

Self-Identity and Risk Mitigation Behavior: Self-Protecting Masks Mandate

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Abstract

A nation's reaction to health risk in the wake of a pandemic reveals ample supply of data potentially highlighting the thematic schemes linking self-identity to risk mitigation behavior. The following thesis proposes an assessment of the self-identify themes motivating the choice to adhere to the self-protection masks mandate, providing discernment for practitioners and academics interested in revealing the diverse idiosyncrasies contributing to health-behavior habits. Literature surrounding risk communication, risk perception and self-identity intertwine to form a lens to interpret the gathered data. Seven qualitative interviews gleaned from a purposeful snowball sample conducted at a Southeastern University from individuals at least 18 years or older aimed to elicit willing, anecdotal evidence to study through thematic analysis against the proposed research question. Findings from the study revealed the self-identity values pertaining to relational connection, mask efficacy, human rights and freedom, the role of advocacy, perception of fear tactics, and individual responsibility as the overarching elements related the use of self-protection masks. The implications drawn from the study seek to progress the field of public relations and communication by narrowing the scope of how publics link self-identity values with their perception of risk – a concept due to remerge in the field as the effects of the Covid-19 pandemic proliferates.

Keywords: public relations, self-identity, risk mitigation, health belief model, risk communication

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Chapter 1

Introduction

A nation's reaction to health risk in the wake of a pandemic reveals how one's perception of relational connection, mask efficacy, human rights and freedom, advocacy, fear tactics, and individual responsibility link to an individual's self-identity values relating to risk mitigation behavior. The following study proposes an assessment of the self-identify qualities motivating the choice to adhere to self-protection masks mandate, providing discernment for practitioners and academics interested in revealing the diverse idiosyncrasies contributing to health-behavior habits. Literature surrounding risk communication, risk perception, and self-identity intertwine to form a lens to interpret the gathered data. Seven qualitative interviews gleaned from a purposeful snowball sample conducted at a Southeastern University from individuals at least 18 years or older aim to elicit willing, anecdotal evidence to study through thematic analysis against the proposed research question. Findings and implications drawn from the study seek to progress the field of public relations and communication by narrowing the scope of how publics link self-identity values with their perception of risk – a concept due to remerge in the field as the effects of the Covid-19 pandemic proliferates.

Chapter 2

Literature Review

Self-Identity

The concept of self through the behavioristic lens is often labeled as an intangible subject marked by its circular terms. Even so, several behavioral scientists unite under the notion that the study of self-concept is a crucial, viable plight. Seymour Epstein serves as a leading author on the development of the theory and offers foundational insights by stating in his 1973 piece, “Self-theorists identified as phenomenologists consider the self-concept to be the most central concept in all of psychology, as it provides the only perspective from which an individual’s behavior can be understood” (p. 404). Literature and studies revolving around the theme of self-identity unite under the mission to unravel the “root” of one’s motivation and perception of themselves contrasted with the world around them. William James projects this understanding in his foundational 1910 literature by proposing the self as an object of knowledge revolving around what an individual perceives as belonging to themselves – material self, social self and a spiritual self. All three of these categorizations encompass one’s views, perceptions, and values held both introspectively and in light of one’s environment. The perceptions of self-identity are further bolstered by researchers Syngg and Combs (1949) promotion of the self as, “the nucleus of a broader organization which contains incidental and changeable as well as stable personality characteristics” (p. 406). From this, we consider self-identity as a fluid, dynamic entity consistently molded and sharpened by one’s interpersonal and external perception of reality.

The theme of self-identity encompasses the salient, constructed aspects of an individual’s perception of themselves (Sparks, 2000). Often these characteristics attributed to oneself manifest in one’s social sphere, creating a multi-dimensional identity linked to both an individual

and the world around them. Self-identities, also known as “me identifications” result from self-perception through the lens of a specific or generalized role within a given categorization of self (Stets & Burke, 2000). Ultimately, such categorizations form a construct of identity standards that have the potential to shape one’s behavior and values. Previous empirical studies provide evidence pointing toward the influence of self-identity on behavioral intentions. Introspective identities one may hold for themselves is worthy of focus when challenged by divergent behavior within a cultural norm. Eliciting repeated behavior closely correlated to one’s self-concept, “conveys meaning over and above the positive or negative attitudes we may hold toward performing the behavior itself” (Sparks & Shepherd, 1992, p. 389). From this understanding, we are able to take a deductive approach to witnessing the varying perceptions of self-identity correlated with one’s divergent health behavior. Specifically, the role of self-identity will act as a thematic scheme to reveal anecdotal insight into how individuals in the wake of risk communication surrounding face masks during Covid-19 elicit behavior in light of their perceived risk.

