get more than one chance to interview someone, semistructured interviewing is the best. It has much of the freewheeling quality of unstructured interviewing, and requires all the same skills, but semistructured interviewing is based on the use of an interview guide. This is a written list of questions and topics that need to be covered in a particular order (Bernard, 1988). Interviewing involves asking questions and getting answers from participants in a study. Interviewing has a variety of forms including: individual, face-to-face interviews and face-to-face group interviewing. The asking and answering of questions can be mediated by the telephone or other electronic devices (e.g. computers). Interviews can be structured, semi-structure or unstructured. Semistructured interviewing works very well in projects where you are dealing with high-level bureaucrats and elite members of a community - people who are accustomed to efficient use of their time. It demonstrates that you are fully in control of what you want from an interview but leaves both you and your respondent free to follow new leads (Bernard, 1988). It shows that you are prepared and competent but that you are not trying to exercise excessive control. Many researchers like to use semi-structured interviews because questions can be prepared ahead of time. Semi-structured in-depth interviews are the most widely used interviewing format for qualitative research and can occur either with an individual or in groups (Dicicco-Bloom & Crabtree, 2006). This allows the interviewer to be prepared and appear competent during the interview. Semi-structured interviews also allow informants the freedom to express their views in their own terms. Semi-structure interviews can provide reliable, comparable qualitative data.

2.4.2. Semi-structured Interviews

- The interviewer and respondents engage in a formal interview.
- The interviewer develops and uses an 'interview guide.' This is a list of questions and topics that need to be covered during the conversation, usually in a particular order.
- The interviewer follows the guide, but is able to follow topical trajectories in the conversation that may stray from the guide when he or she feels this is appropri.

2.4.3. When to use semi-structured interviews

Semi-structured interviewing is the best used when you won't get more than one chance to interview someone and when you will be sending several interviewers out into the field to collect data (Bernard (1988). The semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable, comparable qualitative data. Semi-structured interviews are often preceeded by observation, informal and unstructured interviewing in order to allow the researchers to develop a keen understanding of the topic of interest necessary for developing relevant and meaningful semi-structured questions. The inclusion of open-ended questions and training of interviewers to follow relevant topics that may stray from the interview guide does, however, still provide the opportunity for identifying new ways of seeing and understanding the topic at hand (Bernard (1988).

2.4.4. Recording Semi-Structured interviews

Typically, the interviewer has a paper-based interview guide that he or she follows. Since semi-structured interviews often contain openened questions and discussions may diverge from the interview guide, it is generally best to tape-record interviews and later transcript these tapes

for analysis. While it is possible to try to jot notes to capture respondents' answers, it is difficult to focus on conducting an interview and jotting notes. This approach will result in poor notes and also detract for the development of rapport between interviewer and interviewee. Development of rapport and dialogue is essential in unstructured interviews. If tape-recording an interview is out of the question, consider having a note-taker present during the interview (Bernard 1988). I constructed the interviews using a Dictaphone. All participants gave me permission to record the interviews as it is important for ethical reasons to gain theirconsent. I took interviews when the team was preparing for Paralympic games in London 2012. The team was based in a rehabilitation center‘‘Reumal‘‘ in Fojnica (Bosnia and Herzegovina). I was allowed to meet the full national team, but with time constraints and knowing the team was preparing for the Paralympics I only took interviews with 9 members. I gave structured information to all members taking part. This made them more enthusiastic to take part. I spent two days with the members of the team, hence them cooperating and allowing me to get to know them on a personal level. They were all willing to speak and discuss information. Each interview was between 40-60 minutes in Bosnian language.

3. AIM AND RESEARCH QUESTIONS

3.1. Rationale

We are led to believe that the re-entry to physical activity after trauma took at least two years. In research of (Skovajsova, 2011) time needed to reentry to physical activitiesafter trauma was 1 year and 8 months so almost two years. According (DePauw & Gavron, 2005) in their bibliography had athletes who had trauma, they needed almost two years to start with physical activities and competitive sport. Through our basic understanding we know that movement and physical activity have a positive influence to man. The people with physical disabilities who do physical activities and effects that contribute to socialization, even they are the limited with some factors to re-entry to physical activities after trauma. Trauma could be from many circumstances. I put particular attention to those of affected by mines trauma after the war in Bosnia and Herzegovina. I have enclosed data to this thesis relating to the massive problems concerning the history of mines.

3.2. Aim of thesis

The main aim of this thesis was to find determinates which influence the re-entry of participants to physical activity after trauma at BiH national Sitting Volleyball team. The main aim can be divided into two sub-aims:

1. To formulate time spent to re-entry to physical activities after the war trauma
2. To compare the data with former results in country with different conditions (Czech Republic).

The results of the aim should define recommendation for practice in Bosnia and Herzegovina.

3.3. Research questions

The aim of the research theses has to we obtained with research questions as follow:

1. Is it possible to formulate the determinants in relation with time of re-entering to physical activity after trauma?
2. Are some of those determinants more important (or typical, most effective)?
3. Are those determinants connected with:
    - technology – economy situation,
    - the origin of the trauma,
    - psychosocial or environmental features ?

3.4. Procedure and schedule

1. Study of literature review related to key words.
2. Compose the project.
3. Obtain consensus of participants.
4. Elaborate semi-structural interviews.
5. Organize situation for interviews.
6. Perform interviews.
7. Process the data from interview.
8. Analyze and evaluate obtained data.
9. Formulate the most effective determinants.
10. Conclusion, final report with documents.
11. Gain feedback from participants.

4. METHODS

4.1. Participants

Table 1.General information about participants

Participants	Age	Time after trauma to re-entry to PA	Years of time in sitting volleyball	Location of living
1	37 years	12 months	18 years	Sarajevo
2	42 years	5 months	18 years	Sarajevo
3	43 years	8 months	18 years	Sarajevo
4	32 years	24 months	17 years	Tuzla
5	26 years	60 months	6 years	Sarajevo
6	28 years	120 months	11 years	Sarajevo
7	32 years	6 months	16 years	Tuzla
8	55 years	60 months	28 years	Sarajevo
9	45 years	6 months	18 years	Tuzla
Sumary	M= 37.7 years	M=33months	M=16.66 years	

4.2. Study of documents

Literature review, inspiration of (Vute, 2009) & (2004), (Skovajsova, 2011), (Proti ,2010), (DePauw PK. & Gavron, 2005), (Kwok Ng, 2012). Statistics data about unenploinment of

disability people in Federation of Bosnia and Herzegovina. I found in the research of (Blatnik, Selimovi and Mujezinovi , 2013), which was supported by a Lifelong Learning Program of the European Commission in Federation of Bosnia and Herzegovina.Data about landmines and UXO (Unexploded Ordnances)in Bosnia and Herzegovina I found in the research of D. Van Beurden (2007), wich was suported of BHMAC (Bosnia and Herzegovina Mine Centre). Data about rights of person with disability and their implemetnation I found in a regular recommendations of the ombudsmen for Human Rights of Bosnia and Herzegovina.

