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Hua, Jacqueline Nga

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Coping Self-Efficacy Influences Health Information Avoidance

A thesis submitted in partial satisfaction of the requirements
for the degree of Master of Arts

in

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by

Jacqueline Nga Hua

Committee in charge:
Professor Jennifer Howell, Chair
Professor Anna Song
Professor Matthew Zawadzki

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University of California, Merced
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Table of Contents

Abstract.....	v
Introduction.....	1
<i>Causes of Information Avoidance</i>	<i>1</i>
<i>Information Avoidance and Coping</i>	<i>2</i>
<i>Coping Self-Efficacy.....</i>	<i>2</i>
<i>The Present Research.....</i>	<i>3</i>
Study 1.....	3
<i>Study 1: Method</i>	<i>3</i>
1. Participants and Procedure	3
2. Measures	4
3. Analysis	4
<i>Study 1: Results</i>	<i>4</i>
<i>Study 1: Discussion</i>	<i>4</i>
Study 2.....	5
<i>Study 2: Method</i>	<i>5</i>
1. Participants and Procedure.....	5
2. Measures	6
3. Analysis.....	6
<i>Study 2: Results and Discussion.....</i>	<i>6</i>
General Discussion.....	7
Implications & Applications	7
Limitations & Future Directions	8
Conclusion	9
References.....	10

Abstract

Coping Self-Efficacy Influences Health Information Avoidance

Jacqueline Nga Hua

Master of Arts in Psychological Sciences

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Dr. Jennifer Howell, Committee Chair

Avoiding information about one's risk for disease can have long-term implications for health. Past research suggests that people avoid health information when they perceive that they lack control and coping resources. We theorized that these two relationships implicate a broader underlying mechanism in health information avoidance—coping self-efficacy. Two studies examined the relationship between coping self-efficacy and avoidance of personal disease risk. Study 1 revealed that coping self-efficacy, but not general self-efficacy, was associated with information avoidance, such that participants who reported greater coping self-efficacy were less likely to avoid their risk. Study 2 established a causal relationship between coping self-efficacy and avoidance. Participants who reflected on their past positive coping strategies were less likely to avoid learning their risk as compared to those who did not reflect on their coping strategies. These findings suggest that coping self-efficacy is likely a good target for reducing health information avoidance.

Introduction

Despite widespread efforts to reduce the prevalence of diabetes by the Office of Disease Prevention and Health Promotion, diabetes remains one of the leading causes of death in the United States (Heron, 2018). Of 136 million adults who met the American Diabetes Association criteria for being screening-recommended, only 46.2% reported screening in the last 3 years (Kiefer, Silverman, Young, & Nelson, 2015). Some may assume that the decision to forego screening is due to structural factors such as lack of access to healthcare. Nevertheless, of those who reported not screening, 76.1% were insured (Kiefer et al., 2015). This suggests that decisions to forego diabetes screening may be driven by other psychosocial factors.

The decision not to screen for disease falls under the broader label *information avoidance*. Information avoidance refers to any behavior aimed at preventing the acquisition of available information (Sweeny, Melnyk, Miller, & Shepperd, 2010). In health contexts, information avoidance can manifest in decisions to avoid risk assessments and screening for disease. In one study, 30% of a college student sample chose to avoid viewing a UV photograph that could reveal their skin damage (Dwyer, Shepperd, & Stock, 2015). In another study, 39% of a U.S.-representative adult sample reported they would rather not know their lifetime risk of developing cancer (Emanuel et al., 2015). Given that early detection and diagnosis are key to better long-term health outcomes (Herman et al., 2015; Levin & Stevens, 2011; Weimer & Sager, 2009), it is important to identify ways to decrease health information avoidance.

Causes of Information Avoidance

Past research suggests three underlying motivators for health information avoidance: perceived threat to beliefs, affect, and behavior (Howell, Lipsey, & Shepperd, in press; Shepperd & Howell, 2015). First, people may avoid health information to maintain cherished beliefs about their identity. Research on selective exposure demonstrates that people tend to seek information that affirms their pre-existing beliefs and to avoid information that challenges their beliefs (Hart et al., 2009; Smith, Fabrigar, & Norris, 2008). For example, in one study, participants were more inclined to avoid viewing a UV photograph of their skin damage if they believed the photograph would show them as ugly (Dwyer et al., 2015).

