

The COVID-19 Mask

Toward an Understanding of Social Meanings and Responses



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The COVID-19 pandemic has imposed unprecedented restrictions on everyday life. Unlike lockdown or shelter-in-place measures, the facemask has emerged as an empowering response to the public spread of the virus, permitting some degree of return to prepandemic life—such as school or work—by disrupting transmission that would otherwise occur. And yet, this utilitarian tool has attracted considerable controversy and polarized opinions. This article uses Blumer’s adaptation of symbolic interactionism as a theoretical roadmap to examine the various meanings ascribed to the facemask and its usage. We discuss how it is socially perceived and consider implications for health care providers within the Canadian social context. **Key words:** *COVID-19, meaning of facemask, symbolic interactionism*

THE FACEMASK, an object commonly reserved for health care workers, has gained new social relevance, and meaning in everyday life during the coronavirus disease-2019 (COVID-19) pandemic. Emergent evidence of both presymptomatic and asymptomatic carriers of COVID-19 led to the identification of facemasks as an important,

effective tool in suppressing the transmission of the virus and saving of human lives.¹ In response, the World Health Organization recommended in June 2020 that “governments should encourage the general public to wear masks in specific situations as part of a comprehensive approach to suppress SARS-CoV-2 transmission.”¹ In Canada, the public health responses have been influenced by the availability of space in intensive care units. Such responses have included the wearing of a facemask in public in conjunction with other protective strategies, including physical distancing, avoidance of large gatherings, and limiting of interactions to close contacts only, as well as regular and thorough hand washing.

Facemasks act as a physical barrier against the transmission of viruses in 2 ways: (1) they protect the individuals wearing the mask by reducing exposure transmission from persons infected with the COVID-19 virus; and (2) they reduce onward transmission by covering the face of the person infected with COVID-19.² Unlike lockdown or shelter-in-place measures, facemasks are an enabling and empowering response strategy that

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Statements of Significance

What is known or assumed to be true about this topic?

Why is it that some people decide not to wear a facemask in public in the midst of a worldwide SARS CoV-2 (COVID-19) pandemic, even though there is mounting contact-tracing and research evidence of its effectiveness in minimizing transmission of what is now known to be a largely airborne virus, and the fact that its usage protects the wearer and all others in close physical proximity alike? How is it that within the context of a global pandemic with its shelter-in-place regulations, furloughs and layoffs, and overall disruption of daily activities geared at “flattening the epidemiological curve” and preventing a catastrophic overwhelming of the health care system, individual psychological well-being, and collective physical health all too often emerge within social discourse and action as seemingly opposing and unreconcilable priorities?

What this article adds:

In this article we examine the deeper meanings associated with the facemask itself to better understand both individual decisions regarding their own usage of the mask and their responses to the decisions made by others. We use a symbolic interactionist approach to analyze how the different symbolisms associated with the mask as a sociocultural artifact are informed through social interaction with others and translate back into the decision to wear or not wear the mask in public. Greater awareness and understanding of the varying perspectives held by diverse social actors is essential if we, as health care professionals, are to develop shared language and strategies geared at identifying a common ground. Implications for health care provision and advocacy are then explored.

permits some degree of resumption of normal everyday life activities, such as return to in-person school or work, as it disrupts the public spread of the virus that would otherwise occur. Despite this, its broader public uptake outside the clinical setting has not been ubiquitous and unquestioned. Instead, misinformation, controversy, and social discord including racism are associated with its use. Somehow this seemingly benign utilitarian object has acquired cultural symbolisms beyond its clearly functional purpose, in ways reminiscent of the misinformation, conspiracy, claims, and partisanship associated, for example, with the antivaccination movement. Given the mounting empirical evidence that supports the use of the facemask as an effective public health strategy to reduce the transmission of COVID-19, how is it that this simple and demonstrably effective tool has become such an object of debate and even mistrust in certain quarters?

By and large, the facemask has been taken up through a post-positivist lens within the literature, with ontological assumptions about the mask as a neutral, replicable, generalizable object that merely requires empirical inquiry and appraisal to establish its effectiveness to ensure usage uptake.³⁻⁵ While such empirical data and analytic findings are both essential and urgently needed, so is an inquiry into the subjectivities, perceptions, and meanings associated with the facemask and its use. As health care workers, it is equally important that we seek to understand how the facemask has come to acquire the various symbolic meanings associated with it, as well as its deeper social and cultural relevance within the context of the COVID-19 pandemic. This article uses Blumer’s adaptation of symbolic interactionism as a theoretical roadmap to explore the various meanings of the mask and its usage by different individuals and groups. Specifically, we discuss how the mask is perceived and has come to possess the various meanings ascribed to it, to consider the implications for health care workers within the Canadian social context.

