



Public Policy and Health: A Self-Affirmation Perspective

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Abstract

Public policies designed to improve health and well-being are challenged by people's resistance. A social psychological perspective reveals how health policies can pose a psychological threat to individuals and result in resistance to following health recommendations. Self-affirmation, a brief psychological intervention that has individuals focus on important personal values, can help reduce resistance to behavior change and help promote health and well-being in four health-policy domains: graphic cigarette warning labels designed to get people to quit smoking, community health programs targeted at high-risk populations, alcohol intervention and prevention programs targeted at problem drinkers, and adherence to medical recommendations and treatment regimens among people coping with disease. Using self-affirmation has important strengths and limitations as a tool to help policymakers and practitioners encourage better health choices.

Keywords

self-affirmation, psychological threat, resistance, health, public policy

Tweet

Health policies can psychologically threaten people, so they resist health recommendations, but self-affirmation can help.

Key Points

- Health recommendations can pose a psychological threat, increasing resistance.
- Self-affirmation—focusing on personal values—reduces threat and resistance.
- Examples include graphic cigarette warning labels, community health programs, alcohol intervention and prevention programs, and adherence to medical regimens.
- Self-affirmation interventions should be timed, targeted, and implemented with contextual awareness.

Introduction

Scientifically informed policies aim to significantly impact public health. Consider the following: (a) the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) to encourage large graphic health warnings on cigarette boxes, adopted by 30 countries (WHO, 2003); (b) the "Let's Move" campaign to combat childhood obesity in the United States (Let's Move, 2014); (c) the U.S. Surgeon General's "Call to Action" for more effective alcohol prevention and intervention programs for underage college student drinkers (National Institute of Alcohol Abuse and Alcoholism

[NIAAA], 2007); and (d) policies designed to increase individuals' adherence to medical recommendations. These and similar policies share the common goal of changing individual behaviors to improve health and well-being (for review, see Fisher et al., 2011).

Focusing on individual behaviors is warranted, considering their role in mortality. In 2005, nearly 500,000 of the 2.5 million deaths in the United States were associated with smoking tobacco, and approximately 400,000 deaths were associated with high blood pressure (Danaei et al., 2009), both under individual behavioral control. However, when changing health behavior, both policymakers and the individuals contemplating change face consistent challenges.

Despite policymakers' goals, individuals may ignore health warnings, maintain unhealthy behaviors, and, sometimes, outright reject health information or opportunities for change. For example, despite multiple countries following the WHO FCTC recommendations for graphic cigarette warning labels, debate continues as to whether this prevention approach is effective. The fear aroused by graphic warning labels may actually promote resistance and undermine the goal of decreasing smoking, particularly when

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self-efficacy, individuals' perceived ability to decrease their smoking, is low (Gallopel-Morvan, Gabriel, Gall-Ely, Rieunier, & Urien, 2011; Peters, Ruiter, & Kok, 2013). Fear induced by the labels may act as a psychological threat, leading smokers to resist or avoid the message to protect the self (Harris, Mayle, Mabbott, & Napper, 2007).

Health policies can sometimes engender resistance to health-behavior change, but the self-affirmation approach (Steele, 1988) can help policymakers understand the nature of this resistance. Many social and health psychology experiments manipulate self-affirmation via random assignment in the health context (Cohen & Sherman, 2014; Harris & Epton, 2009), and health policymakers could implement this approach to potentially reduce resistance and promote healthy behavior changes. Four health policies illustrate: graphic cigarette warning labels, community health programs, alcohol interventions, and medical regimen adherence. To anticipate, self-affirmation interventions that focus people on important personal values—reinforcing their perceptions of being capable, worthy, and adaptive individuals—can catalyze change by defusing defensive responses to potentially threatening messages (Cohen & Sherman, 2014). When self-affirmation achieves self-protection, health-promoting messages can become more effective, with implications for developing and implementing future health policies.

