

IMPRESSION MANAGEMENT CONCERNS AND INFORMATION AVOIDANCE

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Abstract of Thesis Presented to the Graduate School  
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## IMPRESSION MANAGEMENT CONCERNS AND INFORMATION AVOIDANCE

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Researchers have proposed three personal motives that prompt people to avoid information: the information might require a change in behavior, challenge a cherished belief, or cause unwanted emotions (Sweeny, Melnyk, Miller, & Shepperd, 2010). However, these three motives may influence information avoidance differently in interpersonal settings. The current study proposes that people will avoid personal information if they fear a public identity threat, which is comparable to a challenge to a cherished belief. Participants ( $N = 123$ ) chose whether to learn if they had a disease that was either embarrassing or not embarrassing. Participants then were offered an opportunity to learn their results either privately or publicly. Participants avoided learning their results significantly more in the public and embarrassment condition (61.3%) than the other three conditions (26.7-33.3%), indicating that fear of a damaged public identity can lead to avoidance of personal information. Mediation analyses revealed that the avoidance primarily occurred because participants feared that others would view them negatively for having the disease. Results indicate that people may make unhealthy decisions when they are forced learn information in front of others.

## CHAPTER 1 INTRODUCTION

The landmark Affordable Health Care Act prohibits insurance companies from dropping coverage for people who have developed an illness (Patient Protection and Affordable Care Act, 2010). Nevertheless, many people likely continue to avoid medical testing out of fear that positive test results will make them unable to get health insurance or will cause an increase in their insurance premiums (Hall & Rich, 2007; Oster, Dorsey, Bausch, Shinaman, Kayson, Oakes, Shoulson, & Quaid, 2008; Peterson, Milliron, Lewis, Goold, & Merajver, 2002). Beyond the financial consequences, information about personal health can also result in social stigma and prejudice from others. Research finds that people with diseases that carry social stigma often hide or ignore their condition to avoid negative interpersonal consequences (Weiss, Ramakrishna, & Somma, 2006). For example, people with Obsessive Compulsive Disorder (OCD) sometimes avoid telling others about their condition for fear of negative reactions such as teasing or disgust (Fennell & Liberato, 2007). Similarly, people sometimes delay testing or treatment for STDs because of the potential stigma associated with diagnosis (Sayles, Wong, Kinsler, Martins, & Cunningham, 2009; Courtwright, 2009).

Evidence that people sometimes avoid information originated in research on selective exposure (Sears & Freedman, 1967). Research on selective exposure finds that people seek information that is consistent with their decisions, behavior, or attitudes, and avoid information that is inconsistent (for review see Hart, Albarracin, Eagly, Brechan, Lindberg, & Merrill, 2009) More recently, researchers have proposed three broad motives for avoiding information (Sweeny, Melnyk, Miller, & Shepperd,

2010). First, people avoid information if they believe it will cause undesired affect. Several studies find that a primary reason people report for avoiding learning the diagnosis for a health condition is the concern that the news will make them feel frightened, anxious, or angry (Cutler & Hodgson, 2003; Leydon, Boulton, Moynihan, Jones, Mossman, Boudioni, & McPherson, 2000). Other research finds that the most common reason pregnant couples report for declining to learn the sex of their fetus is a desire to avoid ruining the surprise (Shipp, Shipp, Bromley, Sheahan, Cohen, Leiberman, & Benacerraf, 2004).

Second, people avoid information if it may obligate undesired action such as forcing them to forego an activity they enjoy, or undertaking an activity they would rather avoid. This second motive is evident in a study on sexually transmitted diseases, which found that people often delay testing because a diagnosis will require painful or embarrassing treatment and potentially require them to abstain from sexual relations for a period of time (Sayles et al., 2009). Another study of women in Nigeria found that the main reason the women gave for not visiting their doctor about a suspicious lump in their breast was concern that they would require a mastectomy (Ajekigbe, 1991).

Finally, people avoid information that potentially challenges a cherished belief. The belief can be about the self, about other people, or about the world. Regarding the self, people are inclined to avoid information that threatens a desired identity such as being attractive, intelligent, or socially skilled. One illustration comes from a study in which women were offered the opportunity to see ratings of their attractiveness from students at their own university (high threat condition) or a university in a distant country (low threat condition). More women declined receiving ratings of their attractiveness in

the high threat condition than the low threat condition (Malone & Shepperd, 2010)

Regarding cherished beliefs about other people or the world, several studies find that people avoid negative information that challenges their beliefs about their favored political candidates (Sweeney & Gruber, 1984) or a cherished world-view (Jonas, Greenberg, & Frey, 2003).

### **Avoidance in Interpersonal Settings**

The research described thus far describes personal reasons for avoiding information. That is, people avoid information because it will make *them* feel bad, threaten cherished beliefs *they* hold, or obligate *them* to take unwanted action. However, information can introduce interpersonal or social consequences. For example, stigmatizing medical conditions can evoke a host of negative social consequences including shame and embarrassment (Heijnders & Van Der Meij, 2006; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Scambler, 2004). It is quite likely that people avoid some information – even information they personally desire – because of concerns over the interpersonal consequences of the information.

I propose that interpersonal settings can introduce new motivations to avoid information, but that the new motives parallel the three personal motives for avoiding information. Specifically, the new motives are fueled by impression management concerns and reflect other's reactions to personal information. According to Impression Management Theory, people strive to influence other people's perceptions of them by regulating the information disclosed in social interaction (Schlenker, 1980). When anticipating information potentially at odds with a desired public identity, people face the possibility of a self-presentational loss. One way to avoid the self-presentational loss is to avoid the information entirely.

Figure 1-1 depicts my revised model for information avoidance, which encompasses both the personal and interpersonal motivations. Information may spoil a desired public identity, cause a change in behavior by the audience toward the actor, or lead to interpersonally-based unwanted affect. The motives in interpersonal setting are distinct from their counterpart personal motives in that people may want the information very much. However, they fear how others will respond if and when the information becomes public. In short, people sometimes may avoid information because public knowledge of the information might negatively influence the perceptions or behaviors of others toward them. In such instances, people may opt to remain ignorant of information to prevent others from learning the information as well.

### **Undesired Interpersonal Affect**

In both public and private settings, the motive to avoid undesired affect is the same. In public settings, however, the undesired affect has a social root. The prospect that others may learn interpersonally damaging information about oneself can lead to a fear of social consequences, and can evoke negative emotions such as shame and embarrassment. Learning information in the presence of others can also introduce a self-presentational dilemma when people feel pressure to project publicly a reaction different from the one they feel privately. In some instances people may feel pressure to feign happiness over a disappointing outcome, such as expressing elation in response to receiving an undesirable gift or joy when a friend receives a promotion over oneself. In other situations, people may feel pressure to suppress happiness over a successful outcome, such as when one is selected for a team while a friend is not. Situations in which people feel pressure to project publicly a reaction different from the one they feel

privately may lead to avoidance to the extent that people feel they lack the resources to successfully portray the desired emotion.