WHAT DO WE KNOW? EMPIRICAL RESEARCH FINDINGS TO DATE

The existing research literature regarding facemasks has primarily been related to considerations for wear and effectiveness of medical grade masks like the N95 and surgical masks.³⁻⁵ A recent narrative review by Clase et al³ analyzed the filtration properties of cloth facemasks within the COVID-19 context. The authors identified 25 relevant studies and concluded with a strong recommendation favoring the use of facemasks to help mitigate against virus transmission. Cotton or flannel facemasks with a minimum of 100 threads per inch and at least 2 layers were found to be the most effective for protecting the wearer and reducing contamination of the environment, also referred to as source control. Indeed, more recent literature has examined the need for double-layer facemasks to minimize droplet dispersion and aerosolization.⁶

A report from Germany used the synthetic control method, a technique used to estimate the effects of aggregated interventions, to evaluate the effect of compulsory masks in public spaces such as transit and stores in the city of Jena.⁷ The authors compared the effectiveness of mask wearing in Jena with data from other municipal districts in Germany and estimated a 40% reduction in COVID-19 transmission spread associated with the implementation of compulsory facemasks. Wang and colleagues⁸ found a 79% reduction in transmission (95% CI) in household spread in Beijing, China, when primary contacts or family members wore a mask prior to the development of their COVID-19 symptoms. A study in the United States also revealed statistically significant declines in daily county-level COVID-19 growth rates ($P \leq .05$) across 16 states that mandated facemasks in public spaces between April 8 and May 15, 2020, compared with states without mask mandates.⁹ A rapid response systematic review and meta-analysis published in the *Lancet* also reported that facemask use

in both community and health care settings could result in a large reduction in the risk of infection ($n = 2647$; 95% CI, 0.07-0.034).¹⁰ These empirical findings provide strong scientific evidence for the effectiveness of the facemask in controlling COVID-19 transmission spread.

Case reports are also providing compelling evidence of the effectiveness of the use of facemasks in public settings. As an illustration, a case report concerning 2 hairstylists from the same salon in Missouri who wore cloth facemasks and continued working with 139 clients, after they had themselves developed respiratory symptoms, found that no secondary transmission occurred, and greatly informed our understanding of the effectiveness of facemasks for reducing community spread.¹¹ Taken together, even with any methodological limitations, the emergent research evidence from these various studies points strongly to the use of facemasks by individuals as an effective public health measure to reduce the spread of COVID-19.^{7-9,12-14} And yet, interpretations of effectiveness and what constitutes legitimate information to corroborate its use seem to be entangled in its meaning. Lupton and colleagues¹⁵ argue that the mask is more of a relational artifact, informed by its sociomaterial meaning, than a question of effectiveness. The authors put forward several rationales for how the question of “effectiveness” became conflated with political ideology, particularly in the United States when President Donald Trump professed mask wearing as a sign of weakness. This article explores various meaning associated with the facemask during the global pandemic.

Missing in the growing body of empirical research are the actual uptake rates across regions, both at a national and a more localized level. Instead, we are left to rely on gray literature public media sources, such as findings from YouGov, a British polling firm, which found early in the pandemic that only 58% of Canadian survey respondents indicated that they wear a facemask when out in public, a

figure that was reported to be significantly lower than that of our American neighbors (71%).¹⁶ The highest population percentages of mask wearing were found in Asian nations, with Singapore reporting 92%, followed by countries in the Middle East.¹⁵ These numbers have certainly changed with the onset of mandatory masking policies. Though helpful, such media public polls often lack the rigor of scientific inquiry, considering associated limitations and various threats to validity, and need to be considered both critically and with caution. While such media reports may offer an intriguing initial glimpse into the prevalence of mask usage, they are also very much decontextualized from the factors influencing individual and group mask-wearing practices themselves.