Psychological Threat: A Barrier to Change

Psychological threat results when individuals feel that their behaviors or beliefs are wrong, inadequate, or personally harmful (Cohen & Sherman, 2014; Steele, 1988). This threat can cause internal turmoil that individuals are highly motivated to resolve. For example, a doctor's recommendation for cancer screening because of one's behaviors (e.g., excessive sunbathing) could threaten one's self-image as capable and adaptive. Such a threat could directly question one's lifestyle choices and imply that these choices were harmful, as well as raise concerns about personal mortality (Goldenberg & Arndt, 2008). Faced with this psychological threat and the aversive psychological state it arouses, individuals seek resolution.

Although people sometimes follow doctors' recommendations, complete cancer screenings, and change their behaviors to reduce cancer risk—resolving the psychological threat—individuals may also resist threatening information. For example, between 2000 and 2005, less than 10% of Americans had an annual screening for skin cancer, one of the most commonly diagnosed cancers in the United States (American Cancer Society, 2014; Fernandez et al., 2012). Defensive responses are common routes to resolving psychological threat, often because they require less effort for individuals and enable desired conclusions about their health status (Kunda, 1987). For instance, foregoing a suggested

diagnostic test that could reveal a serious condition may seem easier than facing the threat of learning the results (K. Sweeny, Melnyk, Miller, & Shepperd, 2010). Or, skepticism about unwelcome medical news may seem easier than facing it (Ditto & Lopez, 1992).

To resist information that signals the need to change health behaviors, individuals use varied strategies: derogating information (e.g., "This information is false"), denying its personal relevance (e.g., "Well, this is not true for me"), and altogether avoiding it (e.g., refusing to learn medical test results; Howell & Shepperd, 2012; Knowles & Linn, 2004). Although defensive responses may psychologically protect people from the psychic pain of confronting unwelcome information (Gilbert, Pinel, Wilson, Blumberg, & Wheatley, 1998), in the context of changing health behaviors, they may obstruct behavior change as they prevent acknowledging problematic behaviors and intending to engage in healthier behaviors.

Consider this article's health policy domains: graphic cigarette warning labels, community health programs, alcohol interventions, and medical treatments. In each domain, behavior change is not the dominant response to policy efforts. Individuals still smoke cigarettes, despite warning labels, as indicated by the estimated one billion smokers in the world (WHO, 2014), community health programs do not reach high levels of engagement from individuals (Morgan, 2001), college students continue to consume alcohol at dangerous rates (Johnston, O'Malley, Bachman, & Schulenberg, 2010), and many people, even when ill, fail to adopt behavior changes and medical recommendations advocated by health care professionals (DiMatteo, 2004). The continued need for these programs and the difficulty of maintaining healthful behaviors, despite the obvious costs of maladaptive health behaviors, suggests that the policies meet resistance. The self-affirmation approach analyzes why people are resistant and defensive, as well as how to reduce such responses. Furthermore, affirmations can catalyze other factors in the environment (e.g., existing interventions) to exert their influence. As such, they strategically couple with presenting health or policy information at times when people might otherwise reject them (Cohen & Sherman, 2014).

Self-Affirmation Approach

The self-affirmation approach assumes individuals are motivated to protect and maintain a sense of self-integrity: a perception of being capable, moral, and adaptive (Cohen & Sherman, 2014; Sherman & Cohen, 2006; Steele, 1988). Both behavior change and defensive responses can restore self-integrity in the face of threat. For example, diabetics can start exercising and change their diet to treat their diabetes and reduce the health threat, or they could deny that diabetes is a personal and potent health risk. Both responses would maintain self-integrity. However, health behavior change is a persistent challenge, and resistance can prevent adaptive responses.

Affirming alternative sources of self-worth can preserve self-integrity and prevent resistance, encouraging subsequent health behavior change. People possess many avenues to self-integrity. The self-system is flexible, going beyond resistance and defensiveness, and can restore self-integrity by drawing on alternative resources—religion, relationships, and other personal strengths, values, and identities—to help people confront difficult information (Sherman & Cohen, 2006).