Focused research combining health behavior and self-identity values is an evolving topic among practitioners and academics alike. Researcher George Engel’s formative 1980’s research suggests the social and psychological analysis required to study self-perception concepts in order for physicians to confront patient-illness conversations. He promotes combatting divergent beliefs between health practitioners and publics serves as a crucial task – one best suited through the lens of social and psychological factors which sustain one’s identity (1980). Authors Richard Contrada and Richard Ashmore (1999) illuminate the role of self in physical health explorations within their explanation of the psychosocial realm of health behavior. “In cognitive appraisals, goals, competencies, valued social roles, and resources that make up the self are evaluated in

relation to potentially stressful environmental events and conditions” (p.8). These cognitive appraisals combine evaluations of both the former and future self in order to elicit behavioral adjustments motivated by protecting one’s identity. Ogden offers foundational literature on how a health behavior can be studied with a focus on one’s perception of self and whether they view themselves by their ability to mitigate risk through their own behavior. Her findings suggest that “health protection is a matter of perceptual and behavioral activity of the self - directed at a conception of self” (1995, p.). Therefore, recognizing the intricacies of self-identity and its dynamic relationship with one’s external environment suggests a worthy study into the thematic perception contributing to health behavior.

Risk Communication/Risk Perception

Health concerns, along with communicative strategies to combat them, revolve around the notion of perceived risk. “A risk is a probabilistic event of various magnitudes that can be augmented or mitigated by various actions and circumstances. Risks happen, and as such, we can define a crisis as a risk manifested” (Heath, Palenchar, Proutheau, & Hocke, 2007, p. 37). Personal biases and perception of consequences in light of the perceived risk lend massive weight to calculate one’s estimation of their potential negative outcomes. Moreover, a health risk is defined by, “The perception of the subjective likelihood of the occurrence of a negative event related to health for a person over a specified period of time” (Menon, Raghubir, & Agrawal, 2008, p. 982). Risk communication, and specifically the themes that affect risk perception serves as an additional lens to glean understanding on how individuals develop behavior during a pandemic. In 1983, Neil Weinstein published an article on people’s unrealistic optimism – a quality often targeted by risk communication. People are typically unrealistically optimistic in regard to their perceived susceptibility towards risk. Excessive optimism plays an integral role in

the negation of risk messages due to publics inaccurate assessment of vulnerability. Therefore, Weinstein suggests three strategies for communicating risk effectively: a) strongly emphasize the link between behavior and susceptibility, (b) provide specific behavioral objectives, and (c) provide descriptions of the preventative actions of others. This three-pronged approach mimics literature surrounding self-identity and the need for individuals to rationalize their choices amidst their perception of self and the world around them.

A 2013 article written by Julie Brake considers the theories behind health risk communication. Brake mentions the multitude of messages publics are subjected to, and the perceptions contributing to the active response to messages of risk. “People welcome favorable and positive information about their health, but will often engage in strategies that reduce or discount unfavorable or more negative health information” (p.271). Depending on which self-identity factor one perceives to be under attack, an individual may shield messages of risk in order to maintain identity-homeostasis. She notes that with any health behavior – the action suggested to mitigate risk falls through one’s perception of how “acceptable” they perceive the task to be. Acceptance by an individual is linked to the perception of deviance or willingness someone is to performing this behavior (Brake, 2013). Two issues are suggested as fundamental assessments of risk communication – people’s perception of health risk and accurate assessment of the impact of health risk intervention. “An intervention should influence knowledge about health risk, beliefs about personal risk and perceptions of how one’s own risk compares with the average person’s risk, or the intentions to act to reduce one’s risk” (p. 271). Providing contextual information throughout risk communication is an imperative objective in the plight to link self and societal expectations.

Behavioral change is closely tied to perception of risk and is therefore crucial for investigators to divulge interventions capable of reducing risk perception biases. Kreuter and Stretcher (1995) reveal the importance of a person's ability to relate to risk during their study of patient's perception of risk of a heart attack, stroke, cancer, and vehicle crash. "Optimistic bias is a function of egocentrism, which can, in turn, be counteracted by comparing a person's risk with that of similar to others" (p.57). If controllability serves as a leading factor in behavioral choices, how can risk communication factor into one's discrepancy in self-efficacy values? A variety of factors affect risk communication processes, and with the aid of data-driven messages and symmetrical dialogues – the plight to develop risk messages is a multi-faceted effort.

