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Weight of Values: From Semantics to Pragmatics of Health Education

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Editorial

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Preoccupation with illness and hyperreactivity to bodily sensations are the main elements of health anxiety. Exposure to the pain of others and increased incidences of disease invoke the mirror neurons as well as anticipatory and innate alarm systems, leading to experiences such as the emergence of global panic about human immunodeficiency virus (HIV), the coronavirus disease 2019 (COVID-19) pandemic, and the medical student syndrome (Kosic, Lindholm, Jarvholm, Hedman-Lagerlof, & Axelsson, 2020).

Over the past decades, as indicated by numerous reviews, we have been experiencing a global rise in health anxiety. There are many factors contributing to this phenomenon (Brown, Skelly, & Chew-Graham, 2020): more convenient accessibility to vast amounts of health-related information, social media as a new platform for health education programs, and an upward trend towards hyper-individuality and intolerance of ambiguity. It seems that our risk assessment has turned from an economic measure into an obsessive craving for more information and prediction. Living in risk societies causes us to become more hypervigilant and preoccupied persons (Goli, Monajemi, Ahmadzadeh, & Malekian, 2016).

Health anxiety is a painful illness with a huge burden on the quality of life and health systems (Lee, Creed, Ma, & Leung, 2015). Furthermore, it disturbs the neuroimmune function, predisposing us to many diseases, and similar to other chronic distresses, decreases the functionality of the hippocampus and the prefrontal cortex (Asmundson & Taylor, 2020). For that reason, it is no longer referred to as hypochondriasis or an imaginary illness.

Our current health education is primarily based on reinforcing illness phobia to inhibit dysfunctional beliefs and behaviors. Health promotion campaigns are typically designed to elicit fear, yet the use of fear is often ineffective in achieving the

desired behavior change.

Current evidence suggests that if people are given information about how bad things could potentially become as a result of their risky behavior, their defensive and paradoxical responses may get prompt (Ruiter et al., 2014). Although fear offset may work in certain circumstances, when it comes to societies that are made up of varying situations, and ultimately, traits, it could induce resistance, paradoxically reinforcing risky behaviors, health anxiety, nocebo responses, and even mass hysteria. Thus, rewarding healthy behaviors, through positive reinforcement and creating opportunities for bodily improvements to become more tangible and imaginable leads to a much more successful intervention than scare tactics, such as threatening strategies (Soames Job, 1988; Goli et al., 2016).

The current fear-inducing health education relies on the warlike medical model which illustrates human beings in a matryoshka of battlegrounds from genes to biosphere.

As such high doses of fear are injected into the global community, albeit for the purpose of directing people towards rational behaviors, caution is strongly advised to avoid misuse and overdose of negative reinforcement. Otherwise, we should expect a critical increase in cultural and social iatrogenic problems due to the counterproductivity of health education systems. There are many ethical and clinical considerations in such a distressing health promotion in community and patient education (Brown & Whiting, 2014).

It is not so hard to imagine our global health discourse as a hypochondriac, fearful patient. When you try to reassure a patient with health anxiety based on his clinical and paraclinical data, it is very common to hear something like this: "*You know Doc all these tests have a certain rate of false negatives, and please accept my apology since medical errors are not very rare, but even 0.1 percent of a population includes many people. How do you know that I am not one of them?"*.

He is right! He can tell you countless logically and statistically correct prepositions, but the crucial point here is the weight of values. An annoying insightful technique that I sometimes apply during such situations involves giving the patient an overwhelming amount of possibilities for being affected by other illnesses or traumas, some of which are much more likely for his condition. Sometimes, after episodes of justifications and confusion, he finally doubts the weight of the risk he had assessed.

This is the insight that we expect highly specialized experts and institutions to reach. Our capacity for cognitive and emotional processing as well as our skills is very restricted and we need economic models of health instead of exclusively experimental ones.

We need a fundamental shift from the rough material of evidence-based facts and semantics of health education propositions to a systemic approach and pragmatics of the instructions. It does not matter what you say; what matters is what you do with what you say in a certain communicative context.

Conflict of Interests

Authors have no conflict of interests.

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