Self-affirmations can arise from self-reflections on values or skills that remind individuals of meaningful aspects of themselves, restoring or reinforcing self-worth and adequacy (Cohen & Sherman, 2014). For example, people can recall a meaningful life event such as getting a promotion at work. Even everyday occurrences such as spending time with family or friends affirm roles and relationships by reminding people of who they are and what is important to them. Self-affirmations do not need to engender superiority or mastery; they simply need to satisfy personal worth (Cohen & Sherman, 2014).

Critical to self-affirmation's efficacy is its relationship to personal threats. When people's self-integrity is on the line—from a potentially life-changing medical diagnosis or negative feedback about health behaviors—small acts of self-affirmation can take on important psychological meaning as they provide necessary support in times of psychological need (Yeager & Walton, 2011). A single affirmation can buffer against psychological threat, allowing healthier decisions (e.g., overcoming the threat of diabetes diagnosis and choosing to get tested; van Koningsbruggen & Das, 2009). Many methods affirm the self (McQueen & Klein, 2006; more recently, Armitage, Harris, & Arden, 2011; Napper, Harris, & Epton, 2009). The most common procedure allows individuals to select a personal value (e.g., relationships with family and friends, religion, or sense of humor) and write a brief essay about why that value is meaningful (Cohen & Sherman, 2014). This psychological buffer attenuates physiological stress responses (Creswell et al., 2005; Sherman, Bunyan, Creswell, & Jaremka, 2009) and defensive responses (Sherman & Cohen, 2006), facilitating message acceptance and behavior change.

Health Effects of Self-Affirmation

Two recent meta-analyses (quantitative summaries across studies) show self-affirmation's impact on health message acceptance, intentions to change, and subsequent health behavior: small but reliable effects on all three outcomes (Epton et al., 2014; A. M. Sweeny & Moyer, 2014). For example, across 46 experimental tests ($N = 2,715$), self-affirmation relative to control affects many different health behaviors (Epton et al., 2014). In addition, self-affirmation decreases health message derogation and increases message relevance, message scrutiny, risk perceptions, intentions to change, and actual changes in health behaviors (Harris & Epton, 2009). Now, consider four illustrative health policy domains to examine the impact of self-affirmations.

Graphic Cigarette Warning Labels

The WHO's (2013) FCTC treaty encourages member countries to implement graphic warning labels (covering at least 50% of the package) on cigarette packages. The labels present images of diseases commonly attributed to smoking (Hammond, 2011). These labeling policies intend to prevent smoking, but considerable debate questions whether they are effective (Hammond, 2011). Resistance to graphic warning labels includes rejecting health messages, avoiding the labels, or even increased smoking (Hastings & MacFadyen, 2002; Ruiters, 2005; Witte & Allen, 2000). Self-affirmation may be particularly relevant in this policy domain; self-affirmation can increase message acceptance and reduce message avoidance.

In one study, affirmed smokers reported that graphic warning label images were more threatening and personally relevant, and they elicited greater intentions to reduce smoking, as compared with non-affirmed smokers (Harris et al., 2007). The participants' increased motivation persisted one week later. Self-affirmation also affects information seeking (Armitage, Harris, Hepton, & Napper, 2008). Low socioeconomic-status factory workers in England completed an affirmation or a control task and then evaluated a government-sponsored leaflet that provided suggestions on how to quit smoking. After participants thought the experiment was over, researchers measured whether they actually took the leaflet when they left: 59% of affirmed smokers versus only 37% of non-affirmed smokers. Moreover, taking a leaflet related to how much affirmed smokers accepted the message and intended to quit, suggesting that these psychological variables fostered quitting-related behavior.