4.3. Instrument

Questioning - semi – structured interview

Semi-structured interview was used with 9 sitting volleyball players as we anticipated sensitive experience of participants in after trauma situation. The interview is more kind and more exact than questionnaire – the same for everybody. The most personal data from personal experience can be expressed to semi-structured interview. The semi-structured interview is original (author of presented thesis) with inspiration of (Skovajsova, 2011) & (Proti , 2010).

Structure of question formulated for the interviews consisted from topics:

1. Life and activities before trauma in BiH national sitting volleyball team;
2. Injury and your perception of your diagnosis;
3. Medical care, rehabilitation and influence of family and friends after post traumatical condition;
4. Sports activities which you participated in after trauma;
5. Economic situation.

6. Their biggest perceived problem?

7. Time taken reentry to physical activities after trauma?

Each interview had introduction part, interview and conclusion

4.3. Data processing

Gained interviews were transferred into electronic format. On the basis of logical analysis, sorting facts got from interviews and material gained, they were sorted into factual categories. In result they were used in the frame of casuistic method of research. I have created my own categorical scale relevant with Skovajsova 2011 for results comparison. The category represents the determinant. Within the category Likert scale of intensity was used. Point are divided by importance, where the first level represents the most important determinant (point 8 – the least important, point 1 the most important). The result is average merit of importance, where counted points by number of participants. As for the impact to return to physical activity determinants are divided into: positive, negative and neutral. Positive determinants are marked with the symbols +, negative - and neutral 0.

4.3.1. Determinants cods

- Family - (FAML)
- Former friends - (FOFR)
- New friends same disabilities - (NFSD)
- Staying in hospital - (STHO)
- Rehabilitation - (REHB)
- Economic situation (ECST)
- Sports environment (SPEN)

- Society - (SOCT)
- Car - (CAR)
- Time to reentry to physical activities - (TRPA)

4.4. Research management

After my original meeting with Doc. PhD. Ifet Mahmutovi , Vice Dean of teaching in Faculty of Sport in Sarajevo, he organized a meeting for me with BiH national team. This allowed me to set up interviews, when the team was preparing for Paralympic games in London 2012. The team was based in a rehabilitation center ‘‘Reumal‘‘ in Fojnica. I was allowed to meet the full national team, but with time constraints and knowing the team was preparing for the Paralympics I only took interviews with 9 members (see Table 1). I gave structured information to all members taking part. This made them more enthusiastic to take part. Each interview was between 40-60 minutes. I constructed the interviews using a Dictaphone. They all gave me permission to record the interviews as it is important for ethical reasons to gain their consent. I spent two days with the members of the team, hence them cooperating and allowing me to get to know them on a personal level. Part of my master thesis, I had to gain information about determinants which influence the re-entry to physical activity after trauma. So to help me, I decided to use semi-structural interviews, with the aid of structured questions designed to gain maximum information of determinants discussed in my thesis. All members who took part treated me like a guest. They were all willing to speak and discuss information which was personal and at times sensitive. For this I am very grateful as it helped me a great deal.

5. RESULTS

In the final part of my thesis casuistic examples are described which are based on the same structure that have logical sequence of events. So they have to be conclusive and if they are relatively extensive, they have all information from where I made specific conclusions. Altogether 9 case studies is presented where each participant was a member of BiH sitting volleyball team. The case study is accompanied with category abbreviation. The documents of interview (in Bosnian language) are in attached CD-rom. The second part of results is oriented on analyses of determinants perceived with sitting volleyball players. I have created my own categorical scale relevant with (Skovajsova, 2011) for comparation results.The category represents the determinant. Within the category Likert scale of intensity was used. Point are divided by importance, where the first level represents the most important determinant (point 8 – the least important, point 1 the most important). The result is average merit of importance, where counted points by number of participants. As for the impact to return to physical activity determinants are divided into: positive, negative and neutral. Positive determinants are marked with the symbols +, negative - and neutral 0.

Outline of eachcase study:

1. Participant No;
2. Age;
3. Diagnosis;
4. Short biography;
5. The cause of his disability and medical treatments after injury;
6. Returning home;
7. Activities he enjoyed;
8. The biggest perceived problem;
9. Conclusion.

5. 1. Case studies

5.1.1. Participant 1

Age: 37

Diagnosis: Tibia, amputated right leg.

Short biography

Before the war, he lived with his father, mother and sister in Sarajevo. He had always been interested and involved in sports such as football and basketball [SPEN+]. After he got wounded, he started playing sitting volleyball. He got married in 2007 and became a father of two children. He is employed as a props manager in a sports hall in Dobrinja [ECST+]. Today he plays for OKI Fantomi and is also a representative of the BiH national team, playing in all positions. He owns a car which is adapted to his handicap [CAR+].

The cause of his disability and medical treatments after injury

He was wounded in 1993 when he was 16 years old in the Sarajevo quarter, Dobrinja. The injury came after two grenades were dropped on a football pitch in the residential buildings where he use to live. He spent three and a half months in hospital in Koševo [STHO-]. He never went for rehabilitation [REHB-].

Returning home

After returning from the hospital he emphasized that the greatest support were friends [FOFR+], who helped him to get out of a severe mental condition, which for him was the one aspect of rehabilitation. He thought that the loss of a leg meant that he no longer would be able to play sports. On the contrary, a year after leaving the hospital in 1994 he meets Mr. Meho oli [NFSD+] who was a sitting volleyball trainer before the war, who urged him to start to train and play sitting volleyball. He says that in the beginning it was very difficult to go to training. He went with his bicycle, and even hitchhiked because there was no public transport [SOCT-].

Activities he enjoyed

He says that walking on crutches was the first physical activity and is what held him in shape. Before he used to ride a bicycle but today besides playing volleyball, he enjoys playing table tennis. He is a member of the OKI Fantomi of Sarajevo and BiH representative in sitting volleyball. He has been working in the sports hall Dobrinja as a props manager [ECST+]. With the BiH representative team he has won gold at the Paralympics, and is a European and World champion.

The biggest perceived problem

He says that he has had more problems. He could not do 40-50% of the things he could before. He could not run or move without crutches or braces. Today there are no barriers and he moves freely with the prosthesis that he has.

Conclusion

Respondent had a problem until he recovered, like all citizens after the war [SOCT-]. There was no electricity, water, gas, and public transportation. But he points out that his friends gave the greatest support and that is thanks to them and the family that he is where he is today [FAML+].

Time to re-entry to physical activities was 12 months.

5.1.2. Participant 2

Age: 41

Diagnosis: tibia, amputated right leg.