Leading scholars Michael Palenchar and Robert Heath (2002) suggest the following variables when constructing risk messages: (a) cognitive involvement, (b) first-hand experience, (c) knowledge, (d) perceived economic benefit, and (e) trust and credibility. Each of the five schemes seek to manage one's perceived uncertainty and control in the wake of risk messages. "Public relations practitioners, including risk communicators, have to understand the actual risk involved, but more importantly people's perceptions of the risks" (Palenchar & Heath, 2002, p.129). The authors promote further analysis on how people decide what risk is acceptable to them based upon their own constructed values. In this way, recognizing the differentiating opinions and beliefs on a risk create a challenging environment for professional communicators and academics to assist in the communication process.

Health Belief Model

Applied research problems stemming from health settings and background experiences were illuminated in the work of investigators from the Public Health Service between 1950 and 1960. The leading scholar behind the model, Irwin Rosenstock, details the origins of the model

in his 1974 piece, “Historical Origins of the Health Belief Model.” Public health concern at the time neglected to attend to the public’s failure to accept preventative health behavior. The Health Belief Model emerged from investigator’s recognition of avoidance behavior and the role environmental barriers played into acceptance of health choices. Rosenstock (1974) mentions how the programmatic issues raised during initial development of the model is attributed to social psychology and phenomenological orientation. From this approach, we can see how the Health Belief Model mimics a constructivist attitude - the perceiver of the world determines their reality rather than the physical environment perceived as the leading determinant. The perk of this model is apparent from its “focus on the current (ahistorical) dynamics confronting the behaving individual rather than on the historical perspective on his prior experiences” (p. 329).

The model’s three leading variables aimed at understanding health beliefs are perceived susceptibility, perceived seriousness and perceived benefits of taking action and barriers to taking action (Rosenstock, 1974). Perceived susceptibility focuses on an individual’s subjective risk towards contracting a given health occurrence, whereas perceived seriousness revolves around one’s judgement of the degree to how difficult such a health condition is perceived to evoke on them. Perceived benefits of taking action and the barriers to taking action is the final factor in the model which seeks to explain how the direction that the action takes “is influenced by beliefs regarding the relative effectiveness of known available alternatives in reducing the health threat to which the individual feels subjected” (p. 331). In other words, the action they predict is required to mitigate the health threat may be outweighed by internal or external factors bearing too high an inconvenience or unpleasant reality. One additional theme is proposed in the Health Belief Model in order to determine the potential “triggers” to set behavior in motion. “Such events or cues might be internal (perception of bodily states) or external (interpersonal

interactions, the impact of media)” (p. 332). Initial observation of the model obtained minimal opportunity to obtain a measurable indicator of the role of cues. Rosenstock (1974) remarks on this discrepancy by concluding that a future study would be necessary in order to assess how one’s perception of stimuli serves as a cue to trigger behavior in an individual.

The following study leans into this projection by seeking to discover an individual’s internal values related to their perception of a specific health risk. Public health settings have recognized the implications from the Health Belief Model in congruence with an individual’s perceived health threat combined with the perceived benefits from preventative action (Deshpande, 2009). The thematic aspects proposed in the model serve our evolving interest surrounding why people make their health choices, and what their perception of that choice is in contrast with their perception of the environment around them. Developed by an expectancy-value framework, the Health Belief Model utilizes both psychological and behavioral theories to understand behavior amidst diverse circumstances. This model focuses on the locus of changed behavior based on one’s susceptibility to a phenomenon while also recognizing the related effects on their life (Gharouni, 2020). Internal and external factors combine through this lens to guide our understanding of what triggers an individuals’ health behavior - offering a focused look into how beliefs transfer into one’s behavior.

A Chinese University published their 2020 study testing the Health Belief Model for its contribution to social beliefs in an effort to recognize strategies which promote alliance with risk mitigation behavior. The study considered adherence to risk mitigation behavior associated with the four HBM factors and social axioms and concluded that “testing the applicability of the HBM has great practical significance because it can inform governments and relevant departments of proper intervention strategies” (Tong, Chen, Yu, & Wu, p. 1207). An additional

study published in 2021 focuses on the Indian state of Kerala and their perception towards the Covid-19 pandemic using the Health Belief Model approach. The study (2021) notes that “According to HBM, an increase in perceived susceptibility to a particular health problem would engage in behaviors to reduce their risk of developing the health problem” (Jose, Narendran, Bindu, Beevi, & Benny, p. 43). Yet those who identify with a low risk of developing illness related to the virus are likely to exhibit more risky behavior. “Risk perceptions influence individual protective behaviors but paradoxically, how people perceive risk is not necessarily correlated with the actual risk” (Jose, et. al., p. 43). This notion circumvents back to the model’s proclivity to understanding phenomena through a constructivist lens. The model ultimately questions an individual’s assessment of external stimuli based upon internal perceptions of health risk and related behavior.

