

Teaching movement quality within the frame of Evidence Based Practice (EPB)



- a possibility?

*How can evidence based practice (EBP) be implemented in
teaching movement quality in the post-graduate course of
Basic Body Awareness Methodology (B BAM)?*

by
Liv Helvik Skjærven
Associate professor

**BERGEN UNIVERSITY COLLEGE
Faculty of Health and Social Sciences
Department of Physiotherapy**

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FORWORD

It has been inspiring to participate in the Scholars Forum in Evidence-Based Practice, meeting the guest professors Judith Clare, Centre for Evidence Based Health Care, Bergen University College, Norway/ Professor of Nursing, Flinders University of South Australia, Adelaide, Australia and Professor in Nursing Sally Borbasi, School of Nursing & Midwifery, Griffith University, Australia, spring 2006.

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Liv Helvik Skjærven

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1. Introduction

Musculoskeletal related pain problems is still increasing in Western society (Kvåle 2005). Self-reported health complaints account for approximately 50% of all long-term sickness compensation and permanent disability in the Northern European countries (Eriksen 1998; Linaker 1999). In Scandinavia efforts has been made within physiotherapy to develop clinical approaches to help people cope and handle their life situation (Roxendal 1985; Skatteboe 1989; Mattsson 1998; Bunkan 1999; Lundvik Gyllensten 2001).

To meet a documented need in the society, the post-graduate course for physiotherapists, Basic Body Awareness Methodology (B BAM) is developed at Bergen University College, to heighten the physiotherapists` clinical practice to meet these problems. The course is a two-year post-graduate course (60 ECTS) designed for physiotherapists working with patients suffering from psychiatric and psychosomatic problems, burn-out syndrome, eating disorders, sexual abuse, having musculoskeletal related pain problems. The course offers a program for use in preventive care and rehabilitation. It rests on the physiotherapeutic modality Basic Body Awareness Therapy (B BAT) (Skjærven 2003).

The course program in B BAM rests on a holistic ground. The course is for those who want to develop as physiotherapist and become experts in the psychosomatic and psychiatric field. One factor in the students` learning process is the self-experience and guidance of movement quality. The students become personally involved in an awareness program during the two years study program.

2. Background

The curriculum of the B BAM course states that it is evidence based (Appendix 1). The research questions in this discipline have mostly had a qualitative nature and randomised controlled trials (RCT) is seldom used, though it exists (Roxendal 1985; Lundvik Gyllensten 2001). A common view among physiotherapists is that Evidence Based

Practice (EBP) will not improve this practice and RCT is not appropriate. This questions the implementation of EBP in B BAM.

3. Purpose

The purpose of this paper is to argue for how teaching movement quality can be possible within the frame of Evidence Based Practice (EBP): *How can evidence based practice (EBP) be implemented in the teaching of movement quality in the postgraduate course of Basic Body Awareness Methodology?*

The intention is to illuminate what Evidence Based Practice is and how we can develop teaching movement quality, mirroring the question of what is the best physiotherapeutic practice for this group of patients.

The term *best practice* generally refers to the best possible way of doing something; it is commonly used in the fields of business management, software engineering, and medicine (en.wikipedia.org/wiki/Best_practice). It is generally described as a comprehensive, integrated and cooperative approach to the continuous improvement of all areas of health care delivery ([www.dva.gov.au/health/provider/ community_nursing/guidelines/Sect4_3.htm](http://www.dva.gov.au/health/provider/community_nursing/guidelines/Sect4_3.htm)).

Content of the paper

The paper will concentrate on two subjects: Teaching movement quality and Evidence Based Practice. The main theme is to argue for what *evidence* is, seen from different paradigms, why there is a world wide acceptance of it and how implementing EBP can improve patient/ student outcomes in this area. The paper will further argue for how colleagues might be resistant to implementing EBP. Finally there will be suggested an EBP strategy for overcoming the resistance. The discussion will search to argue for the implementation of EBP.

4. Theory

In this section theory of movement quality will be presented followed by theory on Evidence Based Practice (EBP).

4.1 Basic Body Awareness Methodology

Historical roots to B BAM

Different movement systems have developed during the last decade within the medical context. A common trait of the different therapies has been the focus on the senses of the body and non-verbal behavior as the gateway to therapy and personal development (Lundvik Gyllensten 2001). B BAM represents a relatively new approach to the multiple clinical settings in physiotherapy. It is based on the humanistic philosophy, existential psychology and a phenomenological oriented movement tradition. Methodological it is inspired from Western and Eastern movement tradition as well as from traditional physiotherapy and movement science (Skjærven 1999; Skatteboe 2000).

What is the best practice to facilitate a rehabilitation process in a person suffering from musculoskeletal pain? The practice of training movement quality has been a physiotherapeutic method for more than 40 years. The clinical approach includes a four dimensional approach to human movement: physical, physiological, psychological/relational and existential (Dropsy 1998). Through recreating a functional balance, freeing of the inner regulating rhythms and breathing and refining the awareness in the body, it is possible for the physiotherapists to create conditions for the client to function as good as possible through facilitating movement quality.

The physiotherapeutic modality is well-known, especially in the Northern part of Europe. It is presented at a university level and is part of research programs. There is an international network, originating from the International group of authorised teachers.

Central principles to movement quality

The course in B BAM includes simple movement-exercises, inviting the student to experience movements lying, sitting, standing, walking, use of the voice, relational and communicational exercises. The movements are an extract of the everyday-movements and are easy to implement in daily life. The program focuses health and empowerment. The practice includes therapeutic and pedagogical guidelines, concerning outer frames (the movement room), creating a atmosphere of trust and acceptance, the therapeutic movement awareness, movement guidance, use of metaphors, movement experiences and reflections, training the presence, therapeutic steps for refining movement quality and steps for building the self through movement (Skjærven 1999).