Short biography

Before the injury he was living with his parents in Sarajevo. Until the war crisis, his major sport was judo. Recently he is Captain of Bosnian national team in sitting volleyball. His father died when he was just eighteen and soon after he left after his mother passed away. Respondent is a war veteran and he received a disability allowance entitling him to rights from the law on additional rights of war veterans. He got married when he was thirty seven and obtained his driving license before the war.

The cause of his disability and medical treatments after trauma

He was wounded when he was 20 years old in Sarajevo's settlement Otes from tank grenade. From December 1992 till march 1993 he spent time in a military hospital in Sarajevo. He was not in the mood for returning home because he was living on the ninth floor. He spent three months in hospital [STHO-0].

Returning home

After he got out from hospital he had received prosthesis, which enabled him to start playing basketball with friends [FOFR+] in 1993. He was living on the ninth floor (last floor), which made problems [REHB-] with going up and down the stairs, considering there was no electricity and the lift was not working. He never went out of the flat during the gun shots. One day he received a phone call from his friend [FOFR+] to come down in front of the building where he give him a new car [CAR+]. It helped him to be more active and to change the bad image about himself and enabled him to start actively with power-lifting and athletics.

Activities he enjoyed

On the recommendation of his brother [FAML+] he was invited to the practice of Disability of Sports Association SPID from Sarajevo and from 1996 year he started playing sitting volleyball. During that time SPID splitted into two teams and that is how the second sitting volleyball club in Sarajevo was established. There was a need for more players [NFSD+]. He joined SPID in April 1996 and already by September he received a call to join the representation of BiH for the preparation for European championship in Estonia [SPEN+]. He is also a member of the club organization and works in the parliament of Sarajevo canton.

The biggest perceived problem

He says that he did not have some major problem and he was aware of his disability all the time. On thought that he could have died, he is grateful to God that he stayed alive and to be where he is now. He had no problems with reintegration in society, uncoutrary, his friends are helping him more now than before the injury [FOFR+].

Conclusion

Respondent has recovered very well and soon after returned home. He started actively participating in sport activities such as basketball, weightlifting and later sitting volleyball. He was not maintaining financial problems [ECST-0] but he emphasized his need of support to his family and friends [FAML+], [FOFR+]. He is a member of a club commission board, works at the Sarajevo canton parliament and gives his maximum contribution to society [SOCT+].

Time to re-entry to physical activities was 5 months.

5.1.3. Participant 3

Age: 43

Diagnosis : amputated left foot, injury right foot and both eyes.

Short biography

Born in 1968 in Sarajevo, where he finished Elementary School and High School. He lived with his parents at the time of being wounded. His father was a good craftsman who worked on famous buildings such as the Presidency or the Cathedral, therefor the financial situation is the family had always been good [ECST+]. He got married during the war in 1992, today he has a 21 year old son. He was actively engaged in little league for soccer until the beginning of the war. At the Faculty of Sports and Physical Education in Sarajevo he acquired the title of Master of Sports. He is a permanent member of the Bosnia and Herzegovina national team since 1997. He is employed in the Ministry of Culture and Sports in the Canton of Sarajevo.

The cause of his disability and medical treatments after injury

He was wounded on 13.08.1995 as a member of the Army of Bosnian and Herzegovina while performing combat tasks from landmines. He was not able to be transported to Sarajevo, therefor he is transported to Tuzla for treatment, where he remained for two months [STHO +]. In Tuzla he meets the secretary of SKISO Sinovi Bosne, VehbijaTokic, who introduces him to sitting volleyball [NFSD+]. He then returns to the Clinical Centre in Sarajevo, where he also remains for two months. He spent eight months in a wheelchair during rehabilitation [REHB-].

Returning home

Upon returning home he spent two years moving around with crutches. At the encouragement of family [FAML+].and fellow brother for the selector, his late neighbor Nihad Hrustemovic he starts training in sitting volleyball [SOCT+], eight months after being wounded. He starts playing actively for ‘‘SDI Spid Sarajevo‘‘ and the Bosnian and Herzegovinan national team.

Activities he enjoyed

In addition to playing sitting volleyball, he is also engaged in basketball, swimming, bicycle riding and playing beach volley [SPEN+].

The biggest perceived problem

After the war in Bosnia and Herzegovina the public transportation was poor, so he went to training in a van but walked home because there were not enough scheduled routes. Sometimes the walk home would last two hours. In 1998 he byes a car that is adapted to his handicap and since the he has had no problems with transportation and going to training [CAR+]. With the normalization of his situation and his awareness of his handicap, he quickly returns to a normal life. He did not have problems with returning to his friend and their company, he was even seen as a hero by his friends who gave him much support [FOFR+].

Conclusion

Today he has a normal life with his family in Sarajevo. He is a permanent member of the SDI SPID Sarajevo and of the national team in sitting volleyball. He is a gold winner at the European and World championships and a winner at the Paralympics in London. He has a Master of Sports and is employed at the Ministry of Culture and Sports in the Canton of Sarajevo. [ECST+].

Time to re-entry to physical activities was 8 month.

5.1.4. Participant 4

Age: 32

Diagnosis: does not have a heel on the left foot.

Short biography

Before the war, he was living with his mother and sister in Lukavac town, near Tuzla. His father died before the war. He started his career in the club named "Sinovi Bosne Lukavac". Today, he is playing for "SDI Spid, Sarajevo" and he is also a member of the BaH National team in sitting volleyball. When he was younger, he was playing soccer and doing karate. Nowadays, besides sitting volleyball he is doing gym and swimming. He also possesses a car, modified to his disability [CAR+].

The cause of his disability and medical treatments after injury

He was injured in 1994. in Jaruska near Tuzla, while he was visiting his house. He stood on a land mine and hurt his left heel. He spent three months in hospital in Tuzla and then went to Germany [ECST+]. where he continued the treatment for another 3 months [STHO+]. and remained two years in rehabilitation [REHB+]. He had great support from the family which did not allow him to fall into any of psychological crisis and to feel handicapped [FAML+]. It took him a year and a half to get back on feet and walk.

Returning home:

After returning home from rehabilitation, he meets his neighbor Ibrak Ibrakovi [SOCT+] and on his Ibrak's persuade, he starts to play sitting volleyball. At the first he did not like it, but his family was pushing him to practice and eventually he started to love sitting volleyball. At the age of 18, he took the driver's license and got a car from his mother as a gift.

Activities he enjoyed

Besides sitting volleyball, he is going to the gym and swimming regularly. As a member of the "SDI Spid Sarajevo" and Bosnia and Herzegovina national team in sitting volleyball, he won the Paralympic games with his team and become the World's and European Champion.

The biggest perceived problem

He had a big psychological problem by thinking that he would not be able to do sports ever again and that because the end of his world. Somehow, it ended that his handicap does not represent a major problem. Both his family and doing the sitting volleyball helped him to overcome mental problems and go back to his everyday life. He possesses braces, but he is not wearing it because he feels uncomfortable with it and also it is making a wound on his foot.