PSYCHOLOGICAL CONSIDERATIONS IN MASK USAGE

Scheid and colleagues¹⁷ analyzed both the physiological and psychological impact of facemask usage. They found only minor physiological drawbacks, such as headaches, as a concern addressed in the literature and noted no evidence of significant changes in blood oxygen or carbon dioxide concentrations.¹⁷ The authors hypothesize that there are several psychological processes affecting facemask usage and suggest that unmet psychological needs may be related to negative attitudes toward mask wearing. *Relatedness*, having social belonging to a particular group, was identified as an important psychological variable affecting mask-wearing practices. The authors argue that people are vulnerable to what is normative within a particular social or political group; therefore, if it is normative behavior to reject the wearing of the facemask, people will conform to satisfy their need for social belonging.¹⁷

Similarly, *competence*, perceptions of government competence in effectively instituting safe measures, was identified as an important psychological need related to mask wearing. The authors note that having confidence in the medical guidance and scientific

information received is an important criterion for conformity and refer to the mixed messages during the early days of the pandemic. They point to the fact that large, trusted organizations such as the Centers for Disease Control and Prevention and World Health Organization advised against wearing masks only to later reverse their positions, as an important event that directly impacted people's degree of confidence in the knowledge, skills, judgment, and actions of their leadership and their ability to master pandemic response.¹⁷

Finally, Scheid and colleagues¹⁷ identified *autonomy* as an important psychological need associated with mask wearing. Autonomy refers to one's self-determination, or choice, in wearing a mask, and the authors note that mandates for mask wearing came into place without public consultation and suggest that this, in turn, affected the optics of whether masks were a choice or an imposed requirement. In addition, the fact that imposed mandatory mask-wearing guidelines were not enforced in many countries may have further contributed to a lower perceived legitimacy of the effectiveness of mask wearing.¹⁷ Scheid and colleagues¹⁷ analysis of mask wearing's psychological impacts is important to understanding both individual and group behaviors related to masks' use during a pandemic.

Tateo¹⁸ examined the meaning of the mask through a cultural psychology lens, using an online questionnaire to assess whether university students in Norway felt "safe" or "unsafe" when offered an image of a mask. The author describes how the "mask," an object with associated meaning, simultaneously evokes fear and safety. When faced with ambivalence feelings, people attribute meaning to reconcile their uncertainty*.¹⁸ Tateo¹⁸ highlights the inherent tension that ensues

*Tateo¹⁸ used Valsiner's work to examine the auto- and heteroregulation that occurs through sign mediation, whereby the mask acts as a semiotic mediator between "I" and "me" (self).

between *the ordinariness and the extraordinariness* of the mask as an integral part of its cultural meaning. On the one hand, masks are used in everyday life for functional purposes, such as going to the grocery store; on the other, they represent the extraordinariness of life during a public emergency that is the pandemic. Adding to this tension is the physical fact that the facemask is an artifact that alters the body (face), thereby heightening its significance to one's sense of self. Modifications to the body, such as covering/uncovering, affect the semiotic relationship between self (me) and identity (the "I" who is presented to the world). Building on Goffman's seminal work of the presentation of self in everyday life,[†] Tateo¹⁸ describes the *aestheticization* of the facemask—how one ornaments or personalizes the mask—as an important cultural process for making sense of the artifact while retaining both a sense of self and agency in self-presentation and expression.¹⁸

Scheid et al¹⁷ and Tateo¹⁸ both underscore the processes that inform the attribution of meaning to the facemask itself, and its usage, by both individuals and groups that go beyond the mere endorsement of and self-management with public health strategies and directives as informed by a rapidly emerging scientific evidence base.

SOCIOCULTURAL AND ETHNOCULTURAL CONTEXTS

Asian countries like China, Japan, and South Korea have a strong communal practice toward mask wearing.¹⁹ In Japan, mask wearing has been a socially embedded ritual since at least the 1990s when there was a decline in public institutions' trust.^{1,20} The emboldened discourse toward self-responsibility

(*jiko sekinin*) and the need to personally mediate risk gave rise to facemask health promotion. Burgess and Horii²⁰ also suggest that diseases like severe acute respiratory syndrome (SARS) and other flu epidemics like H1NI "stimulated the routinized public mask-wearing." In their survey study of 120 passers-by in Tokyo, the authors found that more than half of respondents (n = 61) reported "regularly" or "always" wearing a mask in public.²⁰ Of their sample, only a small portion (n = 6) reported not wearing a mask at all. Most respondents did not report a precise purpose, such as limiting exposure to a specific organism like the flu, but rather indicated the facemask was a general protective device. The authors explore mask wearing as a risk ritual, an unquestioned social practice whereby the practical considerations for mask wearing are trumped by the culturally symbolic character of the mask itself.²⁰