Educational principles to movement quality

The educational principles to movement quality rests on three aspects on learning human movement: 1) Clinical practice: learning *through* movement, 2) Theory: learning *about* movement and 3) personal experience: learning *in* movement (Arnold 1973, Dropsy 1974, Duesund 1995). All three is integrated in that B BAM course. The aspect of learning *in* movement leads to a profound change in the structure of the movement training. This *movement-experience-model* focuses movement experience of well-being being as an aim for the treatment. The traditional physiotherapy represents what can be measured and compared with others, while the *movement-experience-model* represents the absence of the comparable; the unique and personal human is focused. This makes a knowledge were the perceptible is the aim thus challenging the traditional seeing of EPB.

4.2 Evidence Based Practice (EBP)

Historical roots of EBP

Evidence Based Practice has roots in Evidence Based Medicine (EBM). Historically EBM can be traced back to the 1800ths (Ekeli 2000), to Bichat, Magendie and Louis (Sackett et al 1997), rooted in the positivistic tradition about evident knowledge referring to the development of a gold-standard (Ekeli 2000). The EBM was introduced by the group of researchers from North – America (Hamer 2003). In the 1960-ies Sackett (Sackett 1997) realised that epidemiological and biostatistics could be made relevant to clinical practice. 20 years later it became an even higher level of awareness of how basic elements from the discipline could strengthen the critical appraisal and be used in clinical actions as Evidence Based Medicine. The most well-known definition on EBM is:

The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical experience with the best available external clinical evidence from systematic research (Sackett 1997; Jamtvedt 2003).

Much research, discourses and work is done to further develop the EBM. Sackett redefined EBM as “*the integration of best research evidence with clinical expertise and patients values`* (Hammel 2004). In this latest definition *best research evidence* has been expanded to emphasize the importance of *patient-centered clinical research* (Hammel 2004, p. 3). This definition clearly acknowledges the important role of clinical experience, clinical wisdom and intuition in making use of the *best* evidence. In that way it challenges the understanding of *evidence*.

5. Implementation of Evidence Based Practice in Basic BAM

5.1. What is “evidence”?

Historically, the philosophical concept of evidence was intended to mean immediate insight, as opposed to a discursive insight (Webster 2000). Discursive insight is reached through intermediaries, through deduction, not directly or instantly. In contrast, the term evidence once denoted “*what we regard as self-evident*”, that which does not stand in need of explanation (Higgs 2004). It was in Anglo-Saxon philosophy that the notion of evidence began to be used. When saying that a fact gives supporting evidence, we mean that the fact gives good grounds for believing something to be the case (Higgs 2004). Today the concept of evidence is most commonly used almost synonymous with confirmation; it rests on the medical research tradition. What counts as proof or evidence differs, however, between different traditions and paradigm of sciences and knowledge. This is much of the core when considering implementing EBP in B BAM.

Evidence seen from different paradigms

Research paradigm provides a framework for generating knowledge. Within a paradigm, assumptions, problems, research strategies, criteria and techniques are taken for granted by a research community. Four distinct research paradigm can be identified being used today (Higgs 2004):

The empirico-analytic science is based on positivist philosophy and utilises the scientific method of observation and experiment in the empirical world, resulting in generalisations about content and events; it can be used to predict future experience (Higgs 2004). Knowledge is justified on the basis of empirical processes that are reductionist, value-neutral, quantifiable, objective and operationable. Methods are experimental design, randomised controlled trials, double blind trials and correlation designs. The objective is to reduce phenomenon to smaller parts carefully controlled and manipulated statistically

The interpretive paradigm acknowledges local, multiple and specific constructed realities (Higgs 2004). The interpretive paradigm seeks to interpret and generate knowledge of human phenomena in particular. The research purpose is understanding, interpretation, explanation and prediction. Methodological used is grounded theory, ethnography, ethno-methodology and case study. Methods are interview, discourse analysis, open ended survey, participant observation, story telling and oral history etc. The objective is that the researcher sees through the eyes of the participant, focusing the whole phenomenon to take account of the context of the situation, the timings, the subjective meanings and intentions within the particular situation.

The critical paradigm generates knowledge that enhances awareness of how our thinking is socially and historically constructed and how this limits our actions (Higgs 2004). This enables us to challenge the learned restrictions and compulsions of habits. The research purpose is liberation, justice, personal, social and political change. Methodology is participatory action research, critical hermeneutics, critical ethnography, feminist research, critical case study. Methods are critical discourse analysis, interview, focus groups, participant-observation. The knowledge is acquired through critical debate. The objectives are subjective, interpretive, socio-political knowledge for action and change.

The artistic/holistic or creative arts paradigm builds on the ideas of E. Eisner (Eisner 1991; Eisner 1994). It is based on the aesthetic, embodied, spiritual, intuitive and cognitive ways of knowing which occurs in the practice of creative arts (Higgs 2004). These ways of knowing have relevance to opening up a rich understanding of practice in a range of professional areas beyond the creative arts, like education for caring professions and the health sciences (Higgs 2004). It is argued for a development of professional artistry requires attention to certain dimensions of practice which are often invisible: the values, beliefs, attitudes, assumptions, expectations, feelings and knowledge lying below the surface and behind the actions of the practitioner.

This overview broadens the definition of *best evidence* and addresses the *missing evidences* that need to support the complexities of practice. This is being increasingly articulated in the rehabilitation literature (Hammel 2004).

Evidence in B BAM

B BAM is based on holistic ground; the physiotherapist role is to interact with the client and to guide movement. To evaluate therapy the assessment tool Body Awareness Rating Scale (BARS) is developed (Skatteboe 2000; Skjærven 2002). It carries a many-faceted view on evidence: 1) observation of movement quality according to a holistic perspective and 2) the patient experience of being in movement is noted by the physiotherapist based on the clients` immediate and direct verbal expression. Evidence is knit to an outer objective world, observed by the therapist, and an inner subjective world, described by the client. The working hypothesis for the physiotherapist is that evidence in B BAM is identified along four human existential, including values, feelings and interactions. Evidence in B BAM depends on the research question (quantitative or/and qualitative) formulated by the researcher. The following steps in questioning are involved: 1) Defining the question, 2) Locating the evidence, 3) Appraising the evidence, 5) Applying the evidence and 6) evaluating the response (Clare 2006, oral reference).