Conclusion:

Respondent had a mental-psychological problems but with big support of his family's and friends [FOFR+], his life started to get normalized. He started his professional career in Club "Sinovi of Bosne Lukavac" and later then playing for the "SDI Speed Sarajevo". He is an active member of Bosnia and Herzegovina national team in sitting volleyball, with whom he won the Paralympics games, became the World's and European Champion, and also the multiple champion of Bosnia and Herzegovina in sitting volleyball [NFSD+], [SPEN+].

Time to re-entry to physical activities was 24 months.

5.1.5. Participants 5

Age: 26

Diagnosis : injured in head from a sniper bullet.

Short biography

He was born in 1988 in Sarajevo, Bosnia and Hercegovina. Recently he lives with his dad, mum and sister in Sarajevo. He graduated high school in Sarajevo. He began his career in 2005 and became a member of the Bosnian sitting volleyball representation in 2010.

The cause of his disability and medical treatments after injury

He was wounded by a sniper shot when he was 5 years old in Sarajevo's settlement Dobrinja. Immediately after the injury he went into operation in Sarajevo's war hospital, where he stayed for two weeks and then went to rehabilitation of physical therapy. [STHO 0], [REHB+].

Returning home

After he returned from the hospital and when he finished his therapy he meet his neighbor mister Mehmedalija Colic [SOCT+]who introduce him on training of sitting volleyball in a Club SDI SPID Sarajevo, where he started his sitting volleyball career. He had big support of his family and friends.

Activities he enjoyed

He enjoyed many activities such as football and basketball and after he started to play sitting volleyball.

The biggest perceived problem

The biggest problem was that he can play basketball but he can not have medical certificate to play on competitive level. Also one of his problem was therapy period because it was dangerous to go to therapy. [REHB-].

Conclusion

Today, he is considered as an very successful man and sitting volleyball player of Representation of Bosnia and Herzegovina. He is one of the best Bosnians libero and the best European libero player. Sports is the this young man opened the door life to him even as a boy, criminals wanted to take. His biggest support through out his career and post traumatic period, were his parents and former friends and after his clubs colleagues. [FAML+],[FOFR+],[NFSD+].

Time to re-entry to physical activities was 60 months.

5.1.6. Participant 6

Age: 28

Diagnosis: Amputated left foot.

Short biography

Before his injuries he lived with his father, mother and older brother in Sarajevo. He was a six year old boy when he was wounded in 1993. His father was a worker in the ‘’Sarajevska pivara’’ (Sarajevo´s brewery), and his mother was a housewife. He finished college at the Faculty of Political Sciences in Sarajevo and awaited a masters from the sports faculty in Sarajevo. The last two years has been working in BH - Telekom in the Security Service. He began his sitting volleyball career in 2003. In 2006 he became a permanent member of the national sitting volleyball team of Bosnia and Herzegovina. He also possesses a car [CAR+].

Injuries and subsequent medical care:

He was wounded in Sarajevo’s settlement ‘’Buca potok’’ in 1992, when he was 6 years old. On that unfortunate day he and his friends were played on the street, located front of the house, when was fell grenade. He spent two months on treatment at the Military hospital in Sarajevo. After that he does not have prosthesis and had complications [STHO-]. When it happened he went to the same hospital to did second operation [STHO+]. He got his first prosthesis and overcome his problems.

Returning home:

When he returned from the hospital, he had some complications from the surgery, which was not easy for him. He had problems with stability from his first surgery as they did not provide him with a prosthetic foot. After two months he returned to the hospital for his second operation, in which the social insurance covered him for a prosthetic foot at the age of 7, every 3 years he changed the prosthetic foot because at this age he was still growing. [SOCT+].

Specific activities:

He was not able to do specific activities because it was impossible in the time of war. Periodically he spent time with friends at home and played games for children. When school started, he participated in all physical education classes, excluding the activities he was unable to do. The whole school understood his situation

Personally the biggest perceived problem:

After the war he began living his normal life, but sometimes he felt ashamed. After he got his prosthetic leg he no longer felt left out and ashamed. During that period his biggest support was from his friends and family.

Conclusion:

Today he lives a normal life with his family, and is included in all social aspects [SOCT+]. Most of his help came from friends and family and the people he met in the Club Fantomi in Sarajevo, where he is still a member and Capitan of the club [FAML+], [FOFR+], [NFSD+].. He has been a permanent member of the national team of Bosniaand Herzegovina. Thanks to his victories with the representation and together with the rest of his team he had the opportunity to visit an unbelievable number of countries and meet people from all over the world [SPEN+]. Because of sitting volleyball, he studied physical education and after he got a job. He is a well respected person in his city. He wanted to say to all young people that wanted to play this sport, ‘‘give yourself the opportunity to play sitting volleyball, as it can change your life‘‘.

Time to re-entry to physical activities was 120 months (becouse he was wounded as very yung).

5.1.7. Participant 7

Age: 32

Diagnosis: Tibia, amputated right leg, unfortunate injuries on the left arm where there was limited extension and no supination of the palm.

Short biography

Before his injuries he lived with his father, mother and brother in a village called Devetak, at the foot of the mountain Ozren near Lukavac. His father was a worker on the Koksara on hold, and his mother took care of the house [ECST+]. He married in 2005 and had a son in 2007. He finished elementary school in the village called Puzecic and secondary electro-technical school in Lukavac. He participated in various seminars, academies, round tables (discussion tables) and symposiums where he talked about the dangers of mines and the need of faster de-mining, as was in his case. He finished college at The Faculty of Physical Education in Tuzla and awaiting a masters in sports management. He began his career in the sitting volleyball Club “Sinovi Bosne“ Lukavac, and later moved on to Sarajevo SDI SPID and is a permanent member of the national sitting volleyball team for Bosnia and Herzegovina. He have a car [CAR+].

The cause of his disability and medical treatments after injury

He was wounded in the village of Devetak, near the county Lukavac on May 19th 1997, when he was 16 years old. On that unfortunate day he and his brother were helping his mother work on the fields, located about 400 meters from the house, when he activated a mine “Prome 1”. He spent two months on treatment at the University Clinical Center Tuzla [STHO+]. and four months in a rehabilitation facility. During his rehabilitation period at the University Clinical Center Tuzla, where the Physiotherapy Clinic was located, he met mr.Vehbija Tokic who at the time was secretary of the club Sons of Bosnia Lukavac, and mr.Fahrudin Muharemovic who was

a coach. They invited him to train and he had until now been actively engaged in sitting volleyball [REHB+].

Returning home:

When he returned from the hospital he had to continue with his education, which for him was not easy. With a lot of hard work and help of friends from school [FOFR+], he got the material needed to return to school in January 1998. He said he was a favorite among friends at school and his twin brother gave him invaluable support and assistance [FAML+]. He said “I lived in a house where there were several steps to the entrance, which created a huge obstacle because I always needed someone to help med.” When he got his first prosthesis he overcame this problem.