In Hong Kong, the facemask was identified as an important tool for containing the spread of the SARS virus. Since then, the use of facemasks became commonplace and an indication of good public health practice and a signal of civic responsibility.²¹ Not surprisingly, these regions have seen widespread universal acceptance of mask wearing. In Western regions prior to the pandemic, it was not uncommon to see people of the Asian diaspora donning a facemask. Since the onset of COVID-19, there have been increased racist attitudes and actions toward members of racialized Asian communities in the West, particularly toward Asian individuals wearing facemasks. In their analysis of facemask symbolism in anti-Asian hate crimes, Ren and Feagin²² note a Western association between the donning masks and being sick and weak. Indeed, the authors note that "facemasks are viewed here [United States] as diseased and as the source of COVID-19."^{22(p5)} The authors proceed to cite 82 incidents in the United States that involved a racist hate crime toward Asian Americans. Emergent from their analysis were the following categories: masked Asian individuals framed as the source of the pandemic, Asian individuals viewed as

[†]Erving Goffman²⁸ explores the realm of human behavior in his book entitled *The Presentation of Self in Everyday Life*. Using the metaphor of a theatrical performance, Dr Goffman explains the human desire to control, conceal, and underplay the true *self* to present an idealized version, the performer *self* to others.

sickly or weak, and a general attribution of racial inferiority.²² They also note that in the early days of the pandemic, racist messaging through media images portraying Asian individuals wearing facemasks amplified the public imagery of the virus and “unmistakably racialized signal of viral danger.”^{22(p 9)} Understanding cultural meanings of the facemask, considering intergroup dynamics, and exploring how these are then interconnected with medical discourse are needed to uncover the various meanings attributed to facemasks that in turn inform their usage.

A CONCEPTUAL ANALYTIC FRAMEWORK—SYMBOLIC INTERACTIONISM

George Herbert Mead (1863-1931), an American philosopher, psychologist, and social theorist, is considered by many to be the founder of symbolic interactionism.²³ Symbolic interactionism is a microlevel theory that focuses on social relationships to examine how exactly we interact with others in society. The underlying premise of symbolic interactionist thought is that human life is lived within and through the symbolic realm. Symbols are objects, events, or actions that represent something abstract and express an idea or value. They are ascribed meaning, which may change over time. According to Mead, symbols are central to the development of individuals and collectives, and foundational to societies, our self-concepts, and our minds. According to symbolic interactionism, symbols provide the means through which social reality itself is constructed and maintained. Even physical objects are not seen as having inherent meanings in and of themselves but rather as symbols inherently socially constructed through social interaction. In brief, as Charon²³ notes, symbolic interactionism explores how we interact with symbols and how they acquire meaning.

Herbert Blumer drew on the works of Mead and others in his essay on symbolic

interactionism, in which the concept is distilled into 3 core principles: (1) people act toward things, including each other, based on meanings they have for them; (2) these meanings are derived through social interaction with others; and (3) these meanings are managed and transformed through an interpretive process that people use to make sense of and handle the objects that constitute their social worlds.²⁴ Although seemingly basic, these fundamental principles provide a useful analytic tool for seeking to identify and better understand underlying and emergent meanings related to symbols as socially and culturally constructed artifacts. As such, we use Blumer’s Adaption of Symbolic Interactionism to uncover and analyze the various meanings associated with and attributed to both the facemask and its usage within Canadian society to better understand the decisions individuals and communities make regarding their own use or nonuse of mutually protective facemasks. Inherent in our analysis are the following additional assumptions proposed by Snow²⁵: (i) symbols are interactively determined, extend beyond the individual and their psychology, and are affected by values, ideology, and social movements created by various actors; (ii) symbols are not static fixtures in culture, but rather can be both fleeting and enduring; (iii) symbols are emergent, with potential for change; and (iv) symbols are created, activated, and sustained through human agency.

MEDICAL MEANINGS ASSOCIATED WITH THE FACEMASK INFORMS ACTIONS

The first principle of symbolic interactionist analytic thought is that people act toward things based on the meanings they have for them.²⁴

In health care practice, health care workers view and treat the facemask as a contaminated object that is not to be touched after being placed on the face and one that should subsequently be disposed of with caution during removal after its usage. As such,

the mask is considered a purely utilitarian object designed for the physical safety of its professional user: it serves as a physical barrier from aerosol and droplet contamination, and also functions as a deterrent to touching one's face, thereby mitigating the risk of viral transmission. Its active use by health care workers as an object of protection from an unseen threat is considered procedurally and undertaken with care, in keeping with clearly articulated professional guidelines and procedures. For example, in the hospital, protocols precisely mandate the sequence of donning and doffing the facemask in relation to other protective equipment, such as a gown, face shield, and gloves. The origins and purpose of the mask in health care practice as a professional tool that is to be taken seriously in turn inform how people act toward it.