The second reason people avoid information is to maintain positive emotions and to avoid negative emotions (Shepperd & Howell, 2015). For instance, multiple studies suggest that people will avoid information such as risk for breast cancer and whether one's marriage will end in divorce if they believe they will regret learning that information (Gigerenzer & Garcia-Retamero, 2017; Melnyk & Shepperd, 2012). The third reason people avoid information is that they think it might obligate them to engage in undesired behavior (Shepperd & Howell, 2015). For instance, women in one study were more receptive to learning their risk for a disease if definitive testing for the condition involved a cheek swab as opposed to a cervical examination (Howell & Shepperd, 2013).

Information Avoidance and Coping

The cognitive, affective, and behavioral underpinnings of information avoidance point to a broader factor underlying avoidance: a sense that one cannot cope with the cognitive, affective, and behavioral implications of bad news. For example, in one study, participants reporting fewer personal/coping and interpersonal/social support resources were more likely to avoid learning their risk for disease (Howell, Crosier, & Shepperd, 2014). Another study demonstrated that experiencing social rejection—which was hypothesized to produce a decrement in social coping resources—caused increased avoidance of health screening feedback (Howell & Shepperd, 2017).

Related to work implicating a sense that one can cope in information avoidance, is evidence linking perceptions of personal control to decreased information avoidance. For example, people avoid learning their risk/disease status more when a disease is treatable than when it is untreatable (Howell & Shepperd, 2013). Similarly, participants in one study were less likely to request genetic testing for untreatable medical conditions as compared to treatable medical conditions (Dawson, Savitsky, & Dunning, 2006). Additionally, emphasizing the controllable aspects of a disease can reduce avoidance. In one study, women who learned about uncontrollable predictors of breast cancer were more likely to avoid learning their risk than women who learned about controllable predictors (Melnik & Shepperd, 2012). Taking together evidence that coping resources matter with the evidence that a lack of control spurs information avoidance, we propose a novel factor that may underlie information avoidance: a lack of coping self-efficacy.

Coping Self-Efficacy

In contrast to general self-efficacy, or one's judgment about their ability to accomplish goals (Bandura, 1977), coping self-efficacy refers to one's judgment about their ability to cope effectively with life challenges (Chesney, Neillands, Chambers, Taylor, & Folkman, 2006). Put another way, coping self-efficacy is the feeling that one can effectively cope with a stressor (e.g., bad news). Coping self-efficacy is associated with a myriad of positive health outcomes including increased mental quality of life and decreased depression and psychological distress (Benka et al., 2014; Mikula et al., 2014; Rodkjaer et al., 2014). Similarly, general self-efficacy is widely implicated in health behavior change such as smoking cessation and engaging in physical activity (O'Leary, 1985). Although general self-efficacy is important to health more broadly, we predict that coping self-efficacy plays a unique role in health information avoidance. Specifically, when a person is faced with potentially threatening health information, having a sense that they can cope with the information is likely more helpful than having a sense that they can achieve goals. Nevertheless, no study has examined the relationship between coping self-efficacy or general self-efficacy and health information avoidance.

If, as we expect, increasing coping self-efficacy can decrease avoidance, it is important to understand how we might intervene to increase coping self-efficacy. The primary literature on improving self-efficacy is not in the domain of coping but is instead typically focused on general self-efficacy. One way to increase general and domain-specific self-efficacy is through mastery experiences; when one achieves a goal, one feels successful and thus capable of taking on new challenges related to that goal (Bandura, 1993). For example, group education sessions that provided both information about how to live a healthy lifestyle as well as opportunities to model and practice exercise

techniques, resulted in improved exercise efficacy and subsequent increases in physical activity among cancer survivors (James et al., 2015). Moreover, women who attended education classes that offered opportunities to perform breast examinations using silicone models reported increased knowledge of breast cancer as well as efficacy for performing self-examinations (Yi & Park, 2012).