### **Undesired Action by Others**

The second interpersonal motive addresses information avoidance arising from the potential behavioral consequences. People sometimes avoid information because the information may obligate them to take action they would rather not take, or forego action that they enjoy. In interpersonal settings, the consequences refer to the behaviors of other rather than to one's own behavior. Specifically, people may avoid information to the extent that they believe the information will prompt others to treat them in some undesired way such as excluding, penalizing, or otherwise harming them. The insurance example described earlier illustrates information avoidance in response to anticipated possible behaviors other others (i.e., the insurance company). This example is not just idle speculation. Participants in one study reported that one of the main reasons for avoiding testing for Alzheimer's disease was a concern about losing health insurance (Cutler & Hodgson, 2003). Interestingly, people may also avoid learning positive information in public because of concerns over the obligations that may follow. For instance, lottery winners often face a barrage of requests for money. Foreknowledge of these requests and the accompanying pressure to oblige may lead some ticket holders to delay learning the outcome of their ticket purchases until they are in a private setting.

### **Public Identity Concerns**

A person reason that people avoid information is that they fear the information will challenge a cherished belief about themselves, others, or their world. In public, people may worry that information, if known to others, will change how others views

them. Interpersonally damaging information can spoil a desired public identity, leading to audience dislike, disgust and rejection. A fear of social rejection can lead people to act in ways to that diminish the likelihood of rejection (Richman & Leary, 2009). Avoiding the potentially image-spoiling information diminishes the possibility of these social consequences. People are quite sensitive to signs of rejection (Baumeister & Tice, 1990). This sensitivity may make them particular alert for information that might eventuate in rejection. Although not pertinent to the present paper, it is noteworthy that concerns with changes in public identity can also arise when learning positive information. People who are affiliated with a low-status group might be motivated to avoid information that suggests they are better than others in that group, because such information could be construed as an attempt to upstage or forsake their peers.

### **Overview and Hypotheses**

Although each of these three interpersonal motives can prompt information avoidance, this research focuses specifically on the motive regarding threats to public identity. I examined in a health context whether concerns with a public identity motivates people to avoid information. The study ties together theories involving impression management, selective exposure, and information avoidance to examine the effect public identity threats the decision to seek vs. avoid important health information.

Participants learned that they were at high risk for a (fictitious) disease called TAA Deficiency that was either embarrassing (i.e., caused by poor hygiene) or not embarrassing (caused by genetic factors). They then received an opportunity to undergo a conclusive test for the disease. Participants learned that they would either receive their feedback privately or publicly in front of other participants. The primary

dependent measure was whether participants chose to undergo a conclusive test for TAA Deficiency.

**Hypothesis 1.** Participants face greater threat of a spoiled public identity in public settings than in the private settings. Thus, I predicted a main effect of publicity, with more participants declining to learn their results in public than in private.

**Hypothesis 2.** Participants face a greater possibility that others will view them negatively when their personal information is embarrassing than when it is not. Thus, I predicted a main effect of embarrassment, with more participants declining to learn their results in the embarrassment condition than in the no-embarrassment condition.

**Hypothesis 3.** Learning that one might have an embarrassing disease in the presence of an audience is particularly threatening and thus will evoke the greatest avoidance. Thus, I predicted that avoidance would be highest when the information is public and embarrassing. Although I predicted an interaction, I also recognized the possibility that the effect of publicity and embarrassing disease might be additive, resulting in two main effects and no interaction.

**Hypothesis 4.** I predict that fears of how others might judge them will mediate the effects of embarrassment and privacy of feedback on avoidance.

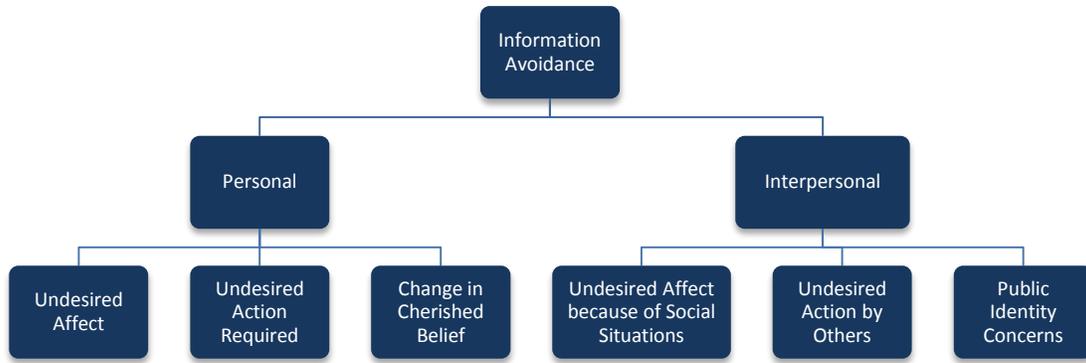


Figure 1-1. Information Avoidance

## CHAPTER 2 METHOD

### **Participants**

Participants were 123 undergraduates (89 women) from the University of Florida who received credit toward an introductory psychology research participation requirement.

### **Design and Procedure**

I assigned participants randomly to conditions in a 2 (publicity: private or public) by 2 (embarrassment: high or low) factorial design. Participants in the private condition participated in the study individually whereas participants in the public condition participated in the study in groups of three or four.

An experimenter dressed in hospital scrubs greeted participants as they arrived for the study and seated them at work stations with a computer where participants received the remaining study instructions. After reading a brief overview consenting to take part in the study, participants completed on the computer a Lifestyle Questionnaire that consisted of demographic and personal health (Appendix A).

Next, participants watched a video on their workstation computers describing a fictitious disease called Thioamine Acetylase (TAA) Deficiency. The video included the logo of the teaching hospital of the University of Florida, and described the symptoms of TAA Deficiency. Participants learned that TAA Deficiency was a relatively new disease that had received little public awareness, but that affected 1 in 5 adults. Symptoms included immune deterioration, loss of metabolism after age 35, and occasional heart problems. The video explained that participants could learn whether they had TAA

Deficiency from a simple saliva test that could be completed in the room at the end of the study.

At the end of the video, participants read a statement on the computer that introduced the embarrassment manipulation. In the *low embarrassment* condition, the statement described TAA Deficiency as caused by genetic factors. In the *high embarrassment* condition the statement described TAA Deficiency as partly caused by genetic factors, but that 80% of cases were the result of poor diet and exercise and a further 16% of cases were the result of poor hygiene habits such as not washing hand thoroughly after using the restroom, masturbating with unclean objects, or sexual promiscuity. All participants read that it is was important to diagnose and treat TAA Deficiency because it could lead to multiple health problems such as lung and heart disease if not caught early.

Participants then viewed a screen indicating that the computer could use their responses to the Lifestyle Questionnaire completed earlier to calculate their risk for TAA Deficiency. On the next screen, all participants saw a statement saying that they were at high risk for TAA Deficiency. Next, participants chose whether they wished to undergo a conclusive saliva test for TAA Deficiency, which entailed holding a treated test strip under one's tongue for 30 seconds and comparing the test strip to a color spectrum. We then introduced the privacy manipulation. Participants in the *private* condition learned that the researcher would teach them how to conduct the saliva test and read their results themselves, then leave the room to give them privacy. Participants in the *public* condition learned that they would undergo the test and learn their results in front of the other participants in their group. All participants learned that the conclusive test would

only take a couple minutes, would be free, and would not significantly increase the time they spent in the study.