The wearing of a mask in health care sometimes comes at the expense of individual comfort (physical), identity (being identified), and social ease (being able to speak with others comfortably).²⁶ In the health care environment, there is a collective understanding and acceptance of the discomforts associated with the facemask because it is perceived as a reasonable toll for the cost of safety.²⁶ Therefore, it is not customary to challenge workplace-masking policies within the health care environment, as a complaint would be interpreted as an act of unprofessional "noncompliance" with a greater value and belief system regarding the overriding importance of public health and safety. Any grievance regarding the wearing of the mask itself would therefore fall on deaf ears. Within this context, complaining about the need to wear a mask would also be perceived as an act of insensitivity toward those who are ill, suffering, and vulnerable, the very individuals whose healing has been entrusted into their care. Wearing a mask is a natural extension of a subscribed way of professional life and conformity to the hospital environment that is founded in a shared professional value system and a culture that deems physical health and safety paramount. Health care workers and how they behave toward the mask have

shaped its meaning and practice in health care workers' everyday lives.

MEDICAL MEANINGS ASSOCIATED WITH THE FACEMASK ARE CREATED THROUGH SOCIAL INTERACTIONS

The second principle of symbolic interactionist analytic thought is that meanings are derived through social interaction with others: in other words, through the lines of action by which individuals construct and interpret meaning.²⁴

The personal sacrifice associated with the discomfort of wearing a mask that health care workers have normalized as an appropriate tool to ensure mutual safety has, in the context of a pandemic, extended beyond the "safely-contained" hospital environment. As such, for the general population outside of the health care environment, the mask itself has become a sociocultural artifact that represents the overflow, and intrusion, of medical discourse into everyday life. This comes without perceived provisions for public consultation or the possibility of unanimous public agreement, acquiescence, or desire for such an extension of medical practice and discourse to mediate and interfere with everyday life. People want hospital walls to serve as secure and clearly defined boundaries between wellness and serious illness rather than an encroachment on their everyday life, particularly for persons who do not see themselves as ill or users of health care. The mask thus becomes a symbolic representation of an erosion of the preexisting boundary between health care and everyday life, between "safety" and "threat." The broader social meaning that emerges is that the mask represents the dissolution of this sense of safety, serves to highlight the seriousness of the pandemic, and symbolizes the need to act procedurally both individually and collectively with "others" to protect both individual and broader public health. Outside the specialized health care environment, there is a public expectation of normalcy and

nonsuffering. Here, the mask has emerged as an emblematic statement of the shared need for physical safety within the emotive-laden reality of a global pandemic, one that for many is misaligned with the need to feel safe and a pressing desire for the continuation or resumption of everyday life. This newly emergent meaning helps to inform, and explain, the dissonance and social disruption that occurs when it is discussed, treated, or used in a way that is contrary to its doubly protective function as occurs when, for example, it is not worn “properly” by being placed appropriately on the face, covering both nose and mouth.

Further resistance to wearing the facemask in public may also be associated with perceived inequities or unfairness. In the hospital environment, the sacrifice associated with wearing the mask is perceived as “equitable.” This is possible because health care workers are by and large healthy, able-bodied adults. In contrast, within the everyday public sphere, the small personal sacrifice made is not always socially perceived as truly equitable, given the exceptions made for young children or persons with respiratory problems. Feelings of resentment regarding an unequal, publicly “mandated” uptake of the wearing of the facemask together with accommodations aimed at ensuring equity may also further heighten concerns regarding physical safety.