Activities he enjoyed

He played table tennis actively and even participated at the state championship for persons with disabilities [NFSD+]. He also played basketball whenever he was able. He said ”I follow football but unfortunately I cannot play.”

The biggest perceived problem

He stated, the hardest part was going back to school. It was a big shock for me and I had to open up in ways so I could continue with a normal life. I was ashamed, and it felt as if my disability was invincible. When I got my prosthesis the thing that bothered me the most was the injury on my arm, as it was quite noticeable. When I returned to school I was under a lot of pressure for 2-3 months, because everyone was asking what had happened, what it was, which created a lot of discomfort for me. But with the help of my friends from school, I realized that the problem was not as I had perceived it. Today, it is an entirely different matter and he speaks about his handicap normally and without any emotions.”

Conclusion

Today he lives a normal life, and is included in all social aspects [SOCT+]. Most of his help came from friends and family and the people he met in rehab who invited him to the first training at the Club Sinovi Bosne, where he is still a member. He is employed in the management of the club, and has been a permanent member of the national team of Bosnia [SPEN+] and says that he feels fulfilled and happy.

Time to re-entry to physical activities was 6 months.

5.1.8. Participant 8

Age: 55

Diagnosis : Infantile paralysis (poliomielitis), paralysis of the left leg up to the left hip.

Short biography

He was born in 1959 in the village Gazije, Bosnia and Hercegovina. His father was a bricklayer and his mother a housewife. He had a sister who he does not remember as she died very young, and two brothers who lost their life during the Bosnian war. He graduated from elementary school in Sarajevo and from junior high in Fojica. He received his high school degree in Titograd (Podgorica, Montenegro). Through his school and sports career he gets to know many people who will be a significant support in his further life [SOCT+]. He lives with his wife and two children in Bosnian capital, Sarajevo. He was a member of sitting volleyball representation of former Yugoslavia from 1986 to 1992. Currently, he is a coach of Bosnians sitting volleyball representation.

The cause of his disability and medical treatments after injury

Unfortunately, his disability was caused due to the medical mistake [STHO-], as he was mistakenly given the wrong immunization at his very young age 20 months. Since then he does not feel his left leg up to his left hip. Medical treatments started right after the injury [STHO+]. He went through multiple rehabilitations centers in former Yugoslavia such as, rehabilitation center for disabled in Banja Luka, rehabilitation center for disabled in Fojnica and finally Titograd, where he as already mentioned above, graduated from high school [REHB+].

Returning home

After he graduated from the high school he returned to his parents house in Sarajevo. As his medical treatments required him to constantly move from place to place, he was very fortunate to

meet many great people who believed in him and helped him to establish his sports career. Shortly after he returned home, his father bought [ECST+] him a handicap vehicle [CAR+].

Activities he enjoyed

He enjoyed many after school activities such as reading and buying hypnosis books, chess, table tennis, picking the fruits, however, soccer was one of his favorite activities. After he had returned to Sarajevo he starts showing more and more interests in gymnastics, swimming, basketball and table tennis. In 1982 a group of athletes from Zagreb [NFSD+], Croatia arrived in Sarajevo (SPD HRABRI). They used to compete in gymnastics, swimming etc. After a while they started playing sitting volleyball, which he happened to like very much. He became member of sitting volleyball representation of former Yugoslavia. Shortly after Bosnian war found an end, he joined the sitting volleyball club in Sarajevo. He used to play for SDI SPID Sarajevo, he was a player of sitting volleyball club of Bosnia and Herzegovina. Currently, as we mentioned above, he is a very successful sitting volleyball representation coach of Bosnia and Hercegovina.

The biggest perceived problem

Considered, that he unfortunately got disabled at an very young age, he learned to solve all of his issues in life through hard work and commitment. What is more important, as he stated, he accepted his disability and tried to push forward as far as he could. And he never stopped believing in himself and never gave up on himself. He used to have an leg braces which enabled him to move around. While playing sports, he used to have a hammer and screwdriver with all the time. It seems important to mention, that after he graduated from the elementary school, he used to play sports on a daily basis, so that the leg braces which helped him move, would give up on many occasions. Due to this, he always had to have the tools with him, so he could fix it when it was not working properly.

Conclusion

Today, he is considered as an very successful man, husband, father and sitting volleyball coach of representation of Bosnia and Herzegovina. His team is achieving great results Bosnia and Herzegovina has won four Paralympic medals, all in men's sitting volleyball, a silver in 2000, a gold in 2004, a silver in 2008, and finally, a gold in 2012. His biggest support through out his carreer and education were his parents and school mates [FAML+],[NFSD+]. He was a member of sitting volleyball representation of former Yugoslavia from 1986 to 1992. He was actively playing for SDI SPID Sarajevo. After his career as a player he gets the great opportunity of being nominated for a coach of sitting volleyball Representation of Bosnia and Hercegovina [SPEN+].

Time to re-entry to physical activities was 60 months.

5.1.9. Participants 9

Age: 47

Diagnosis : amputation of the left foot, paralysis of the left fingers of leg.

Short biography

He was born in 1968 in Zvornik, Bosnia and Hercegovina. Nowdays he live with his wife, two children and mum in Tuzla. He graduated high school in Zvornik and after war started he moved with his family to live in Tuzla. His wife working in school and his mum is in pension. His children going to schoole in Tuzla. He is a member of Bosnians sitting volleyball representation.

The cause of his disability and medical treatments after injury

Unfortunately, he was wounded on 14.6.1995 as a member of the Army of Bosnian and Herzegovina while performing combat tasks from landmines in Kalesija. Since then he does not feel his fingers of the left leg and does not have the left foot. Medical treatments started right after the injury at the hospital in Tuzla [STHO+] , where he stay six month. In the beginning of 1997 he went to rehabilitations center in Fojnica [REHB+].

Returning home

After he returned from the hospital he meet mister Fadil Džirak [NFSD+]. who introduce him on training in ‘‘Club 8 April Zvornik‘‘ where he started his sitting volleyball career. He had big support of his father who died in 2004 [FAML+]. His former friend bought him a car [FOFR+],[CAR+].

Activities he enjoyed

He enjoyed many activities such as football and karate, soccer was one of his favorite activities because he used to live near to football stadium. [SPEN+].

The biggest perceived problem

The biggest problem was that he taught that doctors will cut his leg and after that did not happened he continued with normal life.

Conclusion

Today, he is considered as an very successful man, husband, father and sitting volleyball member of Representation of Bosnia and Herzegovina. His team is achieving great results Bosnia and Herzegovina has won four Paralympic medals, all in men's sitting volleyball, a silver in 2000, a gold in 2004, a silver in 2008, and finally, a gold in 2012 [SPEN+],[NFSD+]. His biggest support through out his carreer and post traumatic period, were his parents and former friends and after his clubs colleagues. [FAML+].