5.2 Why there is a world wide acceptance of use of EBP in Physiotherapy

From a global perspective there is an increasing focus on developing EBP in the general health care system (Clare 2006, oral reference). In Norway EPB is found useful to bridge the gap between research and clinical practice (Jamtvedt 2003).

5.3 Implementing EBP can improve students` outcome

Wealth of information

To what do we give our attention in the daily clinical practice or in the course of B BAM? How can the physiotherapist/ student handle the enormous amount of knowledge that exists? Not only need the physiotherapist/ students to keep themselves up to date, they know that in clinical practice they will deal with up-to-date consumers. Archie Cochrane is the creator of the Cochrane database (www.cochrane.no), made on the intention to pull research together: “*The Cochrane Collaboration is an international organization that aims to help people make well-informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions*” (<http://som.flinders.edu.au/cochrane/cochrane/leaflet.htm>). Enormous amount of work is behind to make sure that EBP provides us with much of the needed information for the clinical situation. The BMJ Public Health Journals questions if you would rather read 50 000 articles then 120 (<http://ebm.bmjournals.com/misc/whyread.dtl>)? There exist systematic reviews of important research material that makes the everyday life as physiotherapist easy and safe to handle the wealth of information. The Users Guide to Evidence-Based Practice is useful (<http://www.cche.net/usersguides/main.asp>).

Searching in www.google.com helps to come into contact with EBP Centres / organizations. It is enriching and stimulating to find information and helpful systems concerning EBP within physiotherapy worldwide: The Centre for Evidence Based Physiotherapy, Australia, Centre for Evidence Based Physiotherapy, the Netherlands, Centres for Health Evidence Canada, Centre for Evidence Based Mental Health, UK, centre for Evidence Based Child Health, UK, to mention some (<http://wcpt.org/programmes/ebp/other.php>). They are like open gates for more information.

It is worth mentioning The Joanna Briggs Institute, Australia, a well-known centre within the EBP (<http://www.joannabriggs.edu.au/pubs/approach.php>). It focuses meaningfulness

and effectiveness of health care, concentrating on health outcomes from the client, community, clinical and economic perspective.

We do not longer spoon-feed the students

EBM evolved from the problem-based learning (PBL) strategy developed at the McMaster University, Canada (1992) (Hammel 2004). This is important when considering implementation of EBP. Within Physiotherapy PBL is an integrated tool for students and teachers. The integration of PBL for graduate and post-graduate students has undergone a development in more than 10 years. Students and teachers are everyday users of PBL; group-work and self-responsibility in the educational system is an ongoing development. EBP is to be an integral part of this because it has grown from the same root.

The librarian is a coworker in the staff. The students need to be skilled to have access to knowledge, to handle computer-packages and the library system. This is why the students need to practice searching skills in different data-basis. The PBL and EBP includes both systematic findings, appraising, and using research findings, asking questions, finding and appraising relevant data-basis for clinical decisions to be made (Hammel 2004). PBL and EBP are both an instructional method that challenges students to *learn how to learn*, they both engage students curiosity and initiate learning preparing students to think and act critically and analytical. They both help to use appropriate learning resources.

There is already a varied use of PBL in the B BAM-course; there is an emphasis on the student to take responsibility; to develop and strengthen the self through movement, to develop the function of self-observation, learning them to reflect upon personal actions and choices in clinical practice. This is why EBP is natural in relation to B BAM.

Implementing EBP improves the patient/ students outcome in B BAM

EPB was introduced in the first course of B BAM 2003 and was evaluated at the end of the course. The most obvious in the evaluation, was the students immediately feedback from their chief: the integration of EBP in B BAM was met with an ovation of positive feedback. Leaders expressed a “*genuine trust*” to the B BAM because of the use of EBP: the course was in line with governmental directions. How implementation of EBP improves clinical practice, is still questioned (Hammel 2004). The students` use of EBP was documented in their Final thesis and brought to a level of presentation in the first International Conference in Mental Health for Physiotherapists, Belgium 2006, when 7 students presented their projects.

5.4 Why colleagues might be resistant to implementing EBP in B BAM

There is a variety of resistance implementing EBP (Jamtvedt 2003). There might be a general resistance in the team to new strategies, there might be underlying attitudes like: “*old is safe and good*”, “*you cannot throw the child out with the bathing water*”, and “*we risk loosing what we have experienced as functional and good*”. Saturation in a team might grow after many years of implementing new strategies: “*now it is enough!*” A shift in paradigm that involves the whole structure, takes time and pain (Kuhn: in Higgs 2004). When this comes together with a shift in staff members, this might affect the possibility of a smooth change. Another element is that not all members in the staff have competence in EBP (Jamtvetd 2003).

Does EBP represent a hierarchy of evidences?

There seems to a misconception of the consideration of EBP that might produce a resistance to EPB. There is a tendency to look at the list of evidence as a hierarchical model. Although it is recognized that scientific evidence may have different sources and perspectives, the EBP is often seen as a hierarchy of standards which are applied according to the design of a research study. A hierarchy of evidence, such as proposed by

the Cochrane Collaboration Library, is based on the degree to which a design is potent to control the independent variable and thus capable of establishing a cause-effect relationship. According to J. Clare (oral reference May 2006) it was never meant to be a hierarchy from the start, but it has come to be seen like that. We are challenged to how we relate to this “listing” of evidence. To build up a body of professional knowledge, there needs to be a multi-method design in practice as well as in research. Evidence is a moving target, always changing (Clare, oral reference 2006).

Is EBP limited to Randomized Controlled Trials?

Randomized Controlled Trials (RCT) is often connected to being the producer of *the best evidence*. According to Ekeli (200b) RCT are put forward as the desired model for attaining evidence. These trials most often take a medical diagnosis as a starting point instead of being framed in the interactive approaches and functional assessments of other health care professions. RCT are considered to be the highest ranked way of obtaining research knowledge in EBM (Higgs 2004). Best available evidence is, however, not restricted to RCT and meta-analysis. Physiotherapy practice is increasingly finding evidence along other axis and dimensions, representing other paradigms within physiotherapy, recognizing that scientific evidence has different sources (Higgs 2004).

