

Oscillation between identities and Subjective psychological health objectives among an informed audience in therapeutic patient education★

Sandrine Roussel^{1,2,*}, Alain Deccache³ and Mariane Frenay²

¹ Faculty of Public Health, Université catholique de Louvain (UCL), Brussels, Belgium

² Research Institute of Psychological Sciences, Université catholique de Louvain (UCL), place du Cardinal Mercier, 10 box L3.05.01, 1348 Louvain-la-neuve, Belgium

³ Institute of Health and Society, Université catholique de Louvain (UCL), Brussels, Belgium

Received: 16 October 2017 / Accepted: 11 April 2018

Abstract – Introduction: The implementation of Therapeutic Patient Education (TPE) remains a challenge. An exploratory study highlighted two tendencies among practitioners of TPE, which could hamper this implementation: an oscillation between identities (as caregivers *versus* as educators) and an inclination towards subjective psychological health objectives. **Objectives:** To verify whether these tendencies can be observed among an informed audience in TPE. Next, to explore the variables associated with one or other of these tendencies. **Method:** A quantitative cross-sectional survey by a self-administered questionnaire was carried out among 90 French-speaking healthcare professionals. Statistical analyses (chi-square, logistic regression) were then conducted. **Results:** Sixty percent of respondents displayed identity oscillation, which was found to be linked to task oscillation, patient curability, scepticism towards medicine and practising in France. Fifty-six percent pursued subjective psychological health objectives, which was found to be associated with health behaviour objectives and a locus of power in the healthcare relationship distinct from those seen in the pre-existing health models (biomedical, global). This tendency seems to constitute an alternative model of TPE. **Discussion & conclusion:** Identity oscillation and subjective psychological health objectives can be both observed. This study stresses the need to deliberate on the form(s) of TPE that is/are desired.

Keywords: therapeutic patient education / healthcare providers / social identification / health objectives / perceptions / representations

Résumé – Oscillation de l'identité et Objectifs de santé psychique subjective parmi une audience avertie en éducation thérapeutique du patient. Introduction: Le déploiement de l'Éducation Thérapeutique du Patient (ETP) reste un défi. Deux tendances, apparues dans une étude exploratoire, parmi les praticiens de l'ETP pourraient l'expliquer : une oscillation de l'identité (entre soignant et éducateur) et une inclination envers des objectifs de santé psychique subjective. **Objectifs :** Vérifier l'existence de ces tendances auprès d'un public averti en ETP. Puis, explorer les variables associées à l'une ou l'autre de ces tendances. **Méthode :** Une étude quantitative transversale, par questionnaire, est conduite auprès de 90 professionnels de santé francophones. Des analyses statistiques (chi-carré, régression logistique) sont ensuite menées. **Résultats :** Soixante pour cent des répondants présentent une oscillation de l'identité, celle-ci est liée à l'oscillation de la tâche, la curabilité du patient, le scepticisme vis-à-vis de la médecine et l'exercice en France. Cinquante-six pour cent poursuivent des objectifs de santé psychique subjective, ceux-ci sont également caractérisés par des comportements de santé et un exercice du pouvoir dans la relation soignant-soigné distincts des modèles de santé existants (biomédical, global). Cette tendance se

★ S. Roussel conducted the whole study and wrote the paper. A. Deccache and M. Frenay successively directed the research, following the accession of A. Deccache to emeritus. Consequently, M. Frenay was more involved in the re-reading of the manuscript.

*Corresponding author: sandrine.roussel@uclouvain.be

profile comme un modèle alternatif en ETP. **Discussion & conclusion :** L'oscillation de l'identité et les objectifs de santé psychique subjective sont observables. Cette étude souligne la nécessité d'une réflexion sur la/les forme(s) d'ETP souhaitée(s).

Mots clés : éducation thérapeutique du patient / professionnels de soins de santé / identité sociale / objectifs de santé / représentations

1 Introduction

Therapeutic Patient Education first emerged in the 1970s and was intended as a way of addressing the challenge posed by chronic diseases in our ageing societies. Therapeutic Patient Education (TPE) is defined by the World Health Organisation (WHO) as a process that 'should enable patients to acquire and maintain abilities that allow them to optimally manage their lives with their disease. It is therefore a continuous process, integrated in health care. It is patient-centered (...). It is designed to help patients and their families understand the disease and the treatment, co-operate with health-care providers, live healthily, and maintain or improve their quality of life' [1]. Forty years later, however, it cannot be denied that there are difficulties with the implementation of TPE [2–9]. In this context, an exploratory study [10] carried out among healthcare professionals revealed two tendencies that may underlie these difficulties: oscillation between identities (as caregivers or as educators) and subjective psychological health objectives, (psychological) well-being evaluated exclusively by the patient. This study has set out to analyse these two tendencies.

What are these tendencies? To what extent do they constitute an obstacle to TPE, as defined by WHO?