Self-affirmation may also contribute to decreased smoking. One study had smokers self-affirm by writing about a value that was meaningful to them, as well as an important person in their life, and also provided them with an affirming cue, a bracelet inscribed with the words, "Remember the values" (Fotuhi, Spencer, Fong, & Zanna, 2014). Among the affirmed participants given the value cue, 60% reported intentions to quit smoking in the next six months compared with only 21% among those in the control condition; four months later, the affirmed smokers smoked nearly five fewer cigarettes per day than those in the control condition (Fotuhi et al., 2014). Although the majority of the findings support the efficacy of self-affirmation at reducing resistance to anti-smoking messages, some studies report null or negative effects.¹ Overall, however, the results are encouraging in small-scale demonstrations and suggest broader incorporation into policy.

Participation in Community Health Programs

Community health programs, targeting people whose behaviors increase their disease risk, can effectively promote health and well-being (Health and Human Services, 2006).

Consider heart disease, heavily influenced by individual behaviors (e.g., diet and physical activity) and the leading cause of death in the United States since 1930 (Jones, Podolsky, & Greene, 2014). Given the benefits of disease prevention and health promotion (e.g., healthier diets, increased physical activity), government policies provide information and encourage lifestyle changes. The U.S. “Let’s Move” campaign (Let’s Move, 2014) aims to increase healthy eating and physical activity among children and adolescents by supporting community events that provide families with information and other resources. However, participation is voluntary, and individuals largely do not participate or fully engage (Morgan, 2001). Self-affirmation may help increase initial engagement, as well as maintain participation and adherence to program suggestions.

In a recent field study, affirmation increased engagement in community programs (i.e., tax assistance programs targeting low-income people) that could be threatening, regardless of their benefits. Low-income participants at a soup kitchen completed either a verbal affirmation or control task (Hall, Zhao, & Shafir, 2014, Study 3). As part of the experiment, but unknown to participants, staffed tables outside the soup kitchen offered informational fliers on benefit programs. Among affirmed participants, 58% stopped to learn about the benefits, and of those affirmed individuals who stopped, 79% took a flier, compared with 40% of controls who stopped and 36% who took a flier.

Effective community health programs also rely on continued engagement and adherence to program recommendations. With the “Let’s Move” campaign, parents might learn more about healthy meal options for their children, but for actual health improvement, parents need to enact them. Self-affirmation may increase engagement and adherence among those already engaged in a community health program. For example, participants who self-affirmed before reading a government-sponsored health factsheet encouraging physical activity to prevent heart disease reported increases in physical activity over a week (Cooke, Trebaczyk, Harris, & Wright, 2014).

Community health programs can reach a large audience, comprising individuals at varying levels of risk. However, they must avoid inducing undue fear about health concerns among those at lower risk, as unnecessary medical tests can cost both individual health and collective finances (Kaplan, 2009). Self-affirmation can help in this effort, by increasing sensitivity to relevant risk among those at risk, without raising health threats among those not at risk (Griffin & Harris, 2011). For instance, after reading a brochure on the risks of mercury consumption, affirmed participants at higher risk reported greater concern, whereas affirmed participants not at high risk did not increase their concern. Community health programs offer promise for improving health and well-being because of their wide audience, and self-affirmation could help improve their efficacy by increasing participation and commitment to health changes.

Alcohol Interventions

College drinking problems persist at U.S. campuses and worldwide (Dantzer, Wardle, Fuller, Pampalona, & Steptoe, 2006; Johnston et al., 2010). Nearly 80% of U.S. college students drink alcohol, and 37% engage in binge drinking (Johnston et al., 2010). High alcohol consumption can lead to negative consequences, including death (Hingson, Heeren, Winter, & Wechsler, 2005). Many policies aim to reduce college drinking and its consequences, including the Surgeon General’s Call to Action encouraging colleges to research and implement effective prevention and intervention programs (NIAAA, 2007). Various interventions have mixed success reducing alcohol consumption (Larimer & Cronce, 2007), indicating both the problem’s stability and the need to enhance existing alcohol prevention and intervention programs. Part of the problem stems from college students resisting alcohol prevention efforts (Leffingwell, Neumann, Leedy, & Babitzke, 2007).