Most self-efficacy intervention research that incorporates mastery experiences has attempted to increase self-efficacy for behaviors (e.g., physical activity, self-examinations). Given that mastery experiences of physical activity and breast self-examinations were successful in promoting efficacy in those domains, we expected that considering mastery experiences of coping—here, specifically focusing on past coping successes—would increase coping self-efficacy and, in turn, reduce health information avoidance.

The Present Research

In two studies, we investigated whether coping self-efficacy influences health information avoidance. Study 1 examined the correlation between health information avoidance and individual differences in coping self-efficacy. We expected that people would avoid health feedback less frequently to the extent that they had higher coping self-efficacy. Study 2 then tested whether a manipulation to increase coping self-efficacy would reduce avoidance of type 2 diabetes risk feedback. In this study, we predicted that focusing on mastery experiences of coping would increase coping self-efficacy and thereby reduce avoidance of health information.

Study 1

We first wanted to examine whether coping self-efficacy related to health information avoidance. We expected that higher coping self-efficacy would relate to a lower likelihood of avoiding health information. We also wanted to ensure that feelings of general control/self-efficacy, do not underlie the hypothesized relationship, but that the relationship specifically stems from feeling like one can effectively cope. As such, we also examined the relationship between general self-efficacy and health information avoidance. We predicted that coping self-efficacy would be associated with desire to avoid health information, but that general self-efficacy would not.

Study 1: Method

Participants and Procedure. Data were collected as part of a study investigating threat, resources, and information avoidance (Howell, 2015). For the purpose of this paper, we focus only on the data relevant to coping self-efficacy, general self-efficacy, and avoidance. No report on the data has examined any of the self-efficacy variables. All data, analysis scripts, and relevant questionnaires for the studies presented here are available at osf.io/kthxc/.

Participants were 107 undergraduates (66 women, 41 men, 6 unreported; $M_{\text{age}} = 18.74$ years old, $SD_{\text{age}} = 1.78$) participating for partial fulfillment of a research participation requirement. Experimenters dressed in medical scrubs greeted participants and told them the study was examining a disease known as thioamine acetylase (TAA) deficiency (Jemmott, Ditto, & Croyle, 1986). In reality, the disease was fictitious, creating an environment where participants did not know their disease risk or have any background in the disease prior to participating. After consenting to participate, participants watched an informational video about TAA deficiency and its prevalence

among college students. Then they completed an ostensible risk calculator which they learned could calculate their lifetime risk for TAA deficiency. Afterward, participants completed online measures for coping self-efficacy and general self-efficacy and received an opportunity to learn their risk for TAA deficiency. At the end of the study, researchers fully debriefed participants. No participant suspected that TAA deficiency was not real.

Measures. Coping self-efficacy. We assessed coping self-efficacy with four items (Howell, 2015; $\alpha = .75$) measuring participants' confidence in their ability to cope with learning that they tested at high risk for a disease. Participants indicated their agreement with items such as "I have the resources necessary to cope with learning that I have TAA deficiency" and "Learning that I have TAA deficiency would require more coping resources than I have available" on a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree).

General self-efficacy. We assessed general self-efficacy with the General Self-Efficacy Scale (Schwarzer & Jerusalem, 2010; $\alpha = .93$). The GSE consists of 10 items measuring participants' confidence in their ability to achieve desired outcomes. Participants indicated their agreement with items such as "I can solve most problems if I invest the necessary effort" and "It is easy for me to stick to my aims and accomplish my goals" on a 7-point scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*).

Health information avoidance. We assessed health information avoidance by asking participants whether they wanted to learn their risk for TAA deficiency based on the risk calculator. Participants selected from one of two options on the screen: "Yes, I would like to learn my risk for TAA deficiency" or "No, I do not want to learn my risk for TAA deficiency." The option to learn risk results was pre-selected, so that participants who decided to avoid viewing their risk results had to do so intentionally by selecting the option to avoid.

Analysis. All data management and analyses for these studies were conducted using R (version 3.4.3) and R Studio (version 3.4.1). We used a logistic regression analysis to examine the unique associations between the predictor variables (general self-efficacy and coping self-efficacy) and the dichotomous outcome variable (avoidance of risk assessment).