## **Measures**

### **Primary Dependent Measure: Avoidance**

Participants chose from two choices: a) *Yes, I would like to be tested for TAA Deficiency at the end of this session*, and b) *No, I am not interested in being tested for TAA Deficiency*. Immediately after making their decision of whether to undergo the conclusive saliva test participants responded to an open-ended item asking them to explain why they made their decision.

We included the eight-item information avoidance scale as a secondary dependent measure. Example items included, *I would rather not know my risk for TAA Deficiency* and *Even if it will upset me, I want to know my risk for TAA Deficiency*. Participants responded using a seven step scale, 1= strongly disagree; 7= strongly agree ( $\alpha = .88$ ).

### **Process and Individual Difference Measures**

#### **Feelings questionnaire**

Participants completed a survey that assessed their “feelings” about TAA deficiency and their decision process (Appendix B), anticipatory and anticipated affect (Appendix C), and information avoidance scale (Appendix D). Embedded in these measures were two items that assessed the success of embarrassment manipulation: a) *TAA Deficiency is an embarrassing disease for someone to have* and b) *I would personally be embarrassed if I learned that I had TAA Deficiency*. Participants responded to each item from 1 = strongly disagree to 7 = strongly agree ( $\alpha = .69$ ).

## **Motive items**

Also embedded in these measures were four items assessing the motives for information avoidance (i.e., potential mediator items): a) The possibility that my test results would make me feel bad influenced my decision to undergo the testing (Undesired Affect Motive), b) The possibility that my test results would challenge my view of myself as healthy influenced my decision to undergo the testing (Change in Cherished Belief Motive), c) The possibility that my test results would require me to do something I don't want to do influenced my decision to undergo the testing (Undesired Action Motive), and d) The possibility that my test results might lead others to have an unfavorable view of me influenced my decision to undergo the testing (Public Identity Concerns Motive).

## **Negative affect**

In other work we found that anticipated negative affect predicts information avoidance (Nielsen & Shepperd, 2012). I thus included a measure of anticipated negative affect, which asked participants how they would feel if they learned they had TAA deficiency (afraid, alone, angry, anxious, distressed, isolated, nervous, and upset). To be thorough I also asked participants how they would feel if they learned they did not have TAA deficiency and how they felt right now (anticipatory negative affect) using the same eight adjectives. Participants responded to each item from 1= very slightly or not at all to 5= extremely ( $\alpha$  for all three scales > .89).

## **Potential confounds**

To test for the potential confounding effects of social desirability responding and social anxiety, participants completed Leary's Brief Fear of Negative Evaluation Scale (Appendix E), Paulhus' Balanced Inventory of Desirable Responding (Appendix F), and

Leary's Interaction Anxiousness Scale (Appendix G). Leary's Brief Fear of Negative Evaluation Scale (BFNE-S) assesses concern with being evaluated unfavorably by others. Researchers commonly use the original Fear of Negative Evaluation (FNE) scale (Watson & Friend, 1969) to determine the degree of apprehension people feel at the prospect of negative evaluation from others. The Brief Negative Evaluation Scale correlates highly (.96) with the original scale and has demonstrated psychometric properties nearly identical to those of the full scale (Leary, 1983). The BFNE-S correlates with the Social Avoidance and Distress Scale ( $r = .44$ ) and previous research reports significant differences in scores between a non-clinical sample and people suffering from social phobia (Pitarch, 2010). Example items include, I worry about what other people will think of me even when I know it doesn't make any difference, and I often worry that I will say or do the wrong things. Participants responded using a five-step scale, 1 = not at all; 5 = extremely ( $\alpha = .91$ ).

Paulhus' Balanced Inventory of Desirable Responding (BIDR) assesses social desirability responding, i.e., the extent to which people misrepresent themselves to manage their self-presentation. The original scale includes two sub-scales: one measuring self-deceptive enhancement and the second measuring impression management (Paulhus, 1991). Because overall impression management concerns are paramount in the present study, only the impression management sub-scale. This sub-scale correlates with other measures of socially desirable responding, such as the MMPI-2 K and S scales ( $r = .48$  and  $.54$ , respectively) (Lanyon & Carle, 2007). Example items include, I sometimes tell lies if I have to, and I have done things that I don't tell

other people about. Participants responded using a five-step scale, 1= not true; 5= very true ( $\alpha = .79$ ).

Leary's Interaction Anxiousness scale assesses participants' overall anxiety when interacting with others. The Interaction Anxiousness scale correlates with other indices of social discomfort such as the Social Avoidance and Distress scale ( $r = .71$ ) and the Social Anxiety subscale of Self-Consciousness scale ( $r = .78$ ) (Leary, 1983; Leary & Kowalski, 1993). Example items include, I often feel nervous even in casual get-togethers, and In general, I am a shy person. Participants responded to each item using a five-step scale, 1= not at all characteristic of me; 5= extremely characteristic of me ( $\alpha = .86$ ).

### **Coping**

Prior evidence suggests that people's level of coping resources can influence avoidance of health information (Melnyk & Shepperd, 2012). To assess whether participants' perceived ability to cope with the news of their TAA Deficiency risk, participants completed seven-items tapping participants reports of how well they would cope with learning that they were at high risk for TAA deficiency. Example items include, Learning that I have TAA would require a lot of time and energy to cope, and Learning that I have TAA would put great demands on me. (Participants responded using a seven step scale, 1= strongly disagree; 7= strongly agree ( $\alpha = .89$ )). Participants also completed two items regarding anticipated regret: a) Imagine that you chose to learn if you have TAA Deficiency. How much do you anticipate regretting that decision later?, and b) Imagine that you chose NOT to learn if you have TAA Deficiency. How much do

you anticipate regretting that decision later? The coping and regret items appear in Appendix B.

After completing these measures, the experimenter debriefed participants. The experimenter explained why it is sometimes necessary to use deception in research, and described the specific deception used in the present study. Participants learned that TAA Deficiency was a fictitious disease, and that they would not be undergoing the conclusive saliva test.

## CHAPTER 3 RESULTS

### **Analyses**

I omitted from analyses data from 8 of our initial 131 participants who responded to the open-ended item asking about their screening decision that they did not believe that TAA Deficiency was real. Of note, including these participants in our analyses negligibly affected our result. The analyses exploring avoidance examined both the dichotomous, behavioral measure of avoidance (seeking v. avoiding TAA risk information) and the continuous, scale measure of avoidance (information avoidance scale). These two measures of avoidance were highly correlated,  $r = .62$ ,  $p < .001$ .

### **Preliminary Analyses**

Three 2 (embarrassment) x 2 (privacy) ANOVAs of participants' responses to Leary's Brief Fear of Negative Evaluation Scale, Paulhus' Balanced Inventory of Desirable Responding, and Leary's Interaction Anxiousness Scale revealed no significant main effects or interactions involving these measures, all  $F_s < 1.77$ , all  $p_s > .16$ . None of the scales were significantly correlated with either avoidance or responses to the Information Avoidance scale. None of the scales significantly predicted avoidance or the information avoidance scale when independently entered into regression equations. Further, none of the scales significantly interacted with embarrassment or privacy when entered into regression equations predicting avoidance, all  $F_s < 1.93$ , all  $p_s > .07$ . I included these measures because I was concerned that individual differences in participants' general responses to interactions with others would affect their responses to our manipulations. Because response to the measures did not vary across conditions and were uncorrelated with avoidance, I excluded them from further

analyses. Table 1 presents the correlations between these scales and the two dependent measures.