Self-affirmation promotes beneficial responses to alcohol-related health messages (e.g., pamphlets warning of binge drinking dangers). Female college drinkers completed either an affirmation or control task before reading an article linking alcohol consumption to breast cancer (Harris & Napper, 2005). For women at higher risk (heavier drinkers), those affirmed were, one month later, more likely to believe they were at higher risk for cancer, find the health message more personally relevant, and report greater intentions to reduce their alcohol consumption, compared with non-affirmed women drinkers. Message acceptance and increased risk perceptions predict health behavior change (Sheeran, Harris, & Epton, 2014; Weinstein, 1988).

In a general community sample, participants who completed a self-affirmation task before reading an alcohol-focused health message decreased alcohol consumption one month later—nearly one drink per day on average—compared with non-affirmed participants (Armitage et al., 2011). Furthermore, this study utilized a novel affirmation: Participants specifically planned when they would remember affirming values (e.g., “If I feel anxious, I will think about the things I value”). Both the standard affirmation and novel affirmation reduced alcohol consumption; moreover, the novel affirmation was briefer than other affirmation tasks, easing its standardized use (Armitage et al., 2011).

These studies all evaluated self-affirmation along with common, easy-to-implement informational interventions. However, there are more extensive intervention programs on college campuses. One frequent intervention targets ambivalent drinkers (who have both reasons to keep drinking and to change): motivational interviewing (MI; Miller & Rollnick, 2002), which has reduced alcohol consumption across contexts (Burke, Arkowitz, & Menchola, 2003). Affirmation may work with MI to enable counselors to focus on treating client drinking, instead of on reducing client resistance (Ehret, LaBrie, Santerre, & Sherman, 2013).

Increasing Adherence to Treatment Regimens

Individuals often receive medical recommendations from doctors. Increasing adherence, from disease screenings to everyday behavioral changes (e.g., exercising regularly), can save lives and reduce health care costs (Danaei et al., 2009). However, the example that more than a third of U.S. adults are obese (Ogden, Carroll, Kit, & Flegal, 2014) suggests that many individuals do not follow recommendations from medical professionals and fail to change their daily behaviors. Furthermore, being diagnosed with a disease or managing a disease can be stressful, and this stress can in turn have negative health effects (Sapolsky, 2004). Self-affirmation can both increase adherence and buffer against stress.

Self-affirmation motivates individuals to engage in beneficial health behaviors. For example, affirmed individuals at risk for diabetes were less likely to reject information about their diabetes risk and more likely to agree to a screening test (van Koningsbruggen & Das, 2009; see also Howell & Shepperd, 2012). As another, 50% of affirmed sexually active participants, compared with only 25% of non-affirmed participants, purchased condoms after hearing about the health risks of unprotected sex (Sherman, Nelson, & Steele, 2000). In addition, self-affirmation increases patient–provider communication in racially mixed doctor–patient relations, with affirmed minority participants being more interested, friendly, and interactive in their interactions with doctors, as well as less depressed and distressed, compared with a control group (Havranek et al., 2012).

Field studies among individuals with chronic diseases find that self-affirmation can increase health and well-being. Hemodialysis patients, a group wherein treatment non-adherence is common, self-affirmed or completed a control activity before reading health-related information emphasizing treatment adherence (Wileman et al., 2014). Affirmed patients were more likely to adhere to their treatment regimen, showing healthier blood tests up to 12 months after the self-affirmation intervention. In addition, three field studies provided participants with workbooks on how they could help treat their specific medical condition. Half the participants also thought about personal moments when they felt proud and about small things that made them feel good throughout their days and when facing challenges (vs. workbook only). Affirmed hypertensive African Americans were more likely than controls to adhere to their prescription regimens at a 12-month follow-up (Ogedegbe et al., 2012). Affirmed patients recovering from a heart condition were more likely to exercise than those in the workbook-only condition (Peterson et al., 2012). A third study found that self-affirmation did not promote physical activity among individuals with asthma, but did increase physical activity among asthmatics who had a serious medical episode during the course of the study (Mancuso et al., 2012). In the past three studies, self-affirmation effectively paired with a multi-component intervention that included follow-up phone calls,

small gifts, and treatment contracts. Overall, self-affirmation enhanced existing interventions to increase health behaviors (Cohen & Sherman, 2014).