Adding to these complexities, in Canada regulations regarding wearing facemasks have been largely left to provinces and municipalities to mandate or enforce. This means that there are different—and changing—guidelines in different places at different times. Most regions strongly recommend or even require the wearing of a facemask in public, but this comes with minimal or no enforcement. In contrast to countries with high uptake rates and where not wearing a mask results in penalty, the expectation in Canada is for persons to wear a mask in the name of civic responsibility, the public good, and collective health. This approach is experienced by some as clashing with strongly ingrained neoliberal values that favor individ-

ualism, competition, and free-market choice. Such civic appeals have also been diluted and even corrupted by thinly veiled commercial advertisements claiming to be “in it together” with the rest of us that frame and rebrand purely commercial endeavors and enterprises as being representative of social solidarity.²⁶ This includes urban storefronts posted signs that read “we are all in it together” in the pandemic’s early days. Similarly, the shortages of N95 facemasks themselves as experienced in the pandemic’s early days contributed to their commodification and coveting as an essential resource only available to some. Such rhetoric was soon met with critiques of intersectional class and race blindness that obscures the inequities faced by Black and other marginalized groups as well as the differential impacts of lockdowns across occupational sectors.²⁷

The challenge with unenforced rules in a social culture that favors individualism is that it transfers the responsibility for the surveillance of mask wearing—in the interest of the collective good—from a perceived authority (public health) to the level of social interaction itself and to individuals themselves. In other words, it requires individuals and groups to self-monitor, other-monitor, and control, giving way to shared YouTube clips of, for example, disgruntled grocery shoppers being publicly humiliated for not wearing a mask. It is not that there is no public enforcement of the wearing of facemasks; rather, the enforcement has shifted to the general population itself, where it is often met with discomfort or resistance. Such “downloading” to the social interactive sphere contributes further to the polarization of social sentiments regarding the mask as an object of both reverence and contempt.

SOCIAL MEANINGS ASSOCIATED WITH THE FACEMASK ARE INTERPRETIVE AND ITERATIVE

The third principle of symbolic interactionist analytic thought is that meanings are managed and transformed through an

interpretive process that people use to make sense of and handle the objects that constitute their social worlds.²⁴

The meaning ascribed to a facemask becomes activated when it signals something *about* us to others. It gratifies our performer self, how we present ourselves to others in an attempt to guide or control their impressions.²⁸ The mask conveys and signals either social “compliance” (rule following) or civil disobedience (rule breaking). This helps us to gain better insight into the lower uptake of facemask wearing among certain demographics, such as adolescents, who are at a developmental stage in which they seek individual self-expression and the testing out-of-consequences associated with rule breaking. It also sheds light on why the facemask as a popular artifact has become entangled in misinformation, resistance, and conspiracy notions. With such powerful meaning attached to the mask, its wearing does not just simply signal ideological stances; its wearing or nonwearing also readily becomes transformed into an overt demonstration and expression of one’s core beliefs. Unlike the antivaccination movement, in which one’s allegiance can be easily concealed, or conveniently reserved for select company, the wearing or nonwearing of the facemask is a very public proclamation of a stance taken. The mask is, in fact, an ideal artifact and vehicle for misinformation, antiscience sentiment, and conspiracy movements, because within the context of the current pandemic itself it is a pervasive, everyday, overt, and readily identifiable object that lends itself especially well for such social proclamations, disruption, and expression of racist attitudes and behaviors.

For many, the facemask has been the emblem of antiscience and the epistemological clash between science (what is known about the COVID-19, the virility of the virus, transmissibility, and contagion) and the concomitant rejection of the pandemic as a sociocultural phenomenon. The facemask is the commodity that showcases one’s level of denial and/or acceptance of a catastrophic global event. It is plausible that this thought is

too overwhelming for some, and as such that conspiracies and misinformation provide a comforting alternate reality. This is evidenced by media articles documenting COVID-19 patients’ shifts in their beliefs about COVID-19 and narrating during their last moment expression of regret for their denial.

Simultaneously, health care workers have been featured in media images with bruising, imprint lines and rashes on their faces from a prolonged wearing of the mask. In the early days of the pandemic, when protective equipment such as facemasks were in short supply, nurses exchanged stories of reusing N95 masks to ration the scarce resource at a time of continuing uncertainty about their own personal risk. For them, the facemask has come to represent the sacrifice of health care workers, a reminder of the trauma they have endured as observers of death and dying associated with the COVID-19 virus. This emotive experience, combined with professional culture and emergent empirical evidence of the mask’s effectiveness, helps us to understand their incomprehension of mask-wearing non-conformance, where it occurs within the general public. The mask is perceived as a simple, affordable, accessible tool to spare both health care workers and the general public itself the suffering of bearing witness to the consequences of the pandemic. And yet, it is so easily weaponized by antiscience discourse precisely because it has such a wide, and deeply experienced, set of different meanings attached to it by diverse groups of people.