In terms of identity, if it is confirmed that oscillation is taking place [10,11], this would mean that these professionals feel that they are sometimes solely caregivers and sometimes solely educators. Care and education are not being integrated. This phenomenon corresponds to the 'cognitive polyphasia' identified by Moscovici [12]. This consists of the coexistence of different or even contradictory social cognitions within a single individual. In other words, these professionals think of themselves sometimes as caregivers and sometimes as educators. While cognitive polyphasia has been observed in the area of health care [13–16], it has not been mentioned specifically in regard to TPE. Such an oscillation would lead to professionals not maintaining a central focus on TPE and would run counter to the definition of TPE as 'a continuous process, integrated in health care' [1].

In terms of health objectives, subjective psychological health might offer an 'alternative', in the context of TPE, to the two coexisting models: the biomedical model and the biopsychosocial/global model. The biomedical model looks at the organic component of a disease. This is diagnosed and treated by doctors. The global model views the disease as the result of complex organic, human and social factors. It requires an approach to management ranging from prevention to rehabilitation, working interdependently with the community [17]. These two models are not contradictory: the global model incorporates the biomedical model, but includes other dimensions as well.

Setting out from these two models of health, TPE may be closer to one model or the other. When it follows the biomedical model of health, TPE consists of the unilateral

transmission of medical knowledge by professionals [18]. This type of TPE targets physical health [17]. The education process is intended to permit the acquisition of typical behaviours in typical situations, to manage the patient's treatment and avoid complications [19]. Professionals hold the power. They define and evaluate the objectives that must be reached [20]. When it follows the global model of health, TPE involves setting out from the patient's concerns and background to help him/her to acquire jointly negotiated competencies in relation to his/her own physical, psychological and social health [18]. The education process should also reinforce the patient's psychosocial competencies (self-efficacy, self-determination, etc.) to allow the patient to pursue his/her own life plan within his/her social environment [19]. The acquisition of medical knowledge (which was the goal of the educational process that corresponds to the biomedical model) represents only a minor component of education. Power is shared between the professional and the patient [20]. This form of TPE corresponds to the WHO definition [1].

Besides these models, the professionals would target the subjective psychological health for their patients. This is in opposition to the objective physical health addressed by the biomedical model. Subjective psychological health is equally one part only of the global health. It would also be characterised by: a preference for being called 'accompanying person or attendants' rather than 'educators', the delegation of power to the patient and the tendency to target competencies enabling to live one's life with no consideration for the treatment [11]. If, as well as pursuing other specific health objectives (that are subjective psychological health ones), these professionals shared other specific characteristics, it could constitute an alternative model of health. If this type of subjective psychological health-based TPE was developed in parallel with TPE based on the global model, it could hamper the implementation of the latter form of TPE.

This study has sought to verify the existence of an oscillation between identities among healthcare professionals and to explore the variables, if any, that predict the oscillation. It has also attempted to verify whether there is a tendency towards subjective psychological health objectives and to determine what, if anything, sets subjective psychological health trend apart from the existing health models. The study has addressed the following specific questions: to what extent can the oscillation between professional identities be observed? What are the predictive variables of that oscillation? To what extent do healthcare professionals aim subjective psychological health? What are its characteristics? More specifically, how is it distinguished from TPE following one of the two 'traditional' health models? With a better understanding of these phenomena, it should be possible to identify steps that can be taken towards a form of TPE that is better integrated with healthcare practices and follows the global model more closely.

2 Methodology

The research hypotheses predicted the existence of an oscillation between identities and an inclination towards subjective psychological health objectives among certain healthcare professionals. If the results confirmed that these do exist, various hypotheses concerning associations with other variables would be considered, based on the tendencies identified by a previous exploratory research [10,11].

2.1 Data collection

This research was conducted by means of a self-administered questionnaire, in a target group of people who are aware of TPE. All the delegates at a conference on TPE and the members of a Nursing association for Patient Health were invited to complete our questionnaire. They were requested to make a dichotomous choice 'mostly agree/mostly disagree' for different statements. The variables were constructed on the basis of one or more statement(s). The content of the variables is explained in detail hereafter.

A set of socio-professional characteristics were also measured: the country of practice, the TPE course completed, the amount of experience in health care, the age, the number of specialties in which the individual practises and the profession.

The questionnaire was pre-tested among 27 professionals undergoing continuous training in TPE at a French University. Six statements were modified to ensure that they were well understood by a French target group.

2.1.1 Oscillation between identities

The hypotheses predicted that oscillation between identities would be linked to the task oscillation, an additional time required for education, the patient's health status (curability) and the practice in multiple specialties. The analysis formed part of an exploratory process looking at the predictive variables. Therefore, analyses were also carried out to identify essential links with other variables: the social health as part of their health objectives, the perception of (biomedical) medicine and all the socio-professional characteristics.

The 'identity' variable comprised two modalities (oscillating *versus* integrated) and was assessed using two statements. Details concerning statements are provided in Table 1.