Another benefit of self-affirmation for people adjusting to medical regimens may be stress reduction. Stress from breast cancer diagnosis and treatment reduces overall quality of life and survival (Montazeri, 2008). For women in early stages, those who wrote about meaningful thoughts and feelings associated with breast cancer, an affirming activity, reported reduced illness-related symptoms at a three-month follow-up (Creswell et al., 2007). Among women concerned about their weight, affirmation led to greater weight loss 10 weeks later, relative to a control condition. The researchers speculated that this resulted from self-affirmation buffering against weight-related stress (Logel & Cohen, 2012), suggesting additional pathways for affirmation affecting health.

Policy Implications

Researchers and policymakers both seek innovative solutions that encourage measurable and meaningful changes in specific behaviors. Policymakers worldwide are already integrating social psychological research into their approaches to policy (Behavioral Insights Team, 2010). Self-affirmation has yet to be used on a large scale, yet it may enhance many health outcomes.

First, consider creating policy that does not arouse defensiveness among those it aims to help. Integrating self-affirmation aided graphic tobacco warning labels in experiments, but other health policy issues pose serious challenges for psychological reasons. For example, many individuals at high risk for HIV/AIDS do not utilize testing services because they resist what could be revealed. To reduce resistance, health policy officials could pilot-test affirmations along with other social psychological approaches (Walton, 2014) to help people see the long-term context of their health decisions, rather than short-term costs associated with quitting smoking or getting tested for HIV.

Second, policymakers may want to find ways to enhance existing health policy both by increasing initial participation and maintaining interest in and program adherence. For example, human resource officers may want to encourage their employees to participate in health and wellness programs. In many contexts, existing policy and program infrastructure could benefit from time-efficient and cost-effective complementary interventions such as self-affirmation.

Third, health care professionals often face multiple challenges, including lack of initial participation, non-adherence to medical suggestions, and resistance to health-behavior change. Self-affirmation can address each of these reactions to psychological threats, making it a versatile tool (but not a panacea; see the next section). Interested policymakers should consult the February 2012 *Archives of Internal Medicine*, which discusses three randomized trials (reviewed earlier) that incorporated elements of self-affirmation at

hospitals among patients confronting acute illnesses. These empirical efforts provide a road map for potential intervention integration. Self-affirmation could be included in the self-reported health history forms that patients complete before seeing the doctor. Given the threatening nature of receiving medical advice that requires lifestyle changes, nurses or other medical personnel could have patients complete a self-affirmation activity before doctors introduce such advice. The self-affirmation activity must be tailored to each specific medical context, but self-affirmation could also be standard in patients' medical treatment plans, to decrease resistance and stress.

Recommendations for Implementation

Considering the range of uses, contexts, and mediums for self-affirmation in public policy, a universal implementation of self-affirmation is not possible. Many self-affirmation procedures are available (for recent alternatives to the commonly used essay writing, see Armitage et al., 2011; Napper et al., 2009), and best serving individuals requires reviewing the different options and balancing ease of implementation, cost, and meaning. Fundamentally, the first step in implementation should be to understand the psychological threat that may hinder the desired policy outcomes. Three principles help the efficacy of self-affirmation: the timing, the target, and the awareness of the intervention among those receiving it.