Time to re-entry to physical activities was 15 mounts.

5.3. Determinants analyses

Table 2. Determinants of relevance and time to re-entry to physical activities

Respondants / Determinants	1 37 years	2 42 years	3 43 years	4 32 years	5 26 years	6 28 years	7 32 years	8 55 years	9 45 years	Average Results
FAML	1	1	1	1	1	1	1	1	1	1
FOFR	2	1	2	2	2	2	2	1	2	1.77
NFSD	1	1	2	3	3	7	3	1	1	2.44
SPEN	3	3	6	4	2	1	3	3	4	2.55
CAR	5	5	4	5	4	4	5	5	6	4.77
REHB	8	8	8	5	5	8	2	1	7	5.77
SOCT	2	3	3	3	5	6	6	8	5	7.22
STHO	7	8	8	7	8	7	8	8	7	7.55
ECST	8	8	8	8	8	8	7	7	7	7.66
Time to returned to participate in PA	12 months	5 months	8 months	24 months	60 months	120 months	6 months	60 months	6 months	33 months

Legend of Table 2: Family – FAML, Former friends FOFR, New friends with same disabilities - NFSD , Sports environment – SPEN ,Car – CAR, Staying in hospital – STHO, Staying in rehabilitation center – REHB, Society – SOCT, Economic situation – ECST, PA – Physical activities

Table 2 shows the participants scoring on the Likert scale. The scale is composed of the determinants in the point system of 1 to 8 degrees in the categorical scale. Determinants are lined by relevance affecting the individual to restore physical activities. The first stage indicates the most important determinant until the eighth level which indicates the least important determinant. The table above shows that the families placed first, in second place the old friends and in the third place new friends with the same or similar disabilities. On the fourth place we

see the sports environment/surroundings, on the fifth place is possession of the car, in sixth place is a stay in rehab and the seventh overall impact of all the social environment. In eighth place is hospital stay and ninth is the economic situation. The table also shows the time needed to re-entry to physical activities that I got from the analysis of semi-structured interviews. The average re-entry time is 33 months.

Table 3. Influence of the determinants to re-entry to physical activity after war trauma in Bosnian and Herzegovinian Sitting Volleyball team

Respondants / Determinants	1 37 years	2 42 years	3 43 years	4 32 years	5 26 years	6 28 years	7 32 years	8 55 years	9 45 years	Averae Results
FAML	+	+	+	+	+	+	+	+	+	+
FOFR	+	+	+	+	+	+	+	+	+	+
NFSD	+	+	+	+	+	+	+	+	+	+
SPEN	+	+	+	+	+	+	+	+	+	+
CAR	+	+	+	+	+	+	+	+	+	+
REHB	+	0	-	+	+	-	+	+	+	+
SOCT	+	+	+	+	+	+	+	+	+	+
STHO	0	-	+	0	0	-	+	0	-	0
ECST	+	0	+	+	0	0	0	+	0	0

Legend of Table 3. Family – FAML, Former friends FOFR, New friends with same disabilities - NFSD, Sports environment – SPEN ,Car – CAR, Staying in hospital – STHO, Staying in rehabilitation center – REHB, Society – SOCT, Economic situation – ECST

Table 3 shows the determinants that affected the participants to re-entry to physical activity. As for the impact to return to physical activity determinants are divided into: positive, negative and neutral. Positive determinants are marked with the symbols +, negative - and neutral 0. The average impact is determined by an analysis of semi-structured interviews. The table shows that the positive determinants include; family, old friends, new friends with the same disability, sports and environment, owning a car, staying in rehabilitation centres and the influence of the society. Neutral determinants are: hospital stays and economic situation. There are no negative determinants.

6. DISCUSSION

6.1. General Overview

The main task of semi – structured interview was to identify determinants, that affected BiH National sitting volleyball team members, and the time needed for them to reentry to physical activities after their trauma. In this case the traumas were caused, due to the war in Bosnia and Herzegovina.

Results show that participants, pointed out, the most important determinants as: family, old friends, new friends with a similar disability, sports environment, and a car that represented an important instrument, because of the lack of public transportation after the war came to an end.

Due to the war, hospital stay and rehabilitation centers were not that important as determinants. Same goes for economic and social situation.

Three participants were wounded at a very young age. One of the participants was given, by mistake, poliomyelitis. He did not practice sports before the trauma because he was only two years old when he was wounded. All the other participants were engaged in some kind of sports activities.

Some of them were professional players and were wounded at the age of 18. Participant 6, stated that he had postsurgical complications. Further, 8 participants stated that he became disabled by doctors mistake.

Participant 7 received some medical treatment at the hospital, and as he returned home, he met people, who were in some way, already engaged in sitting volleyball, and under their influence, the participant started engaging in sport activities.

Participant 8 started engaging in sports at the initiative of the Croatian athlete, who came to Bosnia and Herzegovina in 1982.

Participant 6 met very important people who were a great help for him in 2003, when he was at a ceremony for the best disabled athlete of Bosnia and Herzegovina. All participants stated, that their family income was good or average, however, that it did not play a major role because of the war and post–war situation. That is why I chose to mark the economic situation as a neutral determinant. In the theory part, I mentioned the trauma and PTSD (post-traumatic syndrome disorder) as well as the overall social situation in Bosnia and Herzegovina after the war .

6.2. Results of Skovajsova

Translation of the pages 51,52 (Skovajsova, 2011), see Appendix 1**.** The main purpose of semi-structured interviews was to find out the determinants that affect the re-entry of participants into physical activity after trauma. Also, in relation to these determinants, to find out the approximate time taken for re-entry into physical activity after trauma. Results show participants, who were injured in the period of adolescence, their main determinants were family, and staying in a rehabilitation centre.

Rehabilitation was important because of the opportunity it gave to make friends and build friendships with people with the same or similar disability and to learn physical activities for disabled people who use a wheelchair.

Four met for the first time at a rebahilitation centre, where they attended a physical activities class, designed for disable people in wheelchairs.

Only one of them had encountered sport activities for the disabled before, during his stay at the hospital.

The next determinant that affected re-entry to physical activity was their economic situation. As they were injured during adolescence, they completely depended on family support. Thanks to good economic situation of the family, they were able to start physical activities and afford a

new car, which also belongs to the list of determinants too. Those determinants mentioned, all had a positive influence. Ellen de Lange said that her family and self – determination were the primary influences on her participation in disability sport. Elen has attained her personal bests as a participant and now as an administrator in elite-level sports. (DePauw & Gavron 2005).

However, the determinant staying in a hospital had a insignificant influence. I clasiffied it into determinants because had an important role in a persons re-entry to physical activities after trauma and, participants spent different periods of time in hospital.