On the basis of the exploratory study, the independent variables addressed in this study were:

- task oscillation (oscillating *versus* integrated) (two statements);
- additional time required for education in comparison with the technical aspect of care (additional *versus* identical) (one statement);
- the health status of the patient ('curability') modulating the approach taken by the professional (modulator *versus* other) (one statement);
- social health as something that is part of the healthcare professional's role (his/her role *versus* not his/her role) (one statement);
- the perception of biomedical medicine (scepticism *versus* other) (one statement).

Table 1. Variables and related statements regarding identity oscillation.

Tableau 1. Variables et propositions concernant l'oscillation de l'identité.

Dependent variable	Independent variables	Related Statements
Identity Oscillation		'With the patient, I feel like both a caregiver and an educator at all times'
		'With the patient, I feel like an educator at certain times, and like a caregiver at other times'
	Task oscillation	'During a consultation, caregiving and education take place at two separate times'
		'During a consultation, caregiving and education are inextricably linked'
	Additional time required of TPE	'Providing education whilst providing care takes more time than administering care'
	Health status, curability	'I provide treatment as long as the patient can be cured. If he/she cannot be cured, I am interested in his/her quality of life'
	Social health, role of the practitioner	'The patient's emotional, family and professional quality of life does not depend on me. Everyone has to play their own part!'
	Perception of biomedical medicine	'You cannot impose to patients a medicine that has not proven its efficiency'

2.1.2 Subjective psychological health objectives

The aim was to determine the characteristics of subjective psychological health objectives. More specifically, whether this is distinct from TPE based on the biomedical health model and from TPE based on the global health model. The aim was therefore to determine whether professionals who support a subjective psychological health trend take a stance in opposition to an approach inherited from the biomedical model and are only partly supportive of an approach inherited from the global model. The hypotheses predicted a link between subjective psychological health objectives and targeting health behaviours which were neither a strict compliance with treatment (biomedical model), nor 'living one's life' including the treatment (global model), in favour of simply 'living one's life'. They also predicted a link between subjective psychological health objectives and a locus of power in the healthcare relationship, which is exercised neither by the caregiver alone (biomedical model) nor jointly by the patient and the caregiver (global model), but where the patient alone has power. In addition to the links with these variables, the hypotheses predicted an association between the subjective psychological health objectives and a preference for the label of an 'accompanying person' [11].

The variable 'subjective psychological health objectives' comprised two modalities (subjective psychological health objectives *versus* no subjective psychological health objectives).

Table 2. Variables and related statements regarding health objectives.**Tableau 2.** Variables et propositions concernant les objectifs de santé.

Dependent variable	Independent variables	Related Statements
Subjective psychological health objectives	Locus of power exercise	'I mainly aim to maintain or restore physiological and biological parameters, not to make people happy'
		'I mainly aim to restore/maintain the patient's physiological and biological parameters. His/her happiness is not my prime objective'
		'I mainly target the patient's well-being, his/her happiness. Physical health is not my primary objective'
		'I mainly target the patient's well-being, his/her happiness, not maintaining/restoring physiological and biological parameters'
		'If the patient says he/she feels well, I am satisfied even if his/her physiological and biological parameters are not as they should be'
		'As a healthcare professional, I know what is good for the patient; I show him/her which way to go'
		'The patient knows what he/she wants to do with his/her life. I try to accompany him/her on the path that he/she has chosen'
		'For me, the decision on treatment should be made together with the patient. It is always a negotiation'
		'I think the patient should be able to protect him/herself from serious risks and comply with the treatment as prescribed'
		'I think the patient should be able to live (his/her life) in his/her own setting and cope with the unexpected'
		'My role is to be an accompanying person for the patient, not an educator'
	Health behaviour objectives	
	Preference for accompanying person	

These health objectives are in opposition to objective physical health objectives. Chosen statements were therefore selected in such a way that professionals were able to express their preference for one or other of these components in the global model. This was assessed using five statements. Details concerning statements are provided in Table 2.

On the basis of the exploratory study, three independent variables were addressed. The first two were designed to test the association between subjective psychological health tendency and characteristics that relate to the existing models:

- the locus of power exercise in the healthcare relationship (shared¹ versus other) (power held by the caregiver only² versus rejection of the statement) (three statements);
- the targeted health behaviour (living his/her life, including the treatment³ versus other) (strict compliance with treatment⁴ versus rejection of the statement) (two statements);
- the attractiveness of the 'accompanying person' label as compared with 'an educator' (more attractive versus other) (one statement).

2.2 Data analysis

Data were then coded using SPSS 21. Respondents with a response rate of below 90% were excluded as the aim of the study was also to explore the associated variables. After the items were grouped to define and dichotomise the variables

(based on the modalities listed in brackets above), the analyses detailed below were carried out.