A 2 (embarrassment) x 2 (privacy) ANOVA of participants' responses to the two-item embarrassment scale revealed a main effect of embarrassment,  $F(1, 119) = 9.56$ ,  $p = .002$ , but no main effect of publicity and no interaction. Participants were more likely in the embarrassment condition ( $M = 2.3$ ,  $SD = 0.76$ ) than in the no-embarrassment condition ( $M = 1.9$ ,  $SD = 0.82$ ) to agree that TAA Deficiency was an embarrassing disease, suggesting that our embarrassment manipulation was successful.

### **Information Avoidance**

Figure 1 displays the percentage of participants in each condition that avoided a conclusive test for TAA Deficiency. Consistent with Hypothesis 1, more participants opted to avoid testing for TAA deficiency in the public conditions (48%) than in the private conditions (30%),  $\chi^2(1, N = 123) = 4.01$ ,  $p < .05$ ,  $\phi = .18$ . Consistent with Hypothesis 2, more participants opted to avoid testing for TAA deficiency in the embarrassment conditions (49%) than in the no-embarrassment conditions (29%),  $\chi^2(1, N = 123) = 4.61$ ,  $p < .05$ ,  $\phi = .19$ .

To examine Hypothesis 3, I analyzed separately the responses of participants in the public and private conditions. As predicted, participants in the private conditions displayed similar levels of avoidance regardless of whether I presented TAA deficiency as an embarrassing (32%) or non-embarrassing (28%) disease,  $\chi^2(1, N = 60) = .16$ , ns,  $\phi = .05$ . However, in the public condition more participants opted to avoid testing for TAA deficiency in the embarrassment condition (65%) than in the no-embarrassment condition (31%),  $\chi^2(1, N = 63) = 6.99$ ,  $p < .01$ ,  $\phi = .33$ .

## Mediation

As noted earlier, participants responded to four items designed to assess possible reasons or motivations for avoiding their TAA risk feedback. I included these items to explore mediation. Table 2 presents the correlations among the potential mediators and the two measures of avoidance. As evident in Table 2, only the item assessing public identity concerns correlated with both measures of avoidance.

I next conducted a logistic regression analysis in which I entered publicity, embarrassment, and the publicity by embarrassment interaction to predict the dichotomous measure of avoidance. The analysis revealed no main effects of publicity or embarrassment on avoidance, both  $B$ 's  $< .23$ , both  $p$ 's  $> .69$ , but a marginally significant embarrassment by privacy interaction,  $B = 1.46$ ,  $p = .06$ .

A 2 (embarrassment) x 2 (privacy) ANOVA of participants' responses to the Information Avoidance scale revealed a main effect of embarrassment,  $F(1, 119) = 12.57$ ,  $p = .001$ ,  $\eta^2 = .09$ , a main effect of privacy,  $F(1, 119) = 5.40$ ,  $p = .02$ ,  $\eta^2 = .04$ , and a significant embarrassment by privacy interaction,  $F(1, 119) = 6.21$ ,  $p = .01$ ,  $\eta^2 = .05$ . The means for the interaction appear in Table 3.

I conducted a 2 (embarrassment) x 2 (privacy) ANOVA on each of the potential mediator items to determine whether responses varied by condition. The means for these four items appear in Table 3. A 2 x 2 ANOVA of participants' responses to the "Cherished Belief" and "Undesired Action" items revealed no main effects or interactions (all  $F$ 's  $< 2.5$ , all  $p$ 's  $> .11$ ) and thus are not discussed further.

The 2 x 2 ANOVA of participants' responses to the "Undesired Affect" motivation item revealed only a main effect of privacy,  $F(1, 119) = 35.30$ ,  $p < .01$ . Participants in

the public conditions ( $M = 2.9$ ,  $SD = 1.80$ ) were more likely than participants in the private conditions ( $M = 1.4$ ,  $SD = .79$ ) to report that the possibility that their results would make them feel bad influenced their decision to get tested for TAA Deficiency. No significant effects were found for the embarrassment main effect or the interaction between embarrassment and privacy (all  $F$ 's  $< 1.2$ , all  $p$ 's  $> .28$ ).

Analysis of the item tapping "Public Identity Concerns" revealed a main effect of embarrassment,  $F(1, 119) = 9.71$ ,  $p < .01$ , a main effect of privacy,  $F(1,119) = 11.39$ ,  $p < .01$ , and a significant embarrassment by privacy interaction,  $F(1, 119) = 3.98$ ,  $p < .05$ . As evident in Table 3, participants were most likely to indicate that the possibility that the results might lead others to have an unfavorable opinion of them influenced their decision to get tested for TAA Deficiency.

Using Preacher and Hayes (2008) macro for bootstrapped multiple mediation, I investigated whether concerns with public identity item explained the pattern of avoidance for the dichotomous outcome measure. Figure 2 presents the mediation model. Analysis revealed that the embarrassment by privacy interaction term predicted public identity concerns,  $b = 1.31$ ,  $SE = .31$ ,  $p < .001$ . Analyses also revealed that greater public identity concerns significantly predicted avoidance,  $b = 1.01$ ,  $SE = .19$ ,  $p < .001$ . More importantly, public identity concerns fully explained the relationship between the embarrassment x privacy interaction and avoidance, bootstrapped indirect effect = 1.42,  $SE = .45$ ,  $BC_A$  95%  $CI = .57-2.21$  (Figure 2). Specifically, the significant embarrassment x privacy interaction on avoidance ( $b = 1.72$ ,  $SE = .46$ ,  $p < .01$ ) was no longer significant when I included the public identity concerns item as a mediator, ( $b = 1.05$ ,  $SE = .56$ ,  $p < .10$ ). A Sobel test indicated a significant reduction of the effect of the

privacy and embarrassment interaction item when including the “Public Identity Concerns” item,  $z = 3.45$ ,  $p < .01$ .

Because the interaction of embarrassment by publicity on the dichotomous measure of avoidance was only marginally significant in the logistic regression analysis, I conducted separate regression and mediation analyses for private and public participants. In the private conditions, logistic regression revealed no effect of embarrassment on avoidance ( $B = .22$ ,  $p = ns$ ). However, in the public condition, analyses revealed a significant effect of embarrassment on avoidance ( $B = 1.69$ ,  $p < .01$ ). Mediation analyses revealed that participants were significantly more likely to avoid learning their risk for TAA Deficiency when they feared it might lead others to have an unfavorable view of them ( $b = 1.14$ ,  $SE = .38$ ,  $p < .01$ ), and this tendency fully explained the relationship between embarrassment and avoidance, bootstrapped indirect effect = 0.70,  $SE = .43$ ,  $BC_A$  95%  $CI = .17-1.73$  (Figure 3). The embarrassment x privacy interaction on avoidance ( $b = 1.68$ ,  $SE = .55$ ,  $p < .01$ ) was no longer significant when I included the Public Identity Concerns item as a mediator, ( $b = 1.17$ ,  $SE = .60$ ,  $p < .10$ ).