It has neutral influence because of the fact, that the majority of respondants (apart from one) did not mention any positive or negatives for staying in a hospital. We can evaluate the societey and old friends as negative determinats. Those negative factors were built by starting friendship with people, that participants had met during their stay in a rehabilitation centre or during sport acitivities. In the theoretical part of my thesis, I had mentioned the most important factors, that have a major influence on coping with stressful situations. In my opinion between the most important factors, that are relevant for the re-entry to physical activity after trauma belongs to their personality as individual beings and the ability to cope with stressful situations.

My konwledge, experience and present studied discipline are not competent to summarize, if participant has a strong personality or if coping with stressful situations were easier in reentry to physical activities after trauma. With regards to the re-entry to physical activities after trauma, they all named this period differentely.

Time of re-entry to physical activity after is given by evaluating time spent in hospital or rehabilitation centeres, and influence of family and friends. After evaluating the time spent by participants, she found time taken to reentry to sports activity after trauma was different for each individual. Difference was infulenced by staying in a hospital and in a rehabilitation centres, and by family and friends. She have calcuated the average time of re-entry to physical

activities after trauma is 1 year and 8 months, so almost 2 years (Skovajsova, 2011). According (DePauw & Gavron, 2005) Heinz Frei is an maraton competitor, world record holder in 400m,800 m, 10000 m and maraton in his classification. Heintz notes that his the rehabilitation time is not over when you go home after a very short time in the center. If you can, find a new sensibility to your body. The impact of family and friends, both able-bodied and those with disabilities, was important to his participation. Also accoording (Shephard 1990) for weelchair bound CP athlets the the influance of peers and friends was dominant, but for ambulatory patients the family had the most important influence. According (Shephard 1990) he had somewhat similar findings in a survey of disabled athlets, mainly paraplegics and amputees the primary percived stimuli to sport involvement in this group were the initiative of the individual participant (29%) and the encouragement of disabled friends (27%), able-bodied friends (27%). or family (9%).

As I said before in my thesis, I divided the main aim into sub aims. One of the sub aims of my thesis was to compare the conditions in Bosnia and Herzegovina and the Czech Republic (Skovajsova, 2011). I would like to stress, that in this case the adults and independent people with disabilities who were involved, the injuries sustained were due to the war in Bosnia and Herzegovina, while Skovajsova had participants, who had experienced trauma caused by car accidents, ski accidents, fall from the balcony etc. in peacetime environment. I would like to mention, that in Bosnia and Herzegovina, the economic situation did not play a major or significant role due to the war, whilst in Skovajsova's research it did. Furthermore, I found out during my research, that old friends were a great help to the people affected by injury, which can be seen in many examples. In Skovajsova‘s research, this was not the case. Rehab stay, in Skovajsa's research played an important role, whilst in Bosnia and Herzegovina, it wasn't due to inability to travel to rehabilitation centers. One example is that, participant 5 stated that he went

by foot through the trenches to rehabilitation. However, I think the (new) friends with similar disabilities had nearly the same impact as in Skovajsova's research with hospital stay, which took a high place on a category scale, while the society impact did not play an important role. I think that the main difference was due to the situation during the war and my participants not having any better opportunity to improve things. With all of the above, I concluded that Bosnia and Herzegovina is a country in transition and that it must invest a lot of effort in coordinating and implementing legislation with EU standards. One of the main problems in Bosnia and Herzegovina is that there is a law for persons with disabilities, unfortunately, is not enforced.

In my opinion among the most important determinants, is the personality of the individual and there ability, and how the individual deals with overcomes stressful situations. They all required different amount of time, in order to re-entry or start physical activities. The average time needed to re-entry to physical activity after war trauma, based on the information provided to me by the participants, is 33 months or 2 years and 9 mouths.

7. CONCLUSION

I took interviews when the team was preparing for Paralympic games in London 2012. The team was based in a rehabilitation center ‘‘Reumal‘‘ in Fojnica, (BiH). I was allowed to meet the full national team, but with time constraints and knowing the team was preparing for the Paralympics I only took interviews with 9 members.

The answer to the first research question:

Is it possible to formulate the determinants in relation with the time of re-entry to physical activity after trauma?

Yes, it is possible and those determinants are: family, new friends with the same disability, use the car, economic situation, former friends, sports environment, economic situation, society, hospitalization and rehabilitation.

The answer to the second research question:

Are some of these determinants more important (or typical, most effective)?

Results are showing that participants, pointed out, the most important determinants are (in order of importance): family, old friends, new friends with the same disability, sports and environment, a car that represent an important instrument, because of the lack of public transportation after the war came to an end. Due to the war, the hospital stay and rehabilitation were not the very important determinants as well as the economic and social situation. That's why I choose to mark the economic situation and hospitalization as a neutral determinant. There were no negative determinants.

The answer to the third research question:

Are those determinants connected with :

- Technology - economy situation,

- The origin of the trauma,
- Psychosocial environment or features?

In my opinion, the technology and the economic situation should be neglected due to the war in Bosniabut it was not case in Skovajsova‘s resarch in Czech Republic.

The origin of trauma is different. Almost all participants were war injured veterans, with the exception of one, who was mistakenly given the poliomyelitis shot by a doctor. I came to the conclusion, that the social environment played an important role. Two participants were motivated by their neighbours, who contributed to their involvement in sitting volleyball, by accompanying them to their first practices. However, each of the participants, emphasized individual combat, a battle with themselves every day, "struggle to find the way into the normal life”.

Theoretical benefit of thesis is confirmation that time for re-entry to physical acitivities is usually about 2 years which is linked with family environment, social environment which can shortened this period.

Benefit for practice is to improved after-trauma care including information about importance of participation in sports.

Limits of thestudy was orientation only on one team from one country.

8. SUMMARY

8.1. Summary in English language

The aim of this thesis was to examine the determinants that affect the reentry to physical activities after the war trauma in Bosnian and Hercegovinan national sitting volleyball team. I have analysed the effect of determinants on influance to sport activities and in relation to these determinants, I found out the approximate time period required for reentry to physical activities after trauma. The work consists of a theoretical and practical part, where the theoretical part discusses the notions such as: disability and physical disability, coping with stress, trauma, post traumatic stress disorder (PTSD), amputation, family, paralympic sports. The practical part tells us about the quantitative research. Before I started with the implementation of the work I had to have a verbal consent of each participant in the interview. The results were gathered by using questionnaires and a semi-structured interview. The participants was 9 members of the Bosnian and Herzegovinian national sitting volleyball team, the goald medailists from Paralympic Games in London 2012. The age of the participants were 26-55 years. The interviews are presented in chapter 5.

The results show that the most important determinants for the participants were; family, old friends, new friends with the same disability, sports environment and a car, which they cite as important because of the lack of public transportation after the war ended. Because of the war situation, the hospital stay and rehabilitation does not stand out as the most important determinants as well as the economic and social situation.