The analysis of the oscillation between identities was very exploratory in its approach. The model first had to be constructed, so a two-stage analysis was carried out. The first step involved performing chi-square tests of independence. A variable selection process was done on this basis. The selection criteria were a *p*-value of less than 0.20 and missing values of below 10%. Subsequently, a logistic regression (ENTER method) was carried out with the variables that had been preselected.

To analyse subjective psychological health tendency, chi-square tests of independence were carried out to determine whether there were links between this tendency and the preselected variables.

The research project was approved by the Ethics Committee of the Psychological Sciences Research Institute (IPSY) at the Université catholique de Louvain (project 24/2012).

3 Results

A total of 90 questionnaires were eligible for inclusion. The response rate was 36% for the attendees at the conference. It could not be determined for the members of the Nursing association since the questionnaire was forwarded by the organisation to its members and could not tell us how many e-mails were sent.

The majority of the respondents (79%) practiced TPE with patients. All respondents were nevertheless considered, as we analysed perceptions. Most of them had completed specific training in this area (76%). Eighty-two percent of the participants were practising healthcare professionals, as nurses

¹ In accordance with the global model.

² In accordance with the biomedical model.

³ In accordance with the global model.

⁴ In accordance with the biomedical model.

Table 3. Factors associated with oscillation between identities (Oscillating/Integrated).**Tableau 3.** Facteurs associés à l'oscillation de l'identité (Oscillante/Intégrée).

	Logistic regression				Associated modalities with 'oscillating'
	B (SE)	Odd Ratio	95% CI of ORs [lower, upper]	p-value	
Task oscillation	3.013 (0.966)	20.34	[3.06;135.17]	0.002	Oscillation
Health status: curability	1.439 (0.647)	4.22	[1.19;14.98]	0.026	Modulation
Social health, as their role	–	–	–	–	
Perception of medicine	1.649 (0.684)	5.20	[1.36;19.89]	0.016	Scepticism
Country	1.608 (0.636)	4.99	[1.44;17.38]	0.011	France
Age	–	–	–	–	

(49%), doctors (32%), pharmacists (10%), dietitians (5%), and occupational therapists (4%). The remainder worked in coordination, training or reception roles. All the professionals were French speakers, most of them from France (58%) and Belgium (34%). The rest came from Switzerland, Luxembourg, Italy and Togo. They were practising in a variety of specialties, with paediatrics, diabetology, psychiatry, general medicine, obstetrics and geriatrics most strongly represented. The majority worked in hospitals (68%).

3.1 Oscillation between identities

Forty percent of the professionals ($n=36$) displayed an integrated identity as a caregiver-educator. Sixty percent ($n=53$) displayed an oscillating identity. Of the latter, 17% ($n=9$) oscillated between caregiver and educator, while 83% ($n=44$) oscillated between caregiver, educator and caregiver-educator. The hypothesis that oscillation between identities takes place among certain professionals was confirmed: a significant proportion of respondents displays an oscillating identity. This oscillation, however, had a specific character. Alongside the expected oscillation between two modalities, an oscillation was also observed between three modalities.

3.2 Variables associated with oscillation between identities

Seven variables met the selection criteria ($p < 0.2$ at the Chi-square and missing values below 10%): the task oscillation ($\chi^2=10.54$, $p=0.001$), the social health as his/her role (FET-Fisher's exact test in bilateral conditions, $p=0.076$), the health status of the patient ($\chi^2=1.88$, $p=0.171$), the perception of biomedical medicine ($\chi^2=3.71$, $p=0.054$), the country of practice ($\chi^2=3.37$, $p=0.066$), the experience ($\chi^2=2.80$, $p=0.094$) and the age ($\chi^2=3.12$, $p=0.077$). Since experience and age display a strong association ($R=0.754$), only age was selected for the regressions because it had a lower p -value and fewer missing values.

Consequently, six variables were selected for the step-by-step logistic regressions. A logistic regression (ENTER method) was then carried out (Tab. 3). The aim was to establish the effects of variables on the probability that the respondents would oscillate between identities.

The logistic regression model was statistically significant $\chi^2(4)=23.90$, $p < 0.001$. The model accounted for 35.6% (Nagelkerke R^2) of the variance in the oscillation between

identities and correctly classified 73.1% of cases. The model did predict the data (Hosmer & Lemeshow Test, $p=0.796$). The missing values were 12.

Four of the six predictive variables were significant: the task oscillation⁵, the health status of the patient, the perception of medicine and the country. The professionals who oscillated between tasks were 20.34 times more likely to oscillate between identities. The professionals who were sceptical about biomedical medicine were 5.20 times more likely to oscillate between identities than those who did not share that scepticism. A professional working in France was 4.99 times more likely to oscillate than one working in Belgium. Finally, oscillation between identities was linked to a different approach depending on the patient's health status (namely: treatment as long as the patient is 'curable'; quality of life when the patient is incurable); professionals who modulate their approach depending on the patient's health status were 4.22 times more likely to oscillate between identities.