What is needed to implement EBP in teaching movement quality?

There is a notion that EBP is connected to a change associated to negative consequences. It is therefore necessary to bring up what a change means, making it concrete, so that the colleagues better can sustain this change, clarifying aim, methods and consequences (Lewin, Clare, oral reference 2006). This is why there is a need for financial resources as well as organizational support; one person can not bring this view and practice alone.

EPB can: 1) be implemented in the curriculum, 2) it takes less time then conventional teaching when learnt the strategy, 3) the need for lectures are fewer (only information), 4) students work in small groups with web based material and library based work, including

clinical assignments etc. 5) librarian provide an on-line assignment about data basis and teachers refer to database searching constantly, referring to recent literature, 6) each topic includes the student doing a review of an article, 7) each topic includes a written critique of research in the field etc (Clare, oral reference 2006).

The most challenging part of implementing EBP in B BAM is the cultivation of the awareness and the awareness program. There seems to be a notion among B BAM-teachers as well as B BAM-therapists that the EBP will “invade” the learning process. Teaching movement quality is demanding concerning the quality of the mind of the student as well as the teacher. In the Western culture there are much “outer” interferences that disturb the persons` concentration. The amount of awareness needed to come into contact with deeper layers in the body is easily disturbed. Another challenge is the fact that there is little research concerning the phenomenon of movement quality. It is necessary to further develop research questions, design, clarifying central phenomenon and search new data-basis (Skjærven 2006, not yet published).

5.6 Evidence based strategies for overcoming resistance in relation to B BAM

EBP is to apply research into practice, to make it clinical applicable. I will here present a 3-step strategy for overcoming resistance.

No 1: Cultivating the researcher in us – through awareness training

The first step is directed towards cultivating the researcher in us. To do this I will invite to a 2- days course, including 1) practical training of B BAM – exercises, 2) theory on EBP and movement quality and 3) practical/clinical EBP-exercises. The three elements included in the course will mutually stimulate each other and should be balanced to awaken the “researcher”. In this way the participants will be invited to explore the aim of the integration of EBP into B BAM. B BAM is a fruitful course in cultivating the researcher in one self. This comes through the quality of the training, changing the position between *consciously being, doing and relating*, challenging the interplay

between body and mind. In the Western society there is little tradition for a culture for bodily refinement unless within the Arts and nor is there a culture for taking care of ones own health or teach through movement. Cultivating the researcher in one self is to search to find, through inside and outward listening (<http://www.ibk.nu/main.php>).

No 2: Cultivating the student in us – learning to learn and to question

The second step is a follow up course, 2 day of B BAM, integrating EBP, focusing the art of learning and questioning. In 1976 the Norwegian Government established a new law introducing the concept “*a life long learner*”. This mirrors a recognition that learning happens through all life and everywhere (<http://www.norge.se/education/education/lifelong/lifelong.htm>). This law represents an invitation to a perspective of identifying oneself with being a learner through life; it is a change in attitude. B BAM has integrated and training the attitude of being curious and open for what is to be found in the “*here and now*”-experience. Ongoing learning and openness to change is a professional obligation and a personal reward (Borbasi, May 2006, Oral reference). In this course there will be an exchange between practical B BAM movements and a playing with concrete EBP-exercises (Jamtvedt 2003, at BUC).

No 3: Creating a culture for EBP in B BAM – direct implementation

The third step is another 2 days practice in B BAM and EBP through direct implementation. The focus will be on the “*I am in charge and have the possibility to create*”-experience. Included in the course will be EBP- exercises in direct clinical use. The aim is to bridge the gap between production of evidence and transfer to clinical practice.

Between the courses there will be exercises included concrete training on data-bases. What is basically needed is to produce a desire to know, to discover and to solve problems, learning to create the best practice with efficacy and quality. The three-step course requires money as well the leaders support.

6. Discussion

The World Confederation for Physical Therapist (WCPT) is committed to EBP (<http://www.wcpt.org/programmes/ebp/index.php>). Leaders of Member Organisations, Regions and Subgroups convened in London, England, in October 2001 for a meeting on EBP. The meeting was a follower of the March 2000 decision of the Executive Committee to support international efforts in the area of EBP. This meeting facilitated the exchange of information, developed a shared vision for EBP in physical therapy and stimulated thinking about plans for collaborative international projects. The outcome of the meeting was a programme of work to support the development of EBP in physical therapy. This is important to bring to the consideration of implementing EBP in B BAM.

EBP in B BAM – an impetus for professional development

The traditional physiotherapist is trained to focus on characteristic like the movement of joints and limbs (Higgs 2004). B BAM sees human movement from a holistic perspective. Research within traditional physiotherapy mirrors the characteristic of the profession, in which medical diagnosis is used as the variable against which intervention or treatment is measured. A medical diagnosis is the result of the assessment of the medical profession and the diagnosis often constitutes no more than a starting point for the treatment plan. This plan deals also with aspects such as problem of function, need for help, need of information, need for caring and support. The ongoing assessments, evaluations and adaptations that form an important part in the interactive physiotherapy are very little named or framed (Higg 2004). It is not enough for the physiotherapist to see that some research fails to address pertinent aspects of the clinical practice and fails to recognise the role of clinical judgement. The practitioner of the 21st century needs to take responsibility for creating new research topics. Such research will help create and promote a deeper and more relevant understanding and evaluation of practice as well as create and develop new knowledge. EBP can be a guide and an impetus to this.