Mask-Usage During Covid-19

In December of 2019, a new coronavirus was identified in Wuhan, China. On February 11, 2020 the World Health Organization announced the official name, Covid-19. In a 2020 briefing written by the Centers for Disease Control and Prevention (CDC) the organization stated, “the principal mode by which people are infected with SARS-CoV-2 (the virus that causes Covid-19) is through exposure to respiratory droplets carrying infectious virus” (CDC, p. 1). Based on these findings, the CDC promotes the use of self-protection equipment such as face masks in order to mitigate risk. Director Dr. Robert R. Redfield states, “Cloth face coverings are one of the most powerful weapons we have to slow and stop the spread of the virus – particularly when used universally within a community setting” (CDC, 2020, p. 1). At the earliest stages of the pandemic, experts advised against the use of facemasks by the public based upon the risk of self-contamination as well as shorting the supply for health care workers. Then, a shift in

potential benefits of masks was communicated by experts in light of protecting others against infection. The above risk communication elicited by the CDC has extended down from national, state and institutional divergent perception of consequences surrounding face coverings. Though there has been evidence of widespread international success by those implementing such risk mitigation behavior, the United States continues to face the consequences of high rates of infection as variability in the CDC's recommendation runs rampant.

To add fuel to the flame, the pandemic manifests in the highly polarized election year, adding grave consequences to the risk communication messages elicited by federal and state governments. The political conflict at hand hosted an arena of partisan perceptions of reality and truth communicated in the United States. "Behavioral change is highly contingent on the communication of risk, individual appraisal of risk, and the perceived ability to make the change" (Early Human Development, 2020, p. 2). The progression of polarized media messages and divergent community health guidelines sets the stage for an increasingly difficult public in which communication strategists attempt to formulate risk messages. The 2020 article *Best Practice Guidelines* published in Early Human Development suggests that adherence is rooted in three factors: individualism versus collectivism, trust versus fear, and obeying social distance rules (p. 3). Such sociocultural framings may begin to uncover the motivating values manifested in public health behavior.

The Journal of Health Psychology published a timely study on the complexities of masculinity pertaining to anti-maskers. Mahalik, Bianca, & Harris (2021) analyzed the relationship between conformity to masculine norms and attitudes toward mask-wearing during Covid-19 in order to address the perceptions and attitudes in an effort to promoting public health. "Men are more likely to feel stigma from wearing a mask because doing so is viewed as a sign of

weakness” (p. 2). The men’s rejection of this health practice in question is examined through the Health Belief Model, in which the researchers suggest the adoption of facemasks would be heightened by those who perceive the health behavior as beneficial to themselves or others. Additionally, the authors noted the role of confidence and perceived value of scientific health policy impacts risk behavior (Mahalik et. al., 2021). The role of anti-intellectualism that suggest scientific findings as effeminate serves as an additional factor to this neglect. Following their study the authors (2021) suggest, “research could identify what resistant groups of men value in relation to ending the pandemic to be able to frame mask-wearing as having benefits to them” (p. 14). Ultimately, reconstructing the masculinity norms within the United States was the critical suggestion posed by the researchers – a weighty plight not easily unraveled without the understanding of self-identity correlated to health risk mitigation.

Research Question

The following research question is proposed in order to guide the data collection and analysis to further examine the experiences posed by anecdotal evidence from interviewees. In correlation with the study’s phenomenological approach, the thematic schemes associated with the research question serve as a catalyst to elicit understanding during the research process and glean informative insight from the question posed.

RQ: What are risk bearer’s self-identity values of their perception of the risk related to the use of self-protection masks during the Covid-19 crisis?

Chapter 3

Methodology

Phenomenological Approach

The purpose of this thesis is rooted in a qualitative analysis – a methodology designed to study the perceptions of individual experiences. Qualitative research takes hold of concepts to propose logic. Edmond Husserl, labeled as one of the foundational researchers for the

phenomenological approach, insists, “We should not let preconceived theories form our experiences but rather let our experience determine our theories” (Davidson, 2013, p.321).

Harnessing a phenomenological approach captures authentic, anecdotal transcriptions for public relations practitioners to build on how individuals categorize meaning to their behavior. Dermot Moran and Tim Mooney (2002) suggest that phenomenology serves an unprejudiced, descriptive study of what appears to consciousness, precisely in the manner in which it appears. Lived experiences are interpreted through a phenomenological epistemology in order to uncover how individuals construct their perceptions of the world around them. This psychology tradition sets the stage for investigating the self-identity factors which serve as a catalyst for perceiving risk to determine health behavior. In this way, we aim to see things for as they appear to others.