Timing

Critical to the efficacy is when individuals have the opportunity to affirm. Individuals most likely benefit from self-affirmation when they affirm before engaging with threatening material (Critcher, Dunning, & Armor, 2010). When individuals affirm and do not experience threat, it can, under some circumstances, lead to overconfidence or decrease motivations to change current behaviors (Briñol, Petty, Gallardo, & DeMaree, 2007). Policymakers should also investigate when psychological threat is most acute, and when other resources (e.g., program efforts) will be provided. Then they should examine, via pilot studies, whether an affirmation intervention would lead to the desired outcomes. By strategically introducing a self-affirmation *before* a potentially threatening context *and* when resources are available for more adaptive outcomes (e.g., before receiving medical test results), self-affirmation can interrupt harmful cycles of behavior (Cohen & Sherman, 2014). These small interruptions can have profound downstream effects, if the doctor appointment a person does not skip reveals a life-threatening disease that could be addressed with treatment.

Targeting

Carefully target which populations will benefit most from self-affirmation. In addition to finding threatened populations,

as just discussed, those who are at moderate-to-high risk for disease, and thus under more psychological threat, may receive the greatest benefits of self-affirmation compared with those at lower risk (Armitage et al., 2008; Harris et al., 2007; Harris & Napper, 2005; Scott, Brown, Phair, Westland, & Schütz, 2013). This is a promising pattern of findings, considering that those at higher risk are those most in need of changing their behaviors (e.g., heavy smokers or binge drinkers).

Awareness

In most current studies, participants are not told what the purpose of the self-affirmation activity is, and this subtle nature of self-affirmation may contribute to its effects (Sherman et al., 2009; Yeager & Walton, 2011). Too much awareness of an affirmation activity's purpose can lead participants to see themselves as targets of remediation (Cohen & Sherman, 2014), detracting from the narrative of capability and efficacy that the affirmation may otherwise cause. This speaks to a broader social psychological point: When people explicitly strive to boost their self-esteem or seek happiness, the focus on extrinsic benefits of the act rather than its intrinsic worth can reduce self-esteem and happiness (Mauss, Tamir, Anderson, & Savino, 2011). As a "wise" intervention (Walton, 2014), self-affirmations should operate with subtlety and emphasize the participant's choice and initiative to engage in all components of the program (Silverman, Logel, & Cohen, 2013; Walton, Logel, Peach, Spencer, & Zanna, 2014). Furthermore, to be beneficial, self-affirmations should not be regarded as a singular cure-all, but rather as a more integrated and natural component of policy (Yeager & Walton, 2011).

Conclusion

Self-affirmation is a powerful tool that helps individuals cope with psychological threat and may promote behavior change, particularly when coupled with positive forces in the environment that can carry an intervention forward by creating cycles of adaptive potential, mutually reinforcing interactions between the self-system and the social system (Cohen & Sherman, 2014). Thus, self-affirmation could be used as a way to nudge people (Thaler & Sunstein, 2008) toward beneficial but self-threatening health programs that people may, or may not, engage.

Policymakers and researchers considering self-affirmation should first analyze whether self-affirmation is an appropriate intervention for a given health context. In some contexts, self-affirmation may benefit health policy, and central to each scenario is psychological threat as a barrier to behavior change. In other health contexts, psychological threat may not be a major barrier, and what is needed is more access to health care or increased health literacy—not a social psychological intervention. Therefore, we call for modesty, as well as incremental testing of interventions to assess their efficacy. When seeking to apply self-affirmation,

policymakers and researchers should work together to examine which contexts and implementations are most appropriate. Working together advances understanding of psychological threat in public policies concerning health, and using this understanding can help institutions, organizations, and individuals achieve their health goals.

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Note

1. One study found that self-affirmation had no effect on daily smokers and might have even had a negative effect on occasional smokers (e.g., decreased message engagement and perceived message strength; Zhao, Peterson, Kim, & Rolfe-Redding, 2012), and another found no effect of self-affirmation on motivations to quit smoking after viewing warning images (Schneider, Gadinger, & Fischer, 2012).

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