B BAM and EPB – consequences for the decision-making process

Teaching movement quality as well as EBP represents new approaches in physiotherapy. Teaching movement quality is directed towards a rising health problem in Western society. The person-centered view demands a concrete change in the physiotherapeutic practice; knowledge, skill, concepts is affected by the new therapeutic view, included the research approach. Also EBP demands a change in the process of decision-making and in clinical practice. Both challenges the professional openness and willingness to integrate new perspectives, reflections, concepts and clinical actions. There are strong forces driving the EBP; there is an increase in consumer knowledge and participation, consumers and students are developing web searching skills and they do not longer think that teachers and health professionals are the only one that possesses the knowledge. The new generation of students expects the teachers to guide in web search and to be updated on new research findings and to stimulate analytical and critical thinking. Critical thinking and teaching for independence is the essence of good practice (Clare 2006).

B BAM and EBP – a question of reliability

To create a culture for EBP in B BAM is important. A culture structures and mediates social processes (Clare, oral reference 2006). Culture is a human construction, constantly changing and language is a key. It is a well-known fact, though not being subject to research that within the physiotherapy profession in Norway the “voice” of the physiotherapist is not strong. How to strengthen the physiotherapist self-awareness, with human movement as the professional core, to develop the uniqueness of the profession and at the same time follow the globalization using EBP? Will the internal voice and self-image of the physiotherapist be strengthened by implementing EBP? Power is strategy and power depends on a “*multiplicity of points of resistance*” (Foucault 1979:93, in Clare 2006). Power can be used by dominant groups to shape the perception of people or control of others. There has been tension between what physiotherapists know to be the value of their work and the value of their work as perceived by other health-professionals. Knowledge and awareness to human movement, is an area for all health-professionals, not only the profession of physiotherapy, though the physiotherapist is specialized in movement. Accomodating new ways of thinking as well as being in

clinical practice, the B BAM and EBP, might provide opportunity for physiotherapists to look to new avenues for taking a lead, to empower themselves and to express the professional reliability.

A new paradigm for physiotherapy is emerging. Through the EBP the physiotherapists are offered a systematic way of integrating research and creating a better clinical practice.

7. Conclusion

B BAM is developed to meet a need in the population. Physiotherapists are patient-focused practitioners and the focus on active involvement of patients will increase. Consumers will expect more information and will have more involvement in the treatment. EBP search to integrate clinical expertise with the best available clinical evidence and patient values. EBP is not restricted to randomized controlled trials and meta-analysis. Physiotherapy will be evidence-based but there will be a place for innovative practice. EBP is come to stay! This is a fact in physiotherapy as for medical doctors and all health professionals.

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List of web-addresses worth knowing:

<http://www.bestpractices.org/>

<http://www.rnao.org/Page.asp?PageID=861&SiteNodeID=133> (nursing)

http://www.physiotherapy.org.nz/index02/Publications/index_stds_of_Practice.html (best practice physiotherapy, New Zealand)

<http://wcpt.org/programmes/ebp/ebpwcpt.php> (best practice physiotherapy WCPT)

<http://www.isqua.org.au/isquaPages/Conferences/paris/ParisAbstractsSlides/Friday/C18/ppt.pdf/232Beswetherick.ppt.pdf>

<http://www.apacongress2006.com.au/program.php>

<http://www.physiotherapy.ca/evidencebased.htm> Canada

<http://ijahsp.nova.edu/articles/1vol2/StruberPhysio.html>

<http://www.isqua.org.au/isquaPages/Conferences/paris/ParisAbstractsSlides/Friday/C18/Abs.pdf/232%20-%20Beswetherick.pdf> (standards for PT)

http://apa.advsol.com.au/physio_and_health/media/download/APA_vision.pdf?CFID=1132004&CFTOKEN=91683390 (Australia)

<http://www.physio-europe.org/pdf/Framework.pdf> (guidelines in PT, WCPT)

<http://www.joannabriggs.edu.au/pubs/approach.php> (levels of evidence)

<http://www.ptjournal.org/ptjournal/january2000/v80n1p28.cfm> (J Gwyer)

<http://www.ptjournal.org/PTJournal/Dec2003/v83n12p1090.cfm> (expert)

APPENDIX

1) Curriculum Basic Body Awareness Methodology, Level 1 and Level 2

Appendix Curriculum Level 1:

Basic Body Awareness Methodology, B BAM, LEVEL 1, 2007/2008

Credits:	30 ECTS
Level:	Post graduate
Subjects:	Subject I, Experience and observation (15 ECTS)
	Subject II, Treatment and interaction (15 ECTS)

INTRODUCTION

The Faculty of Health and Social Sciences, Bergen University College (BUC), offers a two-year, part-time, international post-graduate course in Basic Body Awareness Methodology (B BAM) for English speaking students. This curriculum describes the first year, Level 1. To complete a degree as Basic BAT-therapist (in total 60 ECTS), the

student attends Level 2 (30 ECTS) that follows automatically on Level 1, see curriculum Level 2.

Profile

Basic Body Awareness Methodology (B BAM) represents a view and approach to human movement and mental health care. The course builds on the physiotherapeutic tradition of Basic Body Awareness Therapy (Basic BAT). The focus is on basic aspects of human movements and mental health, on action, interaction and communication, observation and interview, all integrated in clinical work. The study is designed for physiotherapists who work with people suffering from long lasting musculoskeletal pain, psychiatric illnesses, psychosomatic problems, eating disorders, violence, sexual abuse, life style problems and for those who want to develop as physiotherapist.

The official demand to the quality of the physiotherapists is increasing. Epidemiological studies of people suffering from long lasting muscle-skeletal pain and mental health problems describe increasing tendencies. There is a need for the physiotherapists to understand more of these states from a body-mind perspective through movement. The course offers a concrete tool to meet a documented need of mental and bodily suffering in society.

The course in B BAM offers a philosophy and therapy in accordance with the profile of the Faculty of Health and Social Sciences. The course is offering a program to preventive care, rehabilitation and empowerment; it is health-oriented and person-centered and focuses the art of movement. Principles of movement education and research methodology will enable the integration of theory, experienced-based and evidence-based practice, into the design and implementation of an effective and human therapeutic approach.