The terms “compliance” and “noncompliance” are indeed institutional language commonly used in public health. The authors recognize this is a contested term denoting power over or authority over one’s agency and self-determination. The concept of “compliance” exists on a continuum and holds different meanings depending upon the identity and agency of the individual. At one end of the spectrum, “noncompliance” lives in the framework and worldview of those who resist the control of the state and glorify not only self-agency but an a priori right to liberty, to defend one’s happiness, and to

ultimately determine deontologically what is good and valuable. Here, the needs of society must necessarily give way to the needs of the individual, and those who have the power, the voice, and the access to platforms seize the opportunity to assert their rights. In this worldview, the right to resist mask wearing is perceived as being similar to the right to bear arms, the right to hoard resources unnecessarily, and to make decisions that are not evidence-informed but fueled by emotions and reflexive self-protection. Taken to the extreme, the need to maintain personal safety and happiness might outweigh the civic duty to share resources or the need to consider the risks to public safety. The concept of “noncompliance” in this sense is not simply exercising choice following well-balanced consideration of science, equity, and community. This might explain some of the behaviors of segments of the population within which public health guidelines evoked marches and conspiracy campaigns. “Noncompliance” that is marked by indifference for the community is an extreme endpoint of a neoliberal society. At the other end of the “noncompliance” scale are those who do not wear the mask itself simply because it is seen as a symbol of suffering and represents the dissolution of identity.

In addition to the meaning attached to the facemask itself, there is an interpretive meaning associated with the use or wear (wearing, nonwearing) of the mask depending on space and place. Wearing a mask can telegraph to others one’s own risk tolerance as an individual as well as their risk tolerance within a collective community. For example, wearing a mask in a public space can be seen as *normative* and responsible, while wearing a mask while driving alone in a car can be perceived as an *unnecessary* behavior. An individual may also judge some public settings to be higher risk (eg, entering a hospital) than others (eg, gathering outdoors) and their ensuing action may predict their actions related to the mask. For example, “going too far” with wearing a mask carries with it another type of social risk, as others can perceive it as

being controlled by the virus, which can also serve to raise the viewer’s anxiety levels and fear responses. People also base their interpretations about others on the many features of a mask, including usage, design, quality of mask, and type (respirator, medical or non-medical, reusable) as well as how it is worn (correctly in accordance, carelessly mouth only, defiantly under the chin).

FUTURE DIRECTIONS AND IMPLICATIONS FOR NURSING PROFESSIONALS AND PRACTICE

This article explored medical meanings of the facemask and the transformed slippage of these meanings into everyday life within the context of the COVID-19 pandemic. Using symbolic interactionist microlevel theory, this article has sought to analyze the subjectivities of the facemask and to examine how we interact with social others in relation to the facemask as a social artifact that creates actions, social interactions, and social meanings. Our analysis suggests that the facemask signals the erosion of boundaries between health care and everyday life, safety and threat, professional, and lay person that occurs during a pandemic. This erosion manifests itself in daily reminders like signage at the grocery store advising patrons of the need to physically distance, limits on congregation, and regular news segments with health care experts sharing their knowledge of the disease. The facemask, an artifact normally used for special health care settings, may be perceived by many as either a necessary or unwelcome intrusion of medical discourse into everyday life as well as a social symbol of one’s required agreement and “compliance” (or not) with public health and safety measures.

Meanings ascribed to the facemask and its usage do not presume Canadians’ homogeneity, but reflect instead our early explorations toward a deeper understanding of these phenomena. Further research is needed to better understand the variations in social

and cultural meanings associated with the facemask as well as its usage both across and within diverse ethnocultural, racialized, and religious groups in our society. This also requires a deeper analysis of how the facemask has become embodied for certain individuals and within certain groups, as well as the responses this often elicits from others.

What are some of the lessons to be learned for nurses and other health care workers surrounding both the facemask and its usage? How may our understanding of these underlying meanings be used—in conjunction with solid empirical evidence that establishes the effectiveness of the facemask in helping to contain broad transmission of the COVID-19 virus—to help safeguard both individual and public health?