Mediation analyses examining responses to the information avoidance scale revealed similar results. Participants who feared learning their TAA Deficiency risk results would lead others to have an unfavorable view of them reported a greater tendency to avoid their feedback ( $b = .20$ ,  $SE = .07$ ,  $p = .002$ ), and this tendency fully explained the relationship between the embarrassment x privacy interaction and avoidance, bootstrapped indirect effect = .23,  $SE = .11$ ,  $BC_A$  95%  $CI = .06-.54$  (Figure 4). The effect of the embarrassment x privacy interaction on avoidance ( $b = .69$ ,  $SE =$

.22,  $p < .01$ ) was significantly reduced when including the “Public Identity Concerns” item, ( $b = .46$ ,  $SE = .22$ ,  $p < .10$ ). A Sobel test indicated a significant reduction of the effect of the privacy and embarrassment interaction item when including the “Public Identity Concerns” item,  $z = 2.30$ ,  $p = .01$ . Analyses examining the other three potential mediators revealed that none explained the embarrassment x privacy interaction.

### **Ancillary Analyses**

As noted earlier, participants responded to seven items designed to assess perceived ability to cope with the news of TAA Deficiency risk. A 2 (embarrassment) x 2 (privacy) ANOVA of responses to the coping scale revealed no significant difference across conditions, all  $F_s < 1.32$ , all  $p_s > .25$ . However, a t-test comparing the responses of participants who sought versus avoided their TAA Deficiency test results revealed that participants who avoided their TAA results reported more coping resources ( $M = 3.5$ ,  $SD = 1.15$ ) than did participants who did not avoid their TAA results ( $M = 3.1$ ,  $SD = 1.06$ ),  $t(121) = 1.99$ ,  $p < .05$ .

Table 3-1. Scale correlations with dependent variables.

	Avoidance	IA scale	BFNE-S	BIDR	Interaction Anxiety
Avoidance	—				
IA scale	-.62**	—			
BFNE-S	.13	-.08	—		
BIDR	.08	-.06	-.15	—	
Interaction Anxiety	-.01	.01	.51**	-.20*	—

\*\*  $p < 0.01$  level.

\*  $p < 0.05$  level.

Table 3-2. Correlations with dependent variables.

	Avoidance	IA scale	Undesired affect	Change in cherished belief	Undesired action	Public identity concerns
Avoidance	—					
IA scale	-.62**	—				
Undesired affect	.06	.14	—			
Change in cherished belief	.20*	.16	.20*	—		
Undesired action	.07	-.10	.17	.19	—	
Public identity concerns	.25**	.31**	.21*	.24*	.16	—

\*\* p < 0.01 level.

\* p < 0.05 level.

Table 3-3. Means for potential mediators.

	Private				Public			
	No Embarrassment		Embarrassment		No Embarrassment		Embarrassment	
	<i>n</i> = 30		<i>n</i> = 31		<i>n</i> = 32		<i>n</i> = 31	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Information Avoidance Scale	2.2 <sub>a</sub>	(0.87)	2.4 <sub>a</sub>	(1.00)	2.2 <sub>a</sub>	(1.24)	3.3 <sub>b</sub>	(1.09)
Change in cherished belief	2.8 <sub>a</sub>	(1.80)	2.6 <sub>a</sub>	(1.52)	2.9 <sub>a</sub>	(1.89)	3.4 <sub>a</sub>	(1.46)
Undesired action	2.7 <sub>a</sub>	(1.16)	2.9 <sub>a</sub>	(0.97)	2.4 <sub>a</sub>	(1.03)	2.7 <sub>a</sub>	(1.36)
Undesired affect	1.4 <sub>a</sub>	(0.48)	2.7 <sub>b</sub>	(1.92)	1.5 <sub>a</sub>	(1.00)	3.1 <sub>b</sub>	(1.69)
Public identity concerns	1.6 <sub>a</sub>	(0.98)	2.0 <sub>a</sub>	(1.20)	1.9 <sub>a</sub>	(1.89)	3.3 <sub>b</sub>	(1.60)

Note. Means with different subscripts differ at  $p < .05$ .

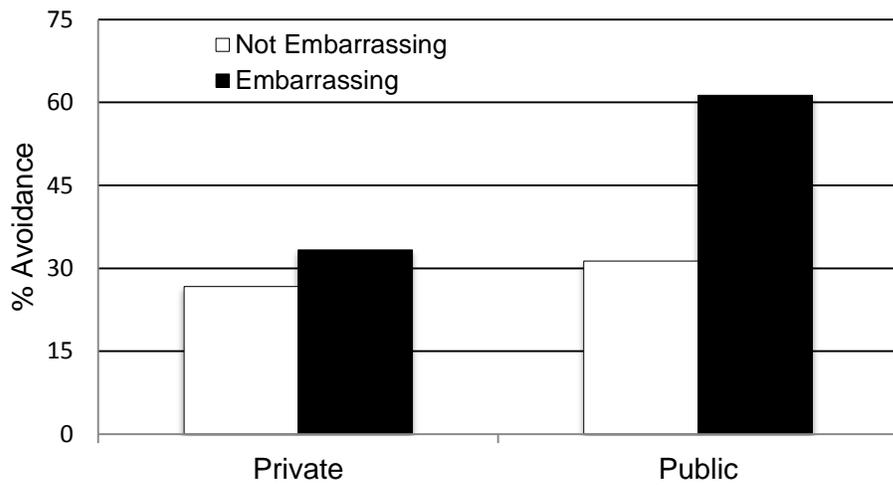
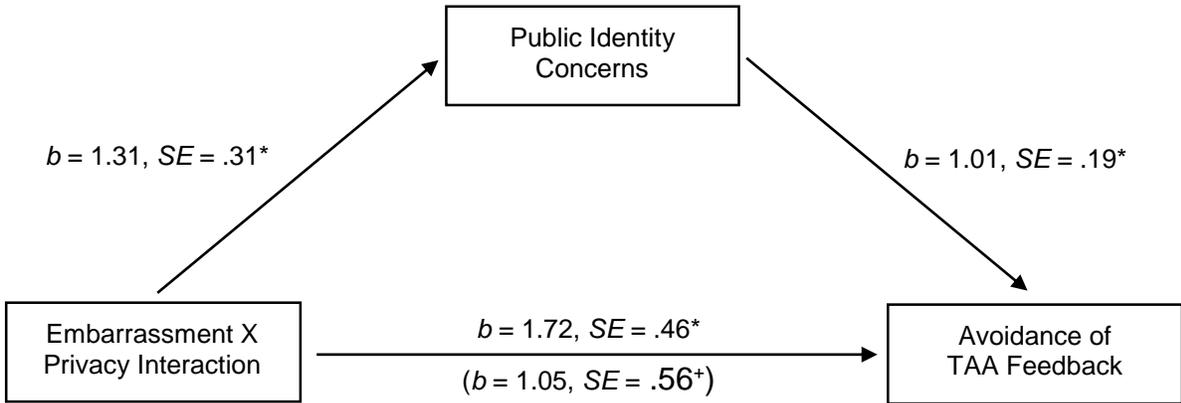
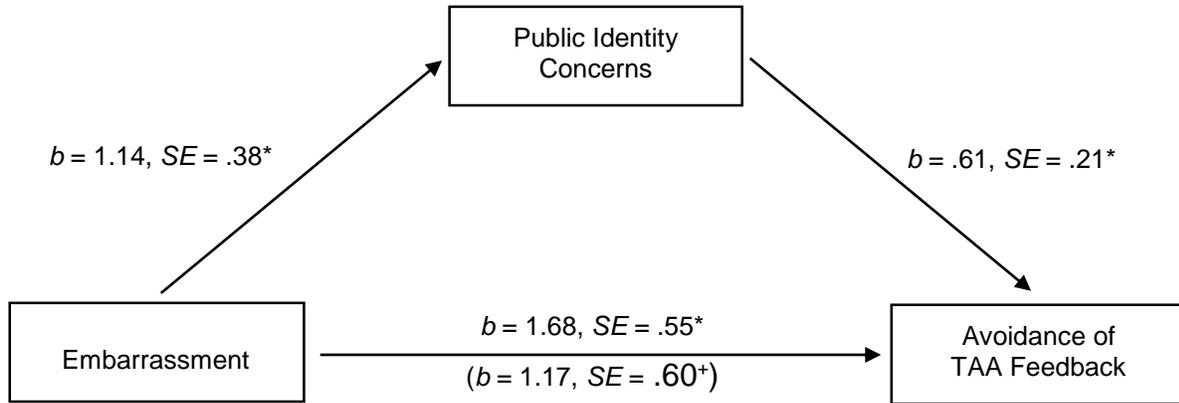