Philosophical and therapeutic roots

The study is based on principles of humanistic and existential philosophy, psychology and movement education including aspects from natural science, movement science, actors training, modern dance and Fine Art. Methodological it is inspired from Western and Eastern movement tradition. Embodiment, awareness of balance, free breathing and movement quality represents a key to becoming a more integrated human being. The health perspective, the Basic BAT-program, the focus on movement quality, health and empowerment gives insight into personal processes and offers a concrete way to keep and restore health through movement.

A number of different movement systems and body-centred therapies have developed during the last 100 years within the medical and psychotherapeutic contexts in the western world. A common trait of the therapies has been the focus on the senses of the body and non-verbal action as the gateway to therapy and personal development. In the East the body/mind/spirit connection has been established for thousands of years, and has served as a source of inspiration to western schools. Some of the best-known methods of

the movement traditions, of therapeutic schools and of expressive art systems serve as part of the theoretical and practical foundation in the development of Basic Body Awareness Therapy (Basic BAT).

To stimulate creativity through movement is central in the study. Creativity can be defined as “*the process of bringing something new into being*” and represents a heightened degree of emotional health. The creative power, as a person, therapist and researcher is stimulated and reflected upon.

Historically, Basic BAT has been a philosophy and training method for more than 45 years, within physiotherapy for about 30. It is originally developed by the French movement educator and psychotherapist Jacques Dropsy. On that background the course aims at a four-dimensional approach to human development, including structural, physiological, psychological/ relational and existential aspects.

Basic BAT is a well-known approach used by physiotherapists in psychiatry, mental health and community-based physiotherapy, especially in the Northern part of Europe. It has been introduced at university level by Basic-BAT teachers and is part of training and research programs. There is an expanding international network, originating from the Swedish-Norwegian group of authorised teachers responsible for the quality-security of the method.

OBJECTIVES AND AIMS

The course is designed to qualify students to work within municipal, county, home-based care and community work. The course offers a program making the student able to handle people with bodily, mental and existential problems through movement and to offer people help to experience new strategies to restore, keep and promote healthy resources.

Aims of the course

- To enable the student to work with body-mind aspects of human movement, with experience and expression, and to apply these aspects in therapeutic work
- To enable the student to use Basic BAT principles as a way of interaction and communication.
- To give the student experiences and factual knowledge with observation, clinical reasoning, guiding, interviewing and evaluation in work with clients.
- To give the student possibilities to develop their own creative power and therapeutic skill from a movement perspective
- To stimulate an active and reflective engagement in using body-mind aspects in movement as means of therapy, clinical reasoning and research.
- To make the student aware of the function of body-mind aspects in human movement in education and society.

The course aims for the student to identify and use body-mind aspects basic to interaction, interrelation and treatment procedures within physiotherapy.

Main focus of Level 1

- History: Western and eastern philosophy, movement and treatment traditions and mental health care from a body-mind perspective.
- Theory: humanistic philosophy, psychology and psychiatry, a four-dimensional approach to human movement, stress management, preventive care and empowerment, the salutogenic model.
- Self-experience as physiotherapist: a four-dimensional approach to balance and movement quality, exploration of therapeutic and educational aspects
- Physiotherapy: observation, assessment, reasoning, treatment and evaluation
- Project work, clinical and research reasoning.

The course consists of theoretical and methodological elements deepened through personal exploration, interaction and process-oriented learning. The practical “floor-work” and self-experience in Basic BAT is a main part in the study. The purpose is to arrange for the process of personal development. The student will experience and train clinically throughout the whole course. Theoretical studies will mainly take place in the period of self-study and will be documented during and at the end of each subject, in portfolio and final project.

TARGET GROUP AND ENTRY REQUIREMENT*Target group*

The course is international and for postgraduate physiotherapists. It is designed for those who want to work in a structured and reflective way gaining knowledge and skill from a four dimensional approach to human movement. The course is for physiotherapists thinking that integration, interaction and communication from a body-mind perspective are essential, and for those in need for a tool that can inspire for further therapeutic development. Level 1 aims at individual physiotherapy for patients being vulnerable, for example within the psychiatric field, but also for promoting health and personal growth.

Entry requirement

The course is made for students abroad as well as for students from Norway and the Nordic countries. All lessons, literature, reports and projects are in English. Minimum 3 years bachelor education in physiotherapy or a similar level of education.

COURSE FORM AND STRUCTURE

Level 1 covers 30 ECTS and is organized as a part time study over a period of one year (12 months). The course starts with a block of four (4) weeks at BUC and finish one year later, with a block of three (3) weeks, the last week with final exam, Level 1. There is arranged for a period 10 months of self-study in between the block periods. The students will have to collaborate online using the Learning Management Systems “*It`s learning*”.

Level 2 starts at the end of Level 1, by adding one (1) week to Block 2 at BUC, see figure 1; thus Block 2 consists of 4 weeks.

Figure 1. Overview of B BAM Level 1 and Level 2

	1st Year	2nd Year	3rd Year
Block number	Block 1	Block 2	Block 3
Weeks at BUC	4 weeks at BUC	4 weeks at BUC	3 weeks at BUC
Level	Level 1	Level 1, 3 weeks	Level 2
Level		Level 2, 1 week	

Level 1 has 2 subjects, each of 15 ECTS. Subject I and II offers together 30 ECTS:
Subject I, Experience and observation starts with a block of 4 weeks at BUC followed by a period of self-study, 4 months, which gives a total of 15 ECTS.
Subject II Treatment and interaction starts with 7 month of self-study and is followed by a block of 3 weeks at BUC, which gives a total of 15 ECTS.

Figure 2. Overview of B BAM Level 1, Subject I and II

	Time period	Valuation time	Valuation form
Subject I	4 months	February -08	Portfolio
Subject II	7months	September - 08	Portfolio
		October - 08	Oral exam, 3 parts

The aim in Level 1 is to let personal and clinical experiences and training, knowledge, research, critical reflections and writing start to grow through a process. Training the personal skill of awareness is a core. In both subjects, self-experience, embodiment, movement quality and health are in focus; Subject I emphasis experience and observation; Subject 2 emphasis clinical implementation and interaction in the meeting with the individual.