Rather than simply assume an alignment of values and belief systems within and outside the health care environment, we need to be aware of and accept the existence of the different socially constructed meanings associated with the mask itself that inform its wearing or nonwearing in both direct and indirect ways. There may be lived experiences of social and economic barriers or other ethical injustices that precede their contact with you as a health care worker. More important and effective efforts to uncover the meaning that each individual associate with the facemask as it is this that translates into their subsequent actions. This requires us to shift away from an expert model, in which objective truth claims hold credence for everyday interaction, toward an appreciation for the underlying subjectivities, perspectives, and needs of others. Further inquiry into why people choose to wear a mask in this case is warranted to acknowledge the positive meanings associated with this behavior. Furthermore, we need to always contextualize both the facemask and understand its meaning as a socially constructed cultural symbol for wearer and nonwearer alike, one that may vary across diverse ethnocultural populations and fluctuate through time. Future work to compare strategies for approaching the

meaning of the mask in various ethnocultural contexts is warranted to ensure culturally safe and inclusive responses. The dialogue could begin by asking the client to explain why they are not wearing a protective mask, and respectfully negotiate what might help them wear a facemask during our contact with them.

In light of these different meanings associated with the facemask, as well as the polarity that all too often is embedded in its usage, we need to find a strategy that helps to mitigate if not neutralize the polarization of meanings—and thus attitudes and associated behaviors—associated with the actual wearing of the mask in public. Declaring a challenge to antimaskers only serves to unnecessarily embolden the divide. Communication and messaging that conveys a deep and informed understanding of people's life circumstances is critically important, especially since the actual risk of contracting the virus is differentially spread across demographics and geography. As noted by Sobande, “marketed notions of ‘we’ gloss over inequalities and (re)present everyone as being part of unified mass of people who are equally susceptible to negative impacts of COVID-19 [. . .].”^{29(p4)} Simply stating that “we are in it together” does not work, and often for that very reason.

Careful, gentle, and respectful dismantling of misinformation is equally pressing and essential if we are to effectively contain virus transmission to better safeguard the health of individuals, families, communities, and populations. Exasperated dismay or flippant disregard for misinformation is neither a useful nor caring strategy. Instead, the sharing of knowledge and the co-creation of truth by applying existing verifiable information in the context of the client and/or our fellow citizens facilitate shared decision-making. Health care workers who collaborate with clients in ways that avoid the duality of “compliance” versus “noncompliance” create stronger partnerships that begin with respectful consideration for the other. Keep in mind that there may be lived

experiences of social and economic barriers or other ethical injustices that preceded their contact with you as a worker. Although more time-consuming, efforts at contextual understanding, cultural acceptance, and respectful dispute resolution might provide a genuine pathway to both cultural and public safety, as we negotiate, both individually and collectively, this pandemic together.

As nurses in particular, it also behooves us to “reclaim” the mask as an object of sincerity and care. This requires us to shift our perspective from “policing” the usage of facemasks toward a “caring for” and “empowering of” others. Communications at an individual level could, for example, focus on and emphasize what the wearing of a mask *enables us each to do* (return to work, return to school, maintain, or resume many of our regular daily activities, protect the health and well-being of others). Reimagining the facemask as an enabling tool may also give rise to further discussions related to the altruism of wearing a mask, and the desire to protect others. Indeed, this is corroborated in the literature. Cheng and colleagues noted mass masking for source control as a measure to “shift focus from self-protection to altruism, actively involves every citizen, and is a symbol of social solidarity in the global response to the pandemic.”^{30(p2)} Hunkering down behind an internalized professional value system and knowledge base is neither helpful nor constructive. The same is true of taking a presumptive or even judgmental approach toward others’ values, belief systems, and worldviews. It is important to recognize that such social judgment simply serves to actively undermine much-needed public “compliance” in wearing the facemask and

can embolden resistance and even the polarization of attitudes toward the mutually protective mask. It is unlikely that individual health care workers will have the capacity, tolerance, or patience to confront those who are actively hostile against science. In contrast, centering care around the history, context, culture, and values of the client facilitates an understanding of their perceptions of safety, and their agency. Finding a common value or goal might serve as a bridge for trust and shared meanings. Merely repeating information without acknowledging and exploring possible differences in perspectives and values with and among clients may only lead to unsatisfactory interactions and ineffective interventions.

Implicit biases around embodied racism, legitimacy following immigration, and tolerance of religious symbols need also be considered, especially since such biases and sentiments have emerged in response to symbolic facial and head covering for many years. Further exploration into the facemask’s cultural meanings and social articulations would strengthen our ability as health care workers to engage in culturally safe and meaningfully productive dialogues with all those entrusted to our care. More needs also to be done on a grander scale to address existing misinformation and improve the communication flow of scientifically supported facts. This would also help mitigate against disruptive notion conspiracy that seeps into everyday life. On a policy level, greater attention to everyday struggles, upheaval, and disruption that comes with the pandemic may go a long way in alleviating the worries and fears of those in denial of the pandemic.

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