Data collection within this approach is done through an in-depth interview strategy. Participants’ experiences reveal a phenomenon through meaning-making of their perception of beliefs and behavior. The responses to the questions are understood as perceptions by the individual, while also taking into account the nature of the qualitative approach. “There seems to have been a development over time toward a greater recognition that ‘thick descriptions’ are unavoidably conditioned by cultural, social, and interpersonal contingencies and that theory and method must necessarily be conflated” (Davidsen, 2013, p. 319). Interpersonal schemes and one’s external environment inevitably affects one’s response to their perception of reality. Theoretical nuances gleaned from this methodology take this constructivist understanding into consideration when both writing the questions and coding the responses. An interview guide structured based on the research question at hand guides the conversation in order for themes to arise. These emerging themes revealed after transcription are then compared and contrasted with the posed research question.

Background and Role of Researcher

The constructionist paradigm suggests individuals create their unique perceptions and beliefs based upon their perception of reality. In this way, both the investigator and the object of the investigation cannot be separated from their lived experiences. Insight and perception of experiences are interdependent to each member of the study, and inevitably influence the investigation. As a masters student at The University of Tennessee studying under the School of Advertising and public Relations, I write this research agenda based upon my meaning-making and perceptions of experiences. While I am unable to be denounced from my construction of reality, I am able to ensure interviews and collection thereof are held in equal regard for the benefit of authentic data collection and analysis.

Recruitment Procedure

The Covid-19 pandemic's wake has affected individuals on a global level. Therefore, the only stipulations framing the study's participation requirements were that individual's must be above the age of eighteen and identified as choosing not to wear self-protection masks. Due to the agenda of studying phenomena through emergent themes – the recruitment procedure did not limit potential interviewees based upon any demographic variables.

Public Facebook and Instagram pages created to support the anti-mask movement were utilized to publicize the study. Public posts on these pages and groups were used to recruit potential interviews. Direct messages through these social media sites progressed the progress from recruitment as the researcher then sent the consent for participation information to the potential interview candidate. Once the individual agreed to participate after reading the study and consent information, an interview time was set up. An additional means of recruitment stemmed from word-of-mouth or personal references in which the same recruitment script was

then communicated via Facebook or Instagram to inform the potential participant of the research study as well as the consent for participation information.

Data Collection

Open-ended interview questions bolstered an informal, interactive phenomenological approach to collecting data. An IRB approved interview guide served to elicit participant's perception of their health behavior given the current risk mitigation norms in their area. Interviews took place during the spring of 2021 and were conducted via recorded Zoom and phone call interviews. The data collection process occurred over two weeks, coming to a completion once the data provided theoretical saturation of the study's categories.

An IRB-approved informed consent form was sent to each participant prior to the interview, and before the interview began the individual confirmed their willingness to participate in the recorded interview. Each participant voluntarily offered to be interviewed and were given the opportunity to withdraw from the interview at any point. Each recording and transcription were transferred from a password protected computer and stored on a password-protected external hard drive. The interviews averaged between fifteen to twenty minutes, totaling two hours and thirty minutes of gathered narratives.

Confidentiality and anonymity were ensured through several safeguards. First, alternate names were given to participants. Zoom and phone call interviews were conducted in an isolated room in an empty house so that no audio was intercepted by anyone other than the interviewer. Second, transcripts from the audio-recorded interview were only available and accessed by the interviewer through a password protected laptop. Lastly, pseudonyms were used in the presentation of findings along with neglecting to use demographic identifiers: Person A, Person B, Person C, Person D, Person E, Person F, Person G. The beginning of each interview included

the interviewer re-reading the Consent Form to the participant and the participant verbally confirming their willingness to participate in the study. After the participant verbally confirmed to their willingness to the audio-recorded interview, the ten questions were posed in order to focus on their experience and perception of risk mitigation measures and norms surrounding self-protection face masks.

Table 1 displays the correlation between the research question theme of self-identity and one's health beliefs and the questions asked during each interview. Each question was written specifically to glean experiential data from individual's perception of the Covid-19 pandemic and facemasks specifically through the lens of behavioral intentions, attitude towards the norm, perception of social role, and perception of risk.

Table 1. Correlation between research question theme and the interview questions

<i>Research question theme</i>	<i>Interview Questions</i>
<i>Self-Identity</i>	How are you doing considering the Covid-19 pandemic? How has that affected your life? How do you communicate your choice to refrain from wearing a mask? How would you describe your role as someone who chooses not to wear a mask?