The block period at BUC

The concentrated block at BUC have intense periods of “floor-work”, and includes 1) systematic personal training in Basic Body Awareness Therapy (Basic BAT) with critical reflection, 2) Individual clinical implementation, presentation and reflections, 3) Theory, 4) Evidence-based practice and 5) Research method.

The period of self-study

There is 1 year of self-study in between Block 1 and 2 at BUC. The period constitutes in total 9 ECTS: 3 ECTS in Subject I and 6 ECTS in Subject II. The student is responsible for organizing the period of self-study, creating situations for 1) personal training in B BAT, 2) clinical practice, 3) study of literature, 4) report writing and 5) project work and 6) working online with BUC and the student fellows through Its` learning.

Personal training and self-experiences in B BAT is integrated in the whole B BAM course. The total amount of personal training in the period of self-study is estimated to about 120 hours personal training at each level.

Portfolio

Subject I and II includes students work, organized and presented in one portfolio for each subject, in total 30 ECTS. The portfolio of Subject I is the evaluation of Subject I, equivalent to 15 ECTS. The portfolio from Subject II is integrated in the final exam of Level 1, equivalent to 15 ECTS.

Clinical practice

Clinical practice is incorporated in the period of self-study. Clinical practice includes client centered work: skill training, user-oriented projects, and cross-professional integration. In subject II, the academic and practitioner standard is set at a higher level, integrating project work in clinical practice. The total client work is estimated to about 1 day a week (6 hours), in 8 months, making 200 hours clinical work at each level. The student is responsible to find a workplace and clients, for documenting the clinical work, all accepted by BUC.

STUDY METHODS AND STUDENT PARTICIPATION

The course is designed on educational principles of self-experience and demands a high degree of personal involvement. It focuses practical skills and personal involvement, making the students work interactive on several levels. This is achieved through a variety of methods constantly changing between personal experience, theory, group work, problem solving assignments and practical studies, through seminars, lectures, project work and reflection. There are periods for intensive “*floor work*”, role-play, case studies and clinical studies. Lectures and seminars will cover selected areas of the curriculum, and the students are expected to work independently within their subject area. Study tasks will be related to the students` initiatives and are based on student active learning. The educational method aims at strengthening the students` personal resources. Integration of theory, practice and research projects is a planned process within the overall arrangement of the course. It ensures that professional competence will develop through practice and will be adequately assessed.

Online communication through “It`s Learning”

The student work through the international Learning Management System “*It`s learning*” in the period of self-study. The aim is to let the students communicate and collaborate online: a) to deliver assignments and discuss experiences, therapeutic role and content, b) to discuss written text and illustrations, c) to discuss questions from the teacher, d) to build international network and e) to create professional, personal and research development. The study is organised around delivered assignments receiving feedback from the teacher at BUC.

Compulsory participation

Lectures, projects, group-works, practice and “*floor-work*” are compulsory if nothing else is stated. If more then 10% not present in the blockperiod at BUC, the student is given specific work that is equivalent to the work in the period he/ she was absent. The work the student will do is based on an agreement between student and teacher and is compulsory to meet to the final exam. It is expected that the student will be involved in all parts of the course.

EXAM AND FORMS OF ASSESSMENT

See the specific description in the written paper of Subject I and Subject II: www.hib.no

Appendix Curriculum Level 2:

Basic Body Awareness Methodology, B BAM, LEVEL 2, 2006/2007

Credits: 30 ECTS

Subjects: Subject III, Group intervention (15 ECTS).

Subject IV, Final project (15 ECTS).

INTRODUCTION

The Faculty of Health and Social Sciences offers Level 2, Basic Body Awareness Methodology, a one-year, part-time, in-depth, post-graduate course in English, within physiotherapy. The course builds on Basic Body Awareness Methodology, Level 1. The main objective of Level 2 is to further enhance the professional competence in body-mind aspects in human movement, focusing on a group perspective, clinical and through project work. The course is for physiotherapists working with health-promoting, stress-prevention, lifestyle problems, especially within the psychiatric field. The course emphasises group processes and leadership, factual knowledge, experiences and qualitative oriented methodology (Interpretive and Critical). The nature and the extent of the education program qualify the physiotherapist to use Basic Body Awareness Therapy, in groups. It challenges the student to gain deeper insight through a personal learning process working with therapeutic groups.

The course is designed for physiotherapists interested in human relations and group-processes, using groups as a therapeutic tool; it is health-oriented and person-centered. It includes learning to assess, making decisions, setting goals, constructing specific plans to achieve these, taking into account relevant contextual factors and to apply and implement these into physiotherapy practice based on the quality of available evidence and experience.

The official demand for an improvement in the quality of the professions of health and social workers is increasing. There is a need for the physiotherapist to understand more of mental states that rises from inadequate relationship with other people, to observe and to act in a structured therapeutic way. From a socio-economic as well as from a communicative point of view, groups as therapeutic tool can be further developed within physiotherapy. Communication and interpersonal skills are vital for competent and effective practice informing effective interaction with patients, peers, managers and other health care professionals. The course offers a tool for the physiotherapist to meet a documented need of mental and bodily suffering in society expressed in movement, especially the very vulnerable patient within the psychiatric field. The process of learning is important for both the patient and the practitioner. These theories underpin continuing professional development, enabling physiotherapists to be effective lifelong learners. The knowledge equips the physiotherapist to become an effective teacher in the wide range of

contexts, e.g. health education, the education of students and working in teams. The course is evidence and experienced based.

The course builds on humanistic / existential philosophy, phenomenology, group-psychology and movement education as well as natural science. Methodologically it is inspired from Western and Eastern movement-traditions, philosophy, theory and research. Awareness in movement-communication and creating relation to others is central in the course.

OBJECTIVES AND AIMS

The course qualifies physiotherapists to work within municipal, county, home-based care and community work. It offers a program making the student able to handle people with bodily, mental and existential problems offering a group rehabilitation program. It aims to qualify the student as a group-leader and to handle group-processes through human movement.