With respect to variables associated with the oscillation between identities, the hypotheses were partly confirmed by the results. The association between identity oscillation and task oscillation and the modulation according to the patient's health status were confirmed. The analysis revealed other associations with identity oscillation: the perception of biomedical medicine and the country of practice.

3.3 Subjective psychological health objectives

The score for subjective psychological health objectives ranged from 0 to 5, with 5 being the highest score. The distribution of the scores within the sample was as follows: 2% for a score of 0 ($n=2$), 5% for a score of 1 ($n=4$), 20% for a score of 2 ($n=16$), 17% for a score of 3 ($n=14$), 17% for a score of 4 ($n=14$) and 39% for a score of 5 ($n=32$). The cut-off definition lay on two elements: the score distribution and the acceptance of the most extreme statement ('If the patient says he/she feels well, I am satisfied even if his/her physiological

⁵ The frequencies of identity and task oscillation were different. Sixty percent of respondents displayed oscillation between identities, as compared with 24% who displayed oscillation between tasks. The integration between health care and education (*i.e.* the task) seemed stronger than the integration between caregiver and educator (*i.e.* the identity). Of those who oscillated between tasks, 90% oscillated between identities.

Table 4. Characteristics associated with subjective psychological health objectives (SPH).**Tableau 4.** Caractéristiques associées aux objectifs de santé psychique subjective (SPH).

	SPH objectives				Chi-square	ddl	<i>p</i> -value	< 0.05 = *
	SPH (n=46)		Not SPH (n=36)					
Preference for ‘accompanying person’ – Yes	14 (46) ^a	30% ^b	10 (36)	28%	0.069	1	0.793	
Health behaviour objectives								
Living one's life including the treatment – Other	25 (41)	61%	8 (34)	24%	10.577	1	0.001	*
<i>Strict compliance with treatment – No</i> ^c	26 (43)	60%	8 (35)	23%	11.098	1	0.001	*
Locus of power exercise								
Power sharing – No	38 (45)	84%	22 (35)	63%	4.893	1	0.027	*
<i>Power for the caregiver – No</i> ^c	37 (45)	82%	20 (36)	56%	6.821	1	0.009	*

^a 14 corresponds to the number of respondents focusing on SPH who answered yes to the statement, ‘preference for accompanying role’; 46 corresponds to the total number of respondents focusing on SPH who responded to this statement.

^b 30% corresponds to the ratio between 14 and 46. This is the percentage of individuals focusing on SPH who had a preference for ‘accompanying person’.

^c The italics indicate a sub-dimension of the characteristic mentioned above.

and biological parameters are not as they should be’), indicating an epistemological gap, which was common among respondents who obtained 4 (11 out of 14). The cut-off was therefore set at four. Fifty-six percent of the respondents ($n=46$) pursued subjective psychological health objectives, while 44% ($n=36$) had little or no focus on them.

3.4 Variables associated with subjective psychological health

A chi-square test of independence was carried out to determine whether there was an association between subjective psychological health objectives pursued by professionals and these different variables (*i.e.* a preference for ‘accompanying person’, distinctive health behaviour objectives and locus of power from those of the biomedical model and the global model) (Tab. 4).

According to the hypotheses, the health behaviours being targeted should be distinct from those addressed by the two known health models:

- To distinguish themselves from the global model, the professionals pursuing subjective psychological health objectives for their patients had to aim for a type of health behaviour distinct from living one's life while complying with treatment. As a matter of fact, 61% of the respondents pursuing subjective psychological health objectives wished their patients to display health behaviours ‘other’ than ‘living one's life including compliance with the treatment’, as compared with only 24% of those not pursuing subjective psychological health objectives. A chi-square test of independence showed a significant difference ($\chi^2=10.58$, $p=0.001$), which indicates that there was a link between subjective psychological health objectives and the specific health behaviour objectives. Respondents who pursue subjective psychological health objectives do aim for health behaviours that are distinct from those who subscribe to the global model. So, what was the nature of the modality ‘other’ than living one's life including the treatment? Eighty-five percent of the respondents who supported the ‘other’ modality aimed for ‘simply living

one's life’. This modality did not include the treatment. This is a distinct modality, different from the one of the global model, which does include the treatment.

- To distinguish themselves from the biomedical model, the professionals pursuing subjective psychological health objectives for their patients also had to aim for a type of health behaviour different from a strict compliance with treatment. One sub-modality of the variable ‘health behaviour’ offers clarification on this point. Sixty percent of the respondents pursuing subjective psychological health objectives rejected the idea of strict compliance with the treatment, as compared with 23% of those not pursuing those health objectives. This difference between the groups was significant ($\chi^2=11.10$, $p=0.001$).

Professionals aiming subjective psychological health did aim for behavioural objectives that are distinct from the behavioural objectives of those who subscribed to the two existing models. They aimed for behaviours along the lines of ‘simply living one's life’ (which does not include the treatment).