Study 1: Results

Overall, 20.6% of participants avoided learning their risk for TAA deficiency. In line with our hypothesis, participants who reported greater coping self-efficacy were less likely to avoid their risk for TAA deficiency, $OR = 0.58$, $X^2 = 5.22$, $p = 0.01$, $CI_{95\%} = [0.36, 0.91]$. General self-efficacy was not significantly related to avoidance, $OR = 1.14$, $X^2 = 0.35$, $p = 0.49$, $CI_{95\%} = [0.64, 2.10]$.

Study 1: Discussion

In line with our hypotheses, Study 1 suggested that having a greater sense that one can cope with stressful events is associated with a lower likelihood of avoiding health feedback. By contrast, general self-efficacy was not significantly related to avoidance, suggesting that the effect of coping self-efficacy was not driven by a general sense of efficacy, but is instead specifically about one's coping ability.

Study 2

Study 1 suggested that coping self-efficacy was associated with health information avoidance. Of course, this correlation does not implicate coping self-efficacy as causal in information avoidance. As such, in Study 2, we aimed to manipulate coping self-efficacy and examine the effect on health information avoidance. Guided by self-efficacy theory (Bandura, 1993), the manipulation involved considering a mastery experience—specifically focusing on one’s past coping successes—as a source of coping self-efficacy. We predicted that participants who considered their own coping successes would show decreased avoidance of risk assessment for type 2 diabetes. We also examined the role of considering one’s past coping failures and predicted that participants who considered their own coping failures would show increased information avoidance.

Study 2: Method

Participants and Procedure. Participants were 270 undergraduates (212 women, 57 men, 1 unreported; $M_{\text{age}} = 19.50$, $SD_{\text{age}} = 2.27$) who participated for partial fulfillment of research requirements. Procedures were similar to those of Study 1: experimenters dressed in medical scrubs greeted participants and told them the study was investigating prevalence of type 2 diabetes among college students. After consenting to participate, participants watched an informational video about type 2 diabetes and responded to an actual diabetes risk calculator (adapted from <http://www.yourdiseaserisk.wustl.edu>) that produces comparative risk estimates based on responses.

Participants were then randomly assigned to either a high coping self-efficacy, low coping self-efficacy, or control condition. Participants in the two coping self-efficacy conditions were directed to an online questionnaire that ostensibly assessed their coping ability. Participants in the high coping self-efficacy condition received an assessment containing a list of common positive coping behaviors (e.g., “Talking about the problem with others” and “Thinking about things that are going well in your life”). Participants in the low coping self-efficacy condition received a similar assessment containing a list of common negative coping behaviors (e.g., “Taking out your negative emotions on others” and “Thinking about things that are going badly in your life”). Participants in the control condition did not complete any assessment of their coping experiences.

Next, we presented participants with the opportunity to learn their risk for type 2 diabetes. Pilot work in the same setting suggested that participants did not feel that the results of the risk calculator alone were consequential for their lives, and therefore were unlikely to opt out from viewing their risk results. As such, we modified the study slightly to make the results have a very small bearing on participants’ lives after the study: we told all participants that receiving a high-risk assessment from the risk calculator would require attendance to a simple 15-minute consultation at the university health center sometime in the two weeks following the study. We chose this model based on the typical “follow up” that one might be subject to after a high-risk diagnosis at a physician’s office. Participants did not actually have to attend the appointment and learned so during debriefing procedures. Those who opted to view their risk assessment for type 2 diabetes were, however, given their actual comparative risk results from the risk calculator. Finally, participants were debriefed and thanked for their time.

Measures. Manipulation check: Coping self-efficacy. We measured coping self-efficacy with a single item assessing participants' confidence in their ability to cope with stressful events. Participants indicated the extent to which they agreed with the statement "Overall, I am good at coping" on a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). Due to a survey software programming error, only about half (52%) of participants in the control condition received this measure.

Primary Dependent Variable: Information avoidance. We measured information avoidance by asking participants whether they wanted to learn their comparative type 2 diabetes risk; they selected from one of two options on the screen: "Yes, please give me my risk for type 2 diabetes" (learning) or "No, I do not want to learn my risk for type 2 diabetes" (avoiding). The option to learn risk results was pre-selected, so that participants who decided to avoid viewing their risk results had to do so intentionally by selecting the option to avoid.