Figure 3-1. Avoidance as a function of experimental condition.



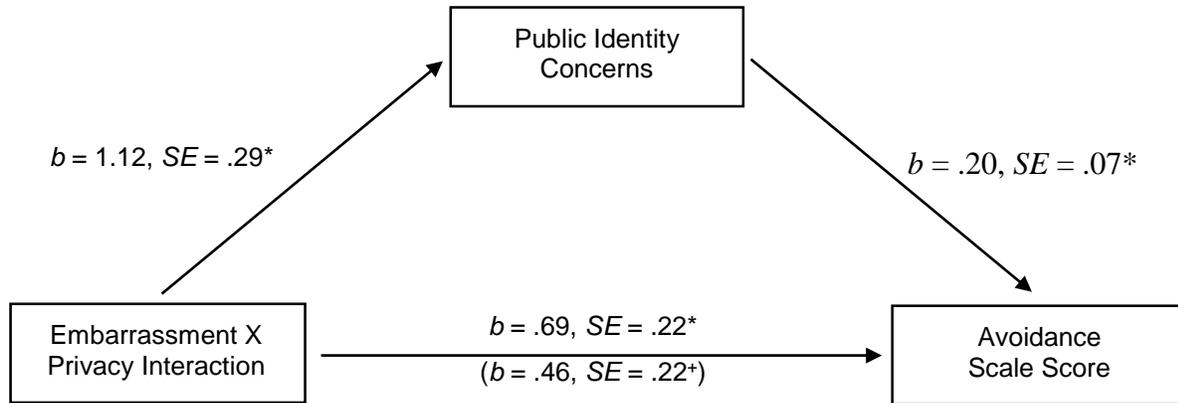
Note:  $b$  = unstandardized coefficients.  $+p < .10$ ,  $*p < .01$ .

Figure 3-2. Mediation with information avoidance decision.



Note:  $b$  = unstandardized coefficients.  $^+p < .10$ ,  $^*p < .01$ .

Figure 3-3. Mediation with information avoidance decision (public conditions)  
Information Avoidance Decision (Public Condition)



Note:  $b$  = unstandardized coefficients.  $^+p < .10$ ,  $^*p < .01$ .

Figure 3-4. Mediation with information avoidance scale.

## CHAPTER 4 DISCUSSION

### **Summary**

The goal of this study was to examine whether public identity threat prompts people to avoid information they personally desire, yet is potentially publicly damaging.

Participants were most likely to avoid their TAA Deficiency feedback when the feedback was public and potentially embarrassing. Mediation analyses indicated the fear of a spoiled public identity accounted for the greater avoidance. Participants were significantly more likely to avoid learning their risk for TAA Deficiency when they feared it might lead others to have an unfavorable view of them, and this tendency fully explained the effect of embarrassment and privacy interaction on avoidance.

This research moves the theoretical boundaries of information avoidance in important ways. Past theorizing suggests that people avoid information for three reasons: to avoid undesired affect, to avoid a challenge to a cherished belief, and to avoid taking unwanted action. I included items tapping each of these motives, yet none accounted for the avoidance I observed in the present study. These results indicate that avoidance in a public setting can stem from motives separate from the motives already studied. While the content of these public motives might mirror the private motives, they can exist independently.

### **Limitations and Implications**

The present study addressed a previously unexplored area in responses to threatening information: avoidance in a public setting. Although the results indicate that privacy can influence people's decisions in situations dealing with personal health test results, the study has several limitations. First, the study was conducted in a laboratory

setting and sampled undergraduates, who are young, affluent, educated, and generally quite healthy. Undergraduates might be more concerned about their social standing and the reaction of their peers than older adults, as college life revolves around social standing and friendship groups. Older adults, on the other hand, might face other obstacles to health information such as a lack of time or money. Also, because of their youth, vitality, generally excellent health, undergraduates study might be less threatened by health risk feedback than older and less affluent individuals. This might lead to a greater level of avoidance overall, if the undergraduates do not believe their personal health is actually at risk.

A second limitation is that I examined a fictitious disease and the results might not generalize to real diseases. If participants had doubted the authenticity of the study or the disease, their behavior would not have been the result of true fear about the test feedback. However, I excluded data from participants that doubted the authenticity of the study. Thus, I have no reason to believe that participants were not reacting to their feedback similarly to how they would react to real disease feedback. A second authenticity concern is that of the setting. It is likely that health providers attempt to give health information privately. However, test results can become public after the fact when the patient reveals their condition to friends and family. Inevitably, people may have to face public reaction to their condition.

The results indicate that physicians and patients should be more aware of the potential effects that embarrassment and publicity can have on patient decisions. Removing either the embarrassment or public factor should result in a significant decrease of avoidance, and thus a decrease in unhealthy health decisions. Physicians

may be able to diminish the embarrassment surrounding a medical condition either by downplaying the embarrassing aspects of a disease. To remove the public factor, health decisions could be made as private as possible. All notification of health information could be made in a private room, and confidentiality could be ensured as much as possible. The presence of a provider might even trigger avoidance, so test results given through email or on a computer would ensure greater privacy. While the present study focused on test results, similar effects could be predicted for patients' willingness to undergo treatment for conditions.