8.2. Summary in Czech language

Cílem mé práce bylo ur it determinanty, které po válce v Bosn a Hercegovin souvisely s návratem závodník do národního týmu ve volejbalu v sed . Na základ t chto determinant jsem také zjiš oval pr m rný as návratu hrá do fyzické aktivity. Moje práce zahrnuje jak teoretickou, tak praktickou ást. V teoretické ásti jsou popsány pojmy jako: invalidita a t lesné postižení, zvládání stresu, trauma, posttraumatická stresová porucha, amputace, rodina, paralympijské sporty. Praktická ást p edstavuje kvantitativní výzkum. Výsledky shromáždil jsem na základ dotazník a semi-strukturovaných pohovor . Ú astníky tohoto výzkumu bylo 9 lenové národního týmu Bosny a Hercegoviny ve volejbalu v sed , kte í v roce 2012 získali na Paralympiád v Londýn zlaté medaile. V k respondent byl: 26 až 55 let. P ed zahájením hovor požádal jsem každého odpovídajícího o slovní souhlas. Mé rozhovory s leny národního týmu Bosny a Hercegoviny jsou prezentovány v kapitole íslo 5.

Výsledky výzkumu prokazují, že nejd ležit jšími determinantamy byly pro participanty: rodina, sta í p átelé, noví kamarádi s podobným zdravotním znevýhodn ním, sportovní prost edí a také auto, které uvád li jako d ležité kv li nedostatku ve ejné dopravy po skon ení války. Hospitalizace a rehabilitace, vzhledem k vále né situaci, nepat í stejn jako ekonomická a sociální situace k nejd ležit jším z determinant. St ední doba jejích návratu k fyzické aktivit po válce byla 33 m síc nebo 2 roky a 9 m síc .

8.3. Summary in Bosnian language

Cilj mog rada je bio utvrditi determinante koje uti u na ponovni povratak ka fizi kim aktivnostima poslije ratne traume u BiH reprezentacije u sjedecoj odbojci. Na osnovu dobijenih determinanti utvrditi prosje no vrijeme do ponovnog povratka ka fizi kim aktivnostima. Rad se sastoji od teoriskog i prakticnog dijela, gdje teoretski dio govori o pojmovima kao sto su: nedostatak i fizi ki nedostatak, suo avanje sa stresom, trauma, post traumati ki stresni poremecaj (PTSP), amputacija, porodica, paraolimijski sport. Prakti ki dio nam govori o kvantitativnom istraživanju. Prije nego što sam krenuo sa realizacijom rada morao sam imati usmenu saglasnost svakog u esnika razgovora. Rezultate sam dobio metodom upitnika pomu u semistrukturovanog intervjua. Razgovore sam obavio sa BiH reprezentacijom u sjedecoj odbojci. Starosna dob ispitanika je bila od 26 do 55 godina. Intervjui su prikazani u poglavlju 5. Rezultati nam pokazuju da participanti isti u kao najzna ajnije determinante: porodicu, stare prijatelje, nove prijatelje sa sli im invaliditetom, sportsko okruženje, auto koje navode kao važno zbog nepostojanja javnog prevoza po završetku rata. Zbog ratnih okolnosti boravak u bolnici i na rehabilitaciji ne isti u kao najvažnije determinante kao ni ekonomsku i drustvenu situaciju. Prosje no vrijeme do ponovnog povratka ka fizi kim aktivnostima poslije ratne traume u BiH reprezentacije u sjedecoj odbojci iznosi 33 mjeseca ili 2 godine i 9 mjseci.

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10. APPENDICES

APPENDIX 1

Tables of Skovajsovas research (pages 48,49,50). Translation of author.

Table 1. Determinants of relevance and time to reentry to physical activities

Respondants / Determinants	1 26 years	2 23 years	3 19 years	4 34 years	5 25 years	Calculation	Average results
FAML	2	1	1	1	1	2+1+1+1+1 = 6:5=	1,2
REHB	1	2	2	8	2	1+2+2+8+2 =15:5=	3
NFSD	3	3	3	3	3	3+3+3+3+3 =15:5=	3
FORFR	4	5	4	5	4	4+5+4+5+4 =22:5=	4,4
ECST	5	4	5	4	5	5+4+5+4+5 =23:5=	4,6
CAR	6	6	6	6	6	6+6+6+6+6 =30:5=	6
STHO	8	8	8	2	8	8+8+8+2+8 =34:5=	6,8
SOCT	7	7	7	7	7	7+7+7+7+7 =35:5=	7
Time to reentry to PA	24 months	18 months	15 months	24 months	18 months	24+18+15+ 24+18=99: 5=	20 Months

Legend of Table 1 : Family – FAML, Staying in rehabilitation center – REHB, New friends with same disabilities - NFSD, Former friends FOFR, Economic situation – ECST, Car – CAR, Staying in hospital – STHO, Society – SOCT, Time to reentry to physical activities - PA

Table 1 shows the participants scoring on the Likert scale. The scale is composed of the determinants in the point system of 1 to 8 degrees in the categorical scale. Determinants are lined by relevance affecting the individual to restore physical activities. The first stage indicates the most important determinant until the eighth level which indicates the least important determinant. The table above shows that the families placed first, in second place

is stay in rehabilitation, in the third place new friends with the same or similar disabilities. On the fourth place we see old friends, on the fifth place is economic situation, in sixth place is possesion a car, on the seven place is a stay in hospital and in eight place is impact of all the social enviroment. The table also shows the time needed to reentry to physical activities that she got from the analysis of semi-structured interviews. The average reentry time is 20 months.

Table 2. Influence of the determinants to re-entry to physical activity

Respondants / Determinants	1 26 years	2 23 years	3 19 years	4 34 Years	5 25 years	Average results
FAML	+	+	+	+	+	+
REHB	+	+	+	+	-	+
NFSD	+	+	+	+	+	+
FORFR	-	+	-	+	-	-
ECST	+	+	+	+	+	+
CAR	+	+	+	+	+	+
STHO	0	0	0	+	0	0
SOCT	–	–	–	–	–	–

Legend of Table 2: Family – FAML, Staying in rehabilitation center – REHB, New friends with same disabilities - NFSD, Former friends FOFR, Economic situation – ECST, Car – CAR, Staying in hospital – STHO, Society – SOCT,

Table 1.shows the determinants that affected the participants to reentry to physical activity. As for the impact to return to physical activity determinants are divided into: positive, negative and neutral. Positive determinants are marked with the symbols +, negative - and neutral 0. The average impact is determined by an analysis of semi-structured interviews. The table shows that the positive determinants include; family, staying in rehab, new friends with the same disability, economic situation, owning a car. Neutral determinant is: hospital stays and negative determinants are: influence of society and old friends.