Analysis. We first examined mean differences in our manipulation check variable (coping self-efficacy) between conditions using between-subjects t-tests. We initially planned to compare the two self-efficacy conditions to the control condition, however, given the programming error that reduced the sample size of those responding to the manipulation check in the control condition, and thereby the power to detect differences based on condition, we also compared the high- and low- self-efficacy conditions. Next, we conducted two chi-squared tests to examine whether avoidance differed as a function of condition.

Study 2: Results and Discussion

Manipulation check. As expected, participants in the high self-efficacy condition ($M = 5.29$, $SD = 1.21$) reported significantly higher coping self-efficacy than did those in the low self-efficacy condition ($M = 4.54$, $SD = 1.39$), $t(220) = -4.33$, $p < 0.001$, $d = 0.56$, $CI_{95\%} = [0.29, 0.83]$. Also in line with our hypotheses, participants in the low self-efficacy condition reported lower coping self-efficacy than those in the control condition ($M = 5.07$, $SD = 1.47$), $t(94) = -2.21$, $p = 0.03$, $d = 0.37$, $CI_{95\%} = [0.10, 0.64]$. However, although the effect was in the expected direction, coping self-efficacy did not differ significantly between the high self-efficacy condition and the control condition, $t(84) = 0.93$, $p = 0.35$, $d = 0.18$, $CI_{95\%} = [-0.09, 0.45]$.

Primary dependent variable. Overall, 54.1% of participants chose to avoid learning their diabetes risk. As expected, participants in the high self-efficacy condition avoided their diabetes risk feedback significantly less often (41.5%) than did those in the control condition (57.0%), $X^2(1,177) = 5.86$; $p = 0.02$; $\phi = 0.17$, $CI_{95\%} = [0.04, 0.30]$. Contrary to our hypotheses, participants in the low self-efficacy condition (51.1%) did not avoid their diabetes risk more often than did those in the control condition, and actually avoided slightly less, though the effect did not meet the traditional cutoff for statistical significance, $X^2(1,177) = 3.55$; $p = 0.06$; $\phi = -0.13$, $CI_{95\%} = [-0.26, 0.004]$.

General Discussion

We conducted two studies to investigate whether coping self-efficacy influences health information avoidance. In Study 1, coping self-efficacy, but not general self-efficacy was related to avoidance of risk for a novel disease. In Study 2, we examined the relationship between coping self-efficacy and information avoidance experimentally. Based on evidence from the general self-efficacy literature that mastery experiences can increase self-efficacy (James et al., 2015; Yi & Park, 2012), we directed participants to consider their past use of positive coping strategies (high self-efficacy condition) or negative coping strategies (low self-efficacy condition), or simply allowed participants to move forward with the study (control condition). We then examined whether participants would avoid learning their risk for type 2 diabetes. Consistent with our hypotheses, those who considered their positive coping strategies were less likely than were those in the control condition to avoid learning their risk for diabetes.

We observed two unexpected results in Study 2. First, contrary to our hypotheses, those participants who considered their negative coping strategies did not avoid learning information more than did those in the control condition. In fact, the effect of the low self-efficacy manipulation was in the same direction as that of the high self-efficacy condition. We think this unexpected finding may implicate one of two processes. First, it is possible that simply making one's coping abilities salient is enough to reduce information avoidance. Second, it is possible that participants in the low coping self-efficacy condition felt compelled to learn their risk in order to reduce the psychological discomfort caused by reflecting on past failures. This latter hypothesis is in line with the literature on cognitive dissonance, which suggests that reflecting on past failures can prompt people to compensate by attempting to succeed in ways they failed before (Harmon-Jones, Peterson, & Vaughn, 2003). Second, the manipulation check in Study 2 did not indicate any differences in coping self-efficacy between the high self-efficacy and control conditions. Due to the programming error that occurred, only half of the participants in the control condition received the manipulation check, which reduced the statistical power needed to detect differences between these two conditions. Furthermore, although the difference in perceived coping self-efficacy between these two conditions was not significant, the effect of the manipulation occurred in the direction that we had anticipated. Still, future research is needed to confirm the size of the effect of our manipulation on in-moment perceived coping self-efficacy.