<i>Perception of Risk</i>	Describe your daily life outside the home. In what locations do you wear masks and why? Describe your thoughts when the mask-mandate was first communicated. From what source did you hear about wearing face masks? (Family, News Outlets, Friends, or Other) Did your mask-wearing behavior change at all between the Spring of 2020 and Thanksgiving/Christmas holidays? How do you view mask-wearing behavior?
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Data Analysis

The phenomenological approach in this study elevates the notion that the whole is greater than the sum of parts. In this way, the transcriptions from interviews are interpreted from their entirety rather than any single phrase or quote from an individual. Deriving meaning from the anecdotal evidence provided by participants requires phenomenological reduction - a thematizing analytical tool which examines each piece of data with shared gravity. Clark Moustakes (1994), a student of Husserl, promotes the strategy within transcendental phenomenology – a process which relies on internal experience of consciousness. The two central questions posed by this

analysis schema are a) What are their experiences b) In what context or situations did they experience it? This research method for data analysis involves seven steps:

1. Discover a topic and question rooted in an experience or phenomenon.
2. Conduct a comprehensive review of the professional and research literature.
3. Construct a set of criteria to locate appropriate co-researchers.
4. Provide co-researchers with instructions on the nature and purpose of the investigation.
5. Develop a set of questions or topics to guide the interview process.
6. Conduct and report a lengthy person-to-person interview that focuses on a bracketed topic and question.
7. Organize and analyze the data to facilitate development or structural meanings and essences.

The initial step in the data analysis stage took place after the audio-recorded interviews, where transcriptions were made through both the Zoom software and manually after each phone call interview. After each interview, the transcriptions were downloaded and edited for accuracy after re-listening to the recording to correct any technical or auditory glitches that may have blurred or tainted the response. After transcription, the thematic coding process began. The phenomenological approach calls for the researcher to return to an experience for comprehensive description without making suppositions, but rather tunes in to the anecdotal evidence with a fresh naivety in which to evoke results (Moustakas 1994). As the transcriptions were reviewed by the researcher, every word and statement were regarded with equal deliberation and consideration. Relevancy to the research question and thematic schemes proposed for study were then used to decipher which information would be deemed as relevant data. A google document

was used to take key quotes and phrases from the transcriptions onto one document in which anecdotes pertaining to each of the ten questions were able to be assessed by their similarities.

This final stage of analysis constructed meanings and experiences by differentiating the realities expressed during the interview while labeling and categorizing from an inductive method – from one experience explained for all. Coding consisted of comparing each interview question between the seven participants for all ten posed questions. As similarities emerged, categories were assigned in order to illuminate shared ideas from participants' responses. Repetitive phrases and categorically significant themes were then collapsed together for emerging experiences and perceptions to rise from the interviews.

Chapter 4

Findings

The research question seeks to uncover the self-identity values linked to their perception of risk related to self-protection masks. Two essential phenomena are at play in the research question: self-identity and people's health beliefs. These two essences reveal four themes which led to the formation of the ten interview questions: behavioral intention, attitude towards the norm, perception of social role, and perception of risk. The deliberate construction of interview

questions served as a tool to analyze the emerging patterns from narratives elicited by the seven research participants. These patterns of responses provide results of the “me” identifications at play within one’s perception risk related to wearing a mask during Covid-19.

Research has commonly linked the perceptions of self-identity with how individuals are motivated to behave. Within identity theory, researchers recognize that in order to understand action and predict behavior, it is crucial to understand the self and the wider social structure as being inextricably linked (Terry, Hogg, & White, 1999). By examining how the self is influenced by the macro-level of social norms, the self is able to be interpreted by its role as a character in social behavior. From the perceptions of self-identity, we evaluate the collection of identities that reflect the roles in which a person occupies in a social structure (Terry et. al., 1999). During the course of asking participants questions surrounding both their own cognitive appraisal of identity and social perception of health behavior, several repetitive themes arose within each narrative.

The six emergent themes revealed through the interviews include the following: (1) relational connection, (2) mask efficacy, (3) human rights and freedom, (4) role of advocacy, (5) perception of fear tactics, and (6) individual responsibility. The following sections expand upon the studies six crucial findings through participant quotes.

Relational Connection

During the interviews, participants revealed their perception of how they are doing considering the pandemic. A massive thread weaved among their responses revolving around a common theme of relational disconnect and a fracture in their social environments. The majority of participants communicated their even-keeled temperament over the course of the past year, yet touched on how the ripples of socially distant expectations manifest in their life.