According to the hypotheses, the locus of power which is exercised in the professional-patient relationship should be distinguished from that targeted by each of the two known models of health:

- To distinguish themselves from the global model, the professionals pursuing subjective psychological health objectives had to regard power as not being shared between the professional and the patient. As a matter of fact, 84% of the respondents aiming subjective psychological health rejected the idea of sharing power with the patient, as compared with 63% of those not aiming subjective psychological health. A chi-square test of independence showed a significant difference ($\chi^2=4.89$, $p=0.027$), which indicates that a relationship does exist between subjective psychological health objectives and the locus of power exercise in the healthcare relationship. So, what was the nature of this modality ‘other’ than sharing power? Eighty-eight percent of the respondents who took a stance against sharing power, actually aimed for power to be exercised by the patient alone.

- To distinguish themselves from the biomedical model, the professionals aiming their patients' subjective psychological health objectives also had to regard power as not being exercised by the caregiver alone. One sub-modality of the variable 'locus of power exercise' offers a better understanding of this point: 82% of respondents aiming subjective psychological health objectives rejected the idea of power being exercised by the caregiver, as compared with 56% of those not aiming those health objectives. This difference between the groups was significant ($\chi^2 = 6.82$, $p = 0.009$).

Professionals targeting subjective psychological health did view the locus of power exercise in the professional-patient relationship distinctively from those who subscribed to the two existing models: power is conceived as being exercised by the patient alone.

The association with a preference for being labelled as an 'accompanying person' was not confirmed ($\chi^2 = 0.07$, $p = 0.793$).

With respect to variables linked to subjective psychological health objectives, the hypotheses were largely confirmed by the results. The analysis showed that professionals who adopted subjective psychological health as health objective for their patients also set themselves apart from the two known models, both in terms of the targeted health behaviours and in terms of the locus of power exercise.

It is worth noting that identity oscillation and subjective psychological health objectives were not founded to be associated ($\chi^2 = 0.31$, $p = 0.576$).

4 Discussion

The oscillation between identities and the pursuit of subjective psychological health objectives among professionals engaged in TPE were both corroborated by the research results. These two tendencies were not founded to be associated.

4.1 Oscillation between identities

A more nuanced picture emerged, however, in relation to the oscillation between identities. As well as an oscillation between two modalities for some professionals, an oscillation between three modalities was seen for some others.

The study showed that identity oscillation was linked to task oscillation, the perception of medicine, the curability of the patient and the country of practice. Its association with the task oscillation tends to confirm a dichotomous (or even trichotomous) perspective that goes beyond identity alone. Its association with the perception of medicine and the curability of the patient poses the question of creating a positive identity as a caregiver-educator. Education seems to be envisaged when it is impossible or futile to act as a biomedical caregiver, whether due to scepticism in relation to a certain form of medicine that is inadequate or due to the impossibility of curing the patient. The link to the impossibility of curing the patient may be a result of the scope of TPE itself: the management of patients affected by a chronic health problem.

If the cognitive polyphasia is not a new phenomenon [12,14–16], it has not been mentioned yet in TPE. Consequently, it is important to question what identity oscillation means in this specific field and how it could be related to its implementation difficulties. While an oscillation between two modalities (caregiver alone or educator alone) was observed during an exploratory research [10,11], the oscillation observed here was, for the most part, an oscillation between three modalities (caregiver, educator and caregiver-educator). What is the significance of such oscillations? Could 'caregiver' be linked to an approach consistent with the biomedical model, while 'educators' is linked to the subjective psychological health tendency, and 'caregiver-educator' to an approach consistent with the global model? Oscillation between three modalities, including that of a caregiver-educator, may also be an indication that an integrated identity as a caregiver-educator is being created.

Differences in identity oscillation between France and Belgium could actually be in favour of a progressive integration of education in health care. The identity oscillation was more frequent among professionals practising in France in comparison with the ones practising in Belgium. Yet, TPE 'recognition' differs in these two countries. This could lead to an alternative hypothesis. In France, period(s) of time dedicated to TPE are actually more common than in Belgium (in which it is limited to a few programmes namely diabetes convention, care paths...). The TPE assignment is nevertheless seldom a full-time one. Consequently, the practitioner might feel 'educator' during those dedicated times whereas he/she might feel 'caregiver' in his/her usual care practice, sometimes qualified as 'purely technical'. Practising TPE during those dedicated times might also affect his/her usual practice and leads to a 'caregiver-educator' identity. The proportion of initiatives labelled as 'TPE' much more represented in France might explain that more practitioners do oscillate in this country. Oscillation might also be the consequence of what some have called the formalism accompanying this institutionalisation of TPE in France [21]. Although, one should note that we do not know what the professional actually meant by 'therapeutic patient education'. In any case, as some professionals had been found to be in favour of subjective psychological health, we can assume that TPE is not always concordant with the global health model.