Implications & Applications

The findings from our studies contribute to both the information avoidance and self-efficacy literatures. Although past theorizing on information avoidance assumes that people avoid information when they think they will be unable to cope with threats to their cognition, behavior, and affect resulting from learning bad news (Shepperd & Howell, 2015), we are unaware of any study that has examined the causal relationship between coping self-efficacy and information avoidance. Thus, the current research represents a promising initial step toward understanding whether prior theorizing about coping and information avoidance is accurate.

Our studies also advance the coping self-efficacy literature, which is primarily correlational in nature, in part because few studies have investigated ways to manipulate coping self-efficacy. Although several interventions to improve domain-specific self-efficacy exist in the broader self-efficacy literature (e.g., Yi & Park, 2012), we know of no intervention that has targeted coping self-efficacy. As such, the coping self-efficacy questionnaires from Study 2 can contribute a framework for a future stronger coping self-efficacy manipulation. Our studies also contribute to the coping self-efficacy literature by differentiating between general self-efficacy and coping self-efficacy. Namely, the results from Study 1 suggest these two constructs are distinct and the relationship between coping self-efficacy and information avoidance is, in fact, driven by a sense that one can effectively cope, and not a general sense of control or belief that one can accomplish goals.

From an applied perspective, reducing health information avoidance may be key to promoting much-needed early detection of disease and promoting long-term health (Sweeny et al., 2010). The present study offers one possible psychosocial factor to target to reducing health information avoidance: coping self-efficacy. Our results suggest that, encouraging people to reflect on past successes with coping can reduce health information avoidance. Although the manipulation occurred in a lab, we believe that it is easy to translate to applied settings. For instance, before physicians make recommendations for screening, they could address any patient concerns about coping with bad news about their health and help them focus them on past coping successes to promote coping self-efficacy. Simply prompting people to focus on their own coping ability might be a simple and cost-free way to discourage health information avoidance.

Limitations & Future Directions

The present findings are limited in a few notable ways that suggest important future directions for research. First, although the coping self-efficacy manipulation in Study 2 significantly decreased avoidance, participants focused on past mastery experiences with coping as opposed to having novel mastery experiences with coping. This may explain why the effect size of our manipulation which, although significant, was somewhat small ($\phi = 0.17$). It is possible that the effect of the manipulation would have been stronger if participants had in-the-moment experiences of mastery, especially in managing negative health news, before deciding to view their risk assessment. Future studies can provide mastery experiences with coping such as having participants write about a current stressor that they are coping well with or having participants devise a plan for how they would successfully cope with a high-risk result.

Second, future research can attempt to generalize the present results to other diseases and populations. From the population standpoint, our sample represents an important target for disease risk feedback: risk detection during emerging adulthood can be key to creating sustainable and effective behavioral change to reduce disease risk (Harris & Eastman, 2000). Thus, our samples of emerging adults are ideal for understanding how young, generally healthy adults make choices regarding learning health information that may influence their health behavior and, subsequently, their long-term morbidity. Future research can expand on this initial work to focus on older populations and those at higher immediate risk for disease. Although these studies bear

replication in different diagnostic contexts and with other populations, they provide important initial insight into risk-feedback avoidance.

Another important future direction is to investigate the causal role of specific facets of coping self-efficacy. Some research on coping self-efficacy suggests that it is a multi-dimensional construct, consisting of one's perceived ability to respond to stressors by engaging in problem-focused coping, stopping unpleasant thoughts and emotions, and receiving support from friends and family (Chesney et al., 2006). Future research can more directly aim to modify various subcomponents of coping self-efficacy, and therefore to test the causal role of each in information avoidance.

Conclusion

Given that early detection and diagnosis are critical to improving long-term health outcomes, it is important to understand what might undermine people's willingness to undergo such tests. Here we test one possible impediment: a lack of coping self-efficacy. We did so in two highly ecologically valid contexts where participants were greeted by experimenters in medical scrubs, completed a disease risk calculator, and faced a decision to view their risk assessment in what felt like a medical context. Collectively these two studies, one correlational and one experimental, suggested that increased coping self-efficacy relates to decreased likelihood of health information avoidance. These findings expand the coping self-efficacy literature by providing a needed manipulation and offer a promising direction for interventions to stem health information avoidance.

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