In an interview with Person D, their narrative on the past year during the pandemic reveals how they and their partner's value of community relationship has been a key perception of their experience. From their vantage point – a major effect of Covid-19 has revealed itself in their ability to meet and gather with friends. Person D states,

I would say personally, we're doing fine. I've been at work the whole time, I've never worked from home at any point - so our business never shut down and everything, so it's all been okay as far as that goes. The only thing in my viewpoint that's been disappointing is all the things, the events, the places etcetera etcetera that have been closed down during this time. We were unable to do, or, unable to go and do those kinds of things so it puts a little added stress on us because we don't have our releases, our outlets. We've at least been able to get out and do things and meet with people where I know there's been a lot of people that have been really locked up. And in this case, both me and my wife were both out in the work force and working. She's a respiratory therapist at one of the hospitals, so we've been out the whole time. It's affected us because we can't do some of the things we want to do, that's really been about it.

A similar theme emerges in an interview with Person B. While they consider how Covid-19 has impacted his life, they compares their previous routine with how they finds themselves connecting with community currently. Person B explains,

It's affected my social life, that's for sure. It's hard for me to connect with certain people because a lot of those people I was connecting with were at bars or clubs. And I was very much so into the night life, so that has changed a lot. I work full-time, but when I'm not at work, I'm either working out or hanging out with a

friend or two. I don't hang out with a huge group of people, but like a friend or two at a time. I mountain bike, I go out to eat a lot, I still try to have as much of a social life as I can ... I don't just sit at home.

While some participants revealed a relaxed temperament as if nearly untainted by any ripples of Covid-19, the interview with Person G sheds insight into a more critical perception of the affects still looming over their life. Person G describes,

At this point, this far out a year later, I will say that I am really over it. I'm over the masks. I'm over the fear factor from all different party lines. I'm just tired of the combativeness and divisiveness that it causes. And I'm part of that, you know. I say I'm tired of it but I'm also part of it - so it's a little hypocritical. I can't get connected - and that makes me angry. My kid is going to a new school and I can't get connected with the community to help us get connected and it has affected us greatly. We moved to neighborhood to be closer to his school and be involved with the community and school and because of Covid-19 we can't do that.

I'm thankful that he's been able to play football but at the same time it's been hard to meet the other kids and their parents and help him develop friendships that carry him through high school. It's been so hard that we feel as though he may need a school change where we know people and have a smaller environment.

Their comments add insight into some crucial evidence pointing to the self-identity values of family and community that she perceives to be at risk due to the pandemic's impact. In their interview, Person G identified as being an extremely community-oriented individual who makes a point to meet strangers. Their frustration largely stems from her lack of access to form and grow in their family's new community. The same thread of familial impact emerges in a

comment from Person C. They are also a parent, and recounts how the wake of the pandemic has placed massive implications on their young children's life. Person C describes,

It's not fun being inside a house. I've got two small children as well, my youngest was born just before Covid started, so he's none the wiser. But my four-year-old, he wanted to go to nursery - he was meant to start his daycare in April, so he missed out on so many months of his education when every morning he was waking up and saying, "Mom when am I going to go to school, when am I going to see my friends?" You know it's hard to say, "Well you can't because this and this..." they don't understand that. They just see, "Oh we're not allowed to go outside, we have to stay inside." It's not something you can easily explain to a child it takes a toll on your mental health and being in lockdown, like we've been in lockdown pretty much since March of last year.. It's not healthy things. So, as most people are feeling it mentally, you know.. It's not good.

Insights from these conversations reveal how the lack of relational connection is an amplified theme throughout interviews. From these findings, it becomes apparent the anecdotal evidence portraying how relational connection with one's social sphere serves as a catalyst to risk mitigation behavior. While further findings will point to the gravity of how self-identity inevitably clashes with the threat's perceived in one's external environment – it is pertinent to notice how the participants first reveal how their social life has been tainted due to the effect of Covid-19. This first key finding from the study lends situational evidence towards the risk-bearer's perceiving a major effect of the risk of Covid-19 limiting their access to their valued friendships and social routines.

Mask Efficacy

As previously described, self-identity perceptions seek to uncover the factors in one's life which construct their perception of reality. The research question seeks to unravel risk-bearer's self-identity values within their perception of risk – a paradigm approach seeking to determining the meaning, validity, reason, rationality, and truth within a particular cultural setting (Fisher, 1984). Each of the interviews intended to capture how these risk-bearers identity values colliding with their perception of wearing face masks, and a massive finding which emerged through participant interviews was their lack of belief in the efficacy of facemasks and their ability to mitigate the risk of the virus. Health belief literature details the three underlying components determining whether one would administer risk mitigation behavior: (1) that they were personally susceptible to it, (2) that the occurrence of the disease would have at least moderate severity on some component of their life, and (3) that taking a particular action would in fact be beneficial in order to reduce the susceptibility to the condition (Rosenstock, 1974). Ultimately, findings reveal participant's lack of trust in the ability for face masks to reduce their probability of contracting the virus.