Conceptual replications of the current study in areas other than personal health would further cement the existence of separate motives of information avoidance in an interpersonal setting. Although the present study illustrates how the privacy of information can influence avoidance, more research would provide greater clarity about how decision-making in from a public vs. private setting. Presumably, any embarrassing information should lead to a similar pattern of results. When faced with the option of learning if their partner was flirting with others, I predict people would avoid that information more frequently in public than in private. When in front of others, people must deal with the fact that others will judge them and their partner for having a less than ideal relationship. In private, people can react in any way they wish without fear of judgment from others.

A fear of a spoiled public identity may not be the only interpersonal motive to cause avoidance. Consequences to information becoming public could be both social and financial in nature. For example, health information becoming public could lead to an increase in insurance fees, or a complete drop in coverage. People might also avoid

learning personal information in public to avoid negative affect. Learning personal information in public does not allow people to react privately to potentially scary or disheartening information. Within the interpersonal motive for avoidance, results might also differ when the embarrassing factor of the situation is related to the test or symptoms of the disease as opposed to the causes of a condition. The publicity effect might also depend on the degree of privacy of information. Although people might not want the others to know their personal health information, they might not mind if a nurse, family member, or close friend learns their test results.

### **Conclusions**

Are personal decisions about health altered by the presence of others? My findings suggest that impression management concerns and fear of negative evaluation can sway decision about personal health. In a world where many health decisions are made in the presence of an audience of family, friends, providers, and sometimes total strangers, people may make unhealthy decisions because of fear of negative evaluations or fear of negative financial consequences. A delay in learning important health information can have negative consequences in that some diseases have a narrow window before they produce harm. Understanding interpersonal factors that influence avoidance of personal health information is the first step in developing interventions to promote healthier decisions. Whether it is a fear of losing insurance over a test result or the potential threat to a public identity, the prevalence of learning information in a public setting may produce disastrous decisions.

APPENDIX A  
LIFESTYLE QUESTIONNAIRE

What is your age?					
What is your gender?	Female			Male	
What is your height in inches? (12 inches = 1 foot)					
What is your weight in pounds?					
Have you ever been told that you have high blood pressure (hypertension) or have you ever been given blood pressure medication?	YES	NO	NOT SURE		
Have you ever had a heart attack or been told that you have heart disease?	YES	NO	NOT SURE		
Have you ever been told that you have diabetes or a problem with high blood sugar?	YES	NO	NOT SURE		
Have you ever been told that you have high cholesterol?	YES	NO	NOT SURE		
Do you exercise weekly?	YES			NO	
If <b>yes</b> , how many hours a week do you exercise?	1	2	3	4	5 or more
Do you smoke or chew tobacco?	YES			NO	
If <b>yes</b> , how many times a day do you smoke or chew tobacco?	1	2	3	4	5 or more
Are you exposed to smoke from other people's cigarettes or cigars?	Regularly	Occasionally	Rarely	Never	
Do you have any relatives in your immediate family who have suffered from TAA Deficiency?	YES			NO	
If <b>yes</b> , how many immediate relatives have suffered from TAA Deficiency?	One	Two	More Than Two		
Do you usually eat fish two or more times per week?	YES			NO	
Do you eat 5 or more servings of fruit and vegetables per day? A serving is one medium apple, banana or orange, 1 cup of raw leafy vegetable (like spinach or lettuce), ½ cup of cooked beans or peas, ½ cup of chopped,	YES			NO	

cooked or canned fruit/vegetable or ¾ cup of fruit/vegetable juice.				
Do you eat 3 or more servings of whole grains per day (wheat bread, whole grain pasta, brown rice, oatmeal, whole grain breakfast cereal, bran or popcorn)? A serving is one slice of bread, 1 ounce of breakfast cereal or ½ cup of cooked cereal, pasta or rice.	YES		NO	
Do you usually eat 3 servings of nuts per week? A serving is 1 ounce, which is about one airline packet of nuts or one tablespoon of peanut butter.	YES		NO	
Do you usually eat butter, lard, red meat, cheese or whole milk 2 or more times per day?	YES		NO	
Do you eat stick margarine, vegetable shortening, store-bought baked goods (cookies, cakes, pies) or deep-fried fast foods on most days?	YES		NO	
Do you eat oil-based salad dressing or use liquid vegetable oil for cooking on most days?	YES		NO	
Do you masturbate?	YES		NO	
If yes, how often do you wash your masturbatory materials after using them?	Regularly	Occasionally	Rarely	Never
How often do you wash your hands after using the toilet?	Regularly	Occasionally	Rarely	Never
Do you take a multivitamin or a B complex supplement on most days?	YES		NO	
How many servings of alcohol do you have on a typical day? One serving is a can of beer, a glass of wine or a shot of hard liquor.	0	1	2	3 or more
What is your total cholesterol level?	Low- Less than 200mg/dL	Borderline High- 200-239mg/dL	High- 240 mg/dL	Don't Know

What is your Blood Pressure?	Normal - 139/89 or below	Mild Hypertensio n- 140/90- 160/100	Moderate Hypertensio n- 161/101- 120/200	Severe Hypertensio n- above 200/above 120	Don' t Know
What is your ethnicity?	Non- Hispanic or Latino			Hispanic or Latino	
Select one or more races to indicate what you consider yourself to be:	American Indian/ Alaskan Native	Black/Africa n-American	Asian	Native Hawaiian or Pacific Islander	White

APPENDIX B  
FEELINGS QUESTIONNAIRE

	Strongly Disagree		Neither Agree nor Disagree			Strongly Agree	
1. The possibility that my test results would make me feel bad influenced my decision to undergo the testing.	1	2	3	4	5	6	7
2. The possibility that my test results would challenge my view of myself as healthy influenced my decision to undergo the testing.	1	2	3	4	5	6	7
3. TAA Deficiency is an embarrassing disease for someone to have.	1	2	3	4	5	6	7
4. The possibility that my test results would require me to do something I don't want to do influenced my decision to undergo the testing.	1	2	3	4	5	6	7
5. The possibility that my test results might lead others to have an unfavorable view of me influenced my decision to undergo the testing.	1	2	3	4	5	6	7
6. I can control whether I develop TAA Deficiency.	1	2	3	4	5	6	7
7. If I had TAA Deficiency, I would not want others to know.	1	2	3	4	5	6	7
8. I would feel distressed if I learned that I had TAA Deficiency.	1	2	3	4	5	6	7
9. I would feel happy if I learned that I did <b>NOT</b> have TAA Deficiency	1	2	3	4	5	6	7
10. I would cope poorly if I learned that I had TAA Deficiency.	1	2	3	4	5	6	7
11. I would personally be embarrassed if I learned that I had TAA Deficiency.	1	2	3	4	5	6	7

	Strongly Disagree		Neither Agree nor Disagree			Strongly Agree	
12. I am confident that I can deal with the news should I learn that I have TAA Deficiency.	1	2	3	4	5	6	7
13. If I had TAA Deficiency, I would keep that information secret from others.	1	2	3	4	5	6	7
14. I can remain calm should I learn that I have TAA Deficiency.	1	2	3	4	5	6	7
15. Imagine that you chose to get tested for TAA Deficiency. How much do you anticipate regretting that decision later? <i>(This is a hypothetical question. To answer this question, imagine choosing to get tested at the end of this session, irrespectively of what option you actually chose.)</i>	Very little 1	2	3	4	5	6	Very much 7
16. Imagine that you chose NOT to get tested for TAA Deficiency. How much do you anticipate regretting that decision later? <i>(This is a hypothetical question. To answer this question, imagine choosing not to get tested at the end of this session, irrespectively of what option you actually chose.)</i>	Very little 1	2	3	4	5	6	Very much 7

APPENDIX C  
AFFECT SCALES

**Current Affect**

The words and phrases below describe different feelings and emotions people may have about learning whether they have TAA Deficiency. Read each and then indicate the extent you currently feel each specific emotion.