Aims of the course

- To enable the student to work with body-mind aspects of human movement, with experience and expression, from a group perspective and to apply these aspects in therapeutic work
- To enable the student to implement Basic BAT principles in small and larger groups, interacting and communicating
- To give the student experiences as well as factual knowledge, observing, planning, guiding, interviewing and evaluating groups
- To give the student possibilities to develop their creativity and skill in being a group-leader
- To stimulate an active, reflective and critical engagement in using body-mind aspects by critical reflection, structured writing, project work and presentation
- To make the student aware of the function of body-mind aspects expressed in human movement, in education, society and in the frame of research.

The study consists of theoretical and methodological elements deepened through self-experience and process-oriented learning. Practical “floor-work” is a main part of the course. The emphasis is on further personal development basic to professional development. The student will experience and implement the content in the different part of the course, now at a higher level. Principles of evaluation and research methodology will enable the integration of theoretical perspectives, into the design and implementation of an effective and humanistic physiotherapy. Theoretical studies will mainly take place in the period of self-study and will be documented at the end of each module and in the final project.

TARGET GROUP AND ENTRY REQUIREMENT

Target group

Level 2 is for postgraduate physiotherapists only and is designed for those wanting to work in a structured way with therapeutic groups and of teaching and training movement awareness through groups. The course is especially for those working with patients that are vulnerable, for example within the psychiatric field, but also for promoting health and personal growth.

Entry requirement

Level 2 builds on Level 1. The student must have followed the course-program in Level 1 to enter Level 2. It is possible for students who have taken a similar education as the Level 1 of B BAM, other places, to apply for B BAM, Level 2 at BUC, being evaluated for acceptance according to the curriculum in B BAM at BUC. The course program is for English speaking students. All lessons, literature, reports and projects are in English. The student must have access to computer basic to work online.

COURSE FORM AND STRUCTURE

Level 2 gives additional 30 ECTS; Level 1 and Level 2 gives in total 60 ECTS. Level 2 is organized as a part time study over a period of one year (12 months). It starts with one week at BUC as a continuation of the last three weeks in Level 1 and finish one year later, with a block of three (3) weeks, the last week is arranged as the final exam. There is arranged for a period of 10 months self-study in between.

1st Year	2nd Year	3rd Year
Block 1	Block 2	Block 3
4 weeks at BUC	4 weeks at BUC	3 weeks at
BUC		
Level 1	Level 1, 3 weeks Level 2, 1 week	Level 2

Level 2 consists of 2 subjects:

Subject III, Group intervention starts with 1 week at BUC followed by a period of self-study, 4 months, which gives a total of 15 ECTS.

Subject IV; Final project starts with 6 month of self-study followed by a block of 3 weeks at BUC, which gives a total of 15 ECTS.

The overruling aim in Level 2 is to let personal training and clinical experience, knowledge, research, critical view and reflections, writing and presenting projects grow through the process of deepened insight. Training the personal skill of awareness is the core also in this level. In both subjects, self-experience, embodiment and movement-dialogue is in focus; in Subject III with the emphasis on group implementation; in Subject IV with the emphasis on the Final project.

The block period at BUC

The concentrated block at BUC have intense periods of “floor-work”, and includes 1) systematic personal training in Basic Body Awareness Therapy (Basic BAT) with critical reflection, 2) Group implementation, training and reflection, 3) Reflections on prior clinical work and 4) Theory, 5) Evidence-based practice and Research method.

The period of self-study

There is 1 year of self-study in between the blocks at BUC. The periods constitutes in total 9 ECTS: 3 ECTS in Subject III and 6 ECTS in Subject IV. This makes the student work in total 25 weeks, equivalent to 1 day per week. The student is responsible for organizing the period of self-study, creating situations for 1) personal training in B BAT, 2) patient/ client work, 3) arranging clinical groups, 4) study of literature, 5) report writing and project work and 6) working online through Its learning.

Portfolio

BUC arranges situations of written assignments to be delivered at specific times through Its learning.

Clinical practice

Clinical practice is incorporated in the period of self-study. Clinical practice includes client centered work: skill training, user-oriented projects, and cross-professional integration mostly focusing group-processes and leadership. In subject IV, the academic and practitioner standard is set at a higher level, integrating project work in clinical practice. The total client work is estimated to about 1 day a week, in 8 months, viz is about 150 hours clinical work. The student is responsible for finding a working place and clients; these are chosen by the student and accepted by BUC.

STUDY METHODS AND STUDENT PARTICIPATION

The course is designed on educational principles of self-experience and demands a high degree of personal involvement basic to future work situations through groups. This is reflected in the study methods. The course focuses practical skills and personal involvement, making the students work interactive on several levels. This is achieved through a variety of methods constantly changing between personal experience, theory, group work, problem solving assignments and practical studies, through seminars, lectures, project work and reflection. There are periods for intensive “*floor work*”, role-play, case studies and clinical studies. Lectures and seminars will cover selected areas of the curriculum, and the students are expected to work independently within their subject area. Study tasks will be related to the students` initiatives and are based on student active learning. The educational method will strengthen the students` personal resources and creativity challenging the whole human being. The integration of theory and practice is a planned process within the overall arrangement of the course. It ensured that professional competence will develop through practice and will be adequately assessed.

Online communication through “*It`s Learning*”

The student work through the international Learning Management System “*It`s learning*” in the period of self-study. The aim is to let the students communicate and collaborate online: a) to deliver assignments and discuss experiences, therapeutic role and content, b) to discuss written text, pictures, c) to discuss questions from the teacher, d) to build international network and e) to create professional, personal and research development. The study is organised around delivered assignments receiving feedback from the teacher at BUC.

Compulsory participation

Lectures, projects, group-works, practice and “*floor-work*” are compulsory if nothing else is stated. If more than 10% not present in the period of concentrated work at BUC, the student is given specific work that is equivalent to the work in the period he/ she was absent. The work the student will do is based on an agreement between student and teacher and is compulsory to meet to the final exam. It is expected that the student will be involved in all parts of the course.

For Subject 3 and 4, go to www.hib.no