4.2 Subjective psychological health objectives

With respect to subjective psychological health, the study revealed links to targeted health behaviours and the locus of power exercise. Next to specific health objectives, they make it possible to define other characteristics of this tendency. These variables relate to the perception of TPE. More than being a simple tendency within TPE, subjective psychological health seems to emerge as an alternative health model. In fact, apart from the original health objectives, which are distinct from those of the global model and the biomedical model, it also distinguishes itself from these two models in terms of the targeted health behaviours (which do not include treatment) and the locus of power (which is left to the patient).

What does subjective psychological health mean with respect to the implementation of TPE? Could subjective

psychological health be an intermediate position on the way to global health model? Is it the regular attitude of the healthcare professional or a fall-back position? A regular attitude rooted in values of the practitioner might also be the outcome of repetitive failure to achieve a 'deliberative model' [22]. Paradoxically, the subjective psychological health might also result from the failure of a practitioner-centered approach. In this case, the practitioner may consider as a failure that the patient does not want to follow the prescriptive medical decision. He/she may reconsider the situation with 'realism': 'Anyway, the patient will do what he/she wants to, when I am not there'. Subjective psychological health may also be related to the phenomenon of clinical inertia, 'the failure of healthcare professionals to initiate or intensify therapy when indicated' [23]. Next to the 'weakness of will' hypothesis which cannot be excluded [24], an alternative could be that subjective psychological health objectives and (temporary) clinical inertia might be the outcome of a 'co-decision' process, in which the choice of the patient is taken first place after the negotiation process. Whatever the reason(s) for subjective psychological health (approach) is/are, it would be interesting to identify what elements or process can support progress to a global health model (ea. negotiation abilities, context, etc.).

4.3 Limitations

The measurement of the dependent variables (oscillation between identity and subjective psychological health) needs to be considered as a first attempt. Preparing those scales, a special attention was given to the choice of words to ensure the construct validity (avoiding ambiguous terms and using of same words to describe the same concept). Although, those scales need to be refined. With respect to the identity oscillation's scale, specific professionals, notably pharmacist and dietitians (15% of the sample) may find it difficult to position themselves as caregivers or as educators. They might not identify themselves with caregivers. A third option, such as a nutrition/medicine technician, can therefore not be excluded. With respect to subjective psychological health's scale, the answer to the other items of the scale is strongly associated with the reply to the most extreme statement, 'if the patient says he/she feels well, I am satisfied even if his/her physical and biological parameters are not as they should be'. Those who responded in favour of subjective psychological health to this statement, responded the same way to the other statements of the scale. Consequently, a subsequent development of this scale should be to reduce and improve it, using the most relevant/extreme statement from this study in combination, for example, with positioning on a continuum between subjective psychological health and objective physical health.

This study did show some other limitations. First of all, the cross-sectional design means that conclusions cannot be drawn on any causal relationships. Next, the small number of respondents who agreed with the biomedical model, the limited number of respondents and the large number of missing values placed statistical limitations on the analyses that could be carried out. Furthermore, respondents might not be representative of the entire population of professionals practising TPE. For example, the number of respondents adopting dimensions coherent with the biomedical model or

the global model is actually very similar. This phenomenon is due to the fact that there were virtually no respondents in our sample who only agreed with the biomedical model. This may be linked to the nature of the sample: a target group consisting of attendees at a conference on TPE or members of the TPE association(s) is not very likely to express agreement with the biomedical model. Finally, this study does not claim to explore all the variables associated with identity oscillation and subjective psychological health objectives. Further research, involving preferably larger numbers of participants, will therefore be needed in order to identify all the variables associated with these two tendencies.

5 Conclusion

This study, which was carried out among a French-speaking target group of professionals aware of TPE, confirms that some professionals do oscillate between identities and that some professionals are inclined to subjective psychological health objectives. These two tendencies may constitute an obstacle to the implementation of TPE in accordance with the definition used by WHO [1]. Oscillation between identities may constitute an obstacle to the integrated implementation of TPE in health care. At the same time, subjective psychological health approach may hamper the implementation of TPE in a way that follows the global model of health.

These results provide exciting directions for research. The approach that was followed to measure identity oscillation and subjective psychological health and to identify links between the variables intended to be exploratory. It needs to be considered as a first step. The results represent useful material that could give rise to further research relevant to the practice of TPE. From this perspective, the fact that a practitioner in France is more likely to oscillate between identities than his/her counterpart practising in Belgium calls into question the context in which TPE is implemented. The results obtained underline the need to carry out comparative studies that will allow analysis of the contexts in which TPE is delivered and of the impact of those contexts on practices. These results also invite political decision makers, practitioners and trainers to reconsider the type(s) of health care being targeted, and consequently the forms of TPE that are desired. Can a focus on subjective psychological health be seen as an eligible alternative? If so, what would be the role of the professional? If not, how can a caregiver-educator identity be promoted? How can patient education be promoted as an integral part of care? What contexts are favourable to this?

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest

The authors declare they have no conflicts of interest in relation to this article.