	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
Afraid	1	2	3	4	5
Alone	1	2	3	4	5
Angry	1	2	3	4	5
Anxious	1	2	3	4	5
Distressed	1	2	3	4	5
Isolated	1	2	3	4	5
Nervous	1	2	3	4	5
Upset	1	2	3	4	5

**Predicted Affect – Good News**

Now, imagine you that receive **good news** – you learn you are at **low** risk for TAA deficiency. Estimate how you would you feel immediately after receiving your test results.

	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
Afraid	1	2	3	4	5
Alone	1	2	3	4	5
Angry	1	2	3	4	5
Anxious	1	2	3	4	5
Distressed	1	2	3	4	5
Isolated	1	2	3	4	5
Nervous	1	2	3	4	5
Upset	1	2	3	4	5

### Predicted Affect – Bad News

Imagine you that receive **bad news** – you learn that you have TAA deficiency.  
Estimate how you would you feel immediately after receiving your test results.

	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
Afraid	1	2	3	4	5
Alone	1	2	3	4	5
Angry	1	2	3	4	5
Anxious	1	2	3	4	5
Distressed	1	2	3	4	5
Isolated	1	2	3	4	5
Nervous	1	2	3	4	5
Upset	1	2	3	4	5

APPENDIX D  
INFORMATION AVOIDANCE SCALE

	Strongly Disagree					Strongly Agree	
1. I would rather not know my risk for TAA Deficiency.	1	2	3	4	5	6	7
2. I would avoid learning my risk for TAA Deficiency.	1	2	3	4	5	6	7
3. Even if it will upset me, I want to know my risk for TAA Deficiency.	1	2	3	4	5	6	7
4. When it comes to learning my risk for TAA Deficiency, sometimes ignorance is bliss.	1	2	3	4	5	6	7
5. I want to know my risk for TAA Deficiency.	1	2	3	4	5	6	7
6. I can think of situations in which I would rather not know my risk for TAA Deficiency.	1	2	3	4	5	6	7
7. It is important to know my risk for TAA Deficiency.	1	2	3	4	5	6	7
8. I would want to know my risk for TAA Deficiency immediately.	1	2	3	4	5	6	7

APPENDIX E  
BRIEF FEAR OF NEGATIVE EVALUATION SCALE (LEARY, 1983)

Please read each of the following statements and indicate how characteristic it is of you.	Not at all	Moderately			Extremely
1. I worry about what other people will think of me even when I know it doesn't make any difference.	1	2	3	4	5
2. I am unconcerned even if I know people are forming an unfavorable impression of me.	1	2	3	4	5
3. I am frequently afraid of other people noticing my shortcomings.	1	2	3	4	5
4. I rarely worry about what kind of impression I am making on someone.	1	2	3	4	5
5. I am afraid others will not approve of me.	1	2	3	4	5
6. I am afraid that people will find fault with me.	1	2	3	4	5
7. Other people's opinions of me do not bother me.	1	2	3	4	5
8. When I am talking to someone, I worry about what they may be thinking about me.	1	2	3	4	5
9. I am usually worried about what kind of impression I make.	1	2	3	4	5
10. If I know someone is judging me, it has little effect on me.	1	2	3	4	5
11. Sometimes I think I am too concerned with what other people think of me.	1	2	3	4	5
12. I often worry that I will say or do the wrong things.	1	2	3	4	5

APPENDIX F  
BIDR (IM ITEMS)

Please indicate how true each statement is of you.	Not True		Somewhat True			Very True	
1. I sometimes tell lies if I have to.	1	2	3	4	5	6	7
2. I never cover up my mistakes	1	2	3	4	5	6	7
3. There have been occasions when I have taken advantage of someone	1	2	3	4	5	6	7
4. I never swear.	1	2	3	4	5	6	7
5. I sometimes try to get even rather than forgive and forget.	1	2	3	4	5	6	7
6. I always obey laws, even if I'm unlikely to get caught.	1	2	3	4	5	6	7
7. I have said something bad about a friend behind his/her back.	1	2	3	4	5	6	7
8. When I hear people talking privately, I avoid listening.	1	2	3	4	5	6	7
9. I have received too much change from a salesperson without telling him or her.	1	2	3	4	5	6	7
10. I always declare everything at customs.	1	2	3	4	5	6	7
11. When I was young I sometimes stole things.	1	2	3	4	5	6	7
12. I have never dropped litter on the street.	1	2	3	4	5	6	7
13. I sometimes drive faster than the speed limit.	1	2	3	4	5	6	7
14. I never read sexy books or magazines.	1	2	3	4	5	6	7
15. I have done things that I don't tell other people about.	1	2	3	4	5	6	7
16. I never take things that don't belong to me.	1	2	3	4	5	6	7
17. I have taken sick-leave from work or school even though I wasn't really sick.	1	2	3	4	5	6	7
18. I have never damaged a library book or store merchandise without reporting it.	1	2	3	4	5	6	7
19. I have some pretty awful habits.	1	2	3	4	5	6	7
20. I don't gossip about other people's business.	1	2	3	4	5	6	7

APPENDIX G  
INTERACTION ANXIOUSNESS SCALE (LEARY, 1983)

Please read each of the following statements and indicate how characteristic it is of you.	Not at all	2	Moderately 3	4	Extremely 5
1. I often feel nervous even in casual get-togethers.	1	2	3	4	5
2. I usually feel comfortable when I'm in a group of people I don't know.	1	2	3	4	5
3. I am usually at ease when speaking to a member of the other sex.	1	2	3	4	5
4. I get nervous when I must talk to a teacher or a boss.	1	2	3	4	5
5. Parties often make me feel anxious and uncomfortable.	1	2	3	4	5
6. I am probably less shy in social interactions than most people.	1	2	3	4	5
7. I sometimes feel tense when talking to people of my own sex if I don't know them very well.	1	2	3	4	5
8. I would be nervous if I was being interviewed for a job.	1	2	3	4	5
9. I wish I had more confidence in social situations.	1	2	3	4	5
10. I seldom feel anxious in social situations.	1	2	3	4	5
11. In general, I am a shy person.	1	2	3	4	5
12. I often feel nervous when talking to an attractive member of the opposite sex.	1	2	3	4	5
13. I often feel nervous when calling someone I don't know very well on the telephone.	1	2	3	4	5
14. I get nervous when I speak to someone in a position of authority.	1	2	3	4	5
15. I usually feel relaxed around other people, even people who are quite different from me.	1	2	3	4	5

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