The following accounts illuminate the common theme of the participant's overall lack of belief in the efficacy of face masks and how their choice to refrain from wearing a face masks is rooted in their doubts of the mask's ability to mitigate the threat of the virus. Person E explains their perception on the efficacy of face masks in the following comment,

I personally I haven't really bought into the whole mask thing - the whole double mask thing because there's not really a lot of - I mean there's a few here & there - but there's not very many scientific or medical studies that show even wearing one mask helps. There's none that really support it, there's none from medical

professionals in my personal research on it. I don't ever and the reason behind that is I feel the reason to build up antibodies, which I already have antibodies because I had the virus, and it passed in three days - but I mean I don't where one because to even build up immunity against the virus you have to be exposed to it. Again, that's what we've done since the dawn of time as human beings. That's how you build up immunity to it. And then all of a sudden, they want to wear masks and gloves and act hysterically against other human beings living their life now is beyond me. It's a political agenda, but again, that's a rabbit hole.

Each of those interviewed stated at some point how their research has influenced their lack of confidence in masks. Person C was the only participant who had a change of behavior from the initial mask mandate. During her interview, Person C revealed their initial stringent mask-wearing behavior and how the paranoia over choosing which mask to wear which crippled their mental health. Person C explains,

I've watched so many videos on the masks because I wanted to do the best thing and wear the best one. And they were all put to the test and all of them, when you talk, or you breathe, your spores are coming out of them. Even with the medical grade ones.

While Person C's experience points to the evolution of their choice to stop wearing face masks, Person D explained how they never chose to wear a mask unless required of them at their job. They sheds light on his perception of face mask efficacy with an anecdotal metaphor portraying their disbelief in the suggested risk mitigation effort. Person D states,

First of all, I don't think masks are effective. There was a study done by the Association of Surgeons and Physicians that say that the only mask that was

effective in blocking the Covid-19 virus from being transmitted was surgical grade M95 masks. Anything else that we have does not work - does not stop the virus from getting in or being transmitted in any way. Now, the next example that I usually give is that if you go to get your haircut, and you wear your mask - do you usually end up getting hair inside your mask? About 99% of the people will say, "Yes." And I tell them, "Okay, the Covid virus is a lot smaller than a follicle of hair. So, it just goes to show that it's not a very effective operation." Now the third thing is if masks really worked, and they really did everything that they wanted it to do - then why haven't we been wearing masks for the last fifty years during flu season?

Person G goes as far as to say that face masks only serve to heighten one's chance of contracting the virus. Person G describes,

I don't believe they really work, because I find that for me and the other people that I talk with - everyone hates them. You can't breathe, you can't see, you can't hear. It hinders your ability to fully communicate and be present because I feel distracted because I'm fighting it. I feel myself touching my face more than if I didn't have it on. I'm a big girl I can wash my hands, I don't really need a mask to protect my body.

The interview with Person F mimics Person G's stance that their health behavior may have changed if the proposed risk would decrease likelihood of the virus' transmission. Person F suggests,

I don't actually think it helps that much - if I really thought it was going to keep me from getting it or keep me from giving it to others, I would be more gung-ho about it I just don't think they actually work that much.

When asked how they communicates his choice to refrain from wearing a mask, Person A recollects on a previous experience in Walmart and states,

Usually, I get confronted by someone who is very militant. I have to bite my tongue and take a deep breath so I'm not slapping the ever-living crap out of them and then I have to look them in the face and say, "Sir or ma'am, I am medical and religious exempt. I am exempt from any mask wearing." If they ask me if I need a mask, I usually turn to them and say, no actually no one does. And I just keep walking and that's it. A lot of the time at Walmart you get people screaming, "SIR! SIR! SIR! DO YOU HAVE A MASK?!" I just keep walking - I ignore them. Then all of a sudden you hear this thing over the loudspeaker and then somebody tracks you down. And I say, "Look around you, look around you. Everybody is wearing a mask, if one person comes in here not wearing a mask, there's got to be a reason, right?"

Human Right and Freedom

The combination of explained theoretical perspectives from the Health Belief Model and self-identity set the stage for how the participant's perceived the internal steps leading