References

1. WHO. Therapeutic Patient Education. Continuing education programmes for health care providers in the field of prevention of chronic diseases. Report of a WHO working group. Technical report series. Copenhagen: WHO Regional Office for Europe; 1998.
2. Hoving C, Visser A, Mullen PD, van den Borne B. A history of patient education by health professionals in Europe and North America: from authority to shared decision making education. *Patient Educ Couns*. 2010; 78:275–281.
3. Sunaert P, Vandekerckhove M, Bastiaens H, Feyen L, Vanden Bussche P, De Maeseneer J, *et al.* Why do GPs hesitate to refer diabetes patients to a self-management education program: A qualitative study. *BMC Fam Pract*. 2011; 12.
4. Rantanen M, Johansson K, Honkala E, Leino-Kilpi H, Saarinen M, Salanterä S. Dental patient education: a survey from the perspective of dental hygienists. *Int J Dent Hyg*. 2010; 8:121–127.
5. Leep Hunderfund AN, Bartleson JD. Patient education in neurology. *Neurol Clin*. 2010; 28:517–536.
6. Kääriäinen M, Kyngäs H. The quality of patient education evaluated by the health personnel. *Scand J Caring Sci*. 2010; 24:548–556.
7. Heyden I. L'ETP à domicile: avis de soignants et de responsables. *Educ Ther Patient*. 2013; 5:229–252.
8. Albano MG, Crozet C, D'Ivernois JF. Analysis of the 2004–2007 literature on therapeutic patient education in diabetes: results and trends. *Acta Diabetol*. 2008; 45:211–219.
9. Balcou-Debussche M, Debussche X. Type 2 diabetes patient education in Reunion Island: perceptions and needs of professionals in advance of the initiation of a primary care management network. *Diabetes and Metabolism*. 2008; 34: 375–381.
10. Roussel S, Libion F, Deccache A. Représentations en matière de santé, éducation et soin chez les soignants-éducateurs en Education Thérapeutique du Patient: pistes pour la formation. *PMED*. 2012; 13:79–90.
11. Roussel S, Deccache A. Représentations variées des concepts en Education Thérapeutique du Patient chez les professionnels de soins: réflexions et perspectives. *Educ Ther Patient*. 2012; 4:401–408.
12. Moscovici S. La psychanalyse, son image et son public. 3^e éd. Paris: PUF; 2004.
13. de-Graft Aikins A. Exploring biomedical and ethnomedical representations of diabetes in Ghana and the scope for cross-professional collaboration: a social psychological approach to health policy. *Soc Sci Inf*. 2002; 41:625–652.
14. do Nascimento AM, Roazzi A. Cognitive polyphasia and the iconic structure of the social representation of death. *Psicologia: Reflexao e Critica*. 2008; 21:499–508.
15. Renedo A, Jovchelovitch S. Expert knowledge, cognitive polyphasia and health: a study on social representations of homelessness among professionals working in the voluntary sector in London. *J Health Psychol*. 2007; 12:779–790.
16. Wagner W, Duveen G, Verma J, Themel M. 'I have some faith and at the same time I don't believe' – Cognitive polyphasia and cultural change in India. *J Community Appl Soc Psychol*. 2000; 10:301–314.
17. Bury J. Éducation pour la santé. Concept, enjeux, planification. Bruxelles: De Boeck Université; 1988.
18. Deccache A. Éducation pour la santé, éducation du patient. Quelques concepts et leur signification en médecine générale. In: L'éducation pour la santé en médecine générale: de la fonction curative à la fonction éducative (B Sandrin-Berthon, I Aujoulat, C Ottenheim, F Martin, Eds), Vanves: CFES; 1997, pp. 51–62.
19. Eymard C. Des modèles de l'éducation et de la santé à l'activité d'éducation thérapeutique. In: Éducation thérapeutique du patient: modèles, pratiques et évaluation (J Foucaud, JA Bury, M Bacoul-Debussche, C Eymard, Eds), Saint-Denis: Inpes; 2010, pp. 39–53.
20. Deccache A. Un cadre théorique pour comprendre et agir sur le problème de la non-compliance aux traitements. *Bulletin d'éducation du patient*. 1995; 14: 6–12.
21. Barrier P. Le patient autonome. Paris: Presses Universitaires de France 2014.
22. Emanuel E, Emanuel L. Four Models of the Physician-Patient Relationship. *JAMA*. 1992; 267:2221–2226.
23. Phillips LS, Branch WT, Cook CB, Doyle JP, El-Kebbi IM, Gallina DL, *et al.* Clinical Inertia. *Ann Intern Med*. 2001; 135:825–834.
24. Reach G. Patient non-adherence and healthcare-provider inertia are clinical myopia. *Diabetes & Metabolism*. 2008; 34:382–385.

Cite this article as: Roussel S, Deccache A, Frenay M. Oscillation between identities and Subjective psychological health objectives among an informed audience in therapeutic patient education. *Educ Ther Patient/Ther Patient Educ* 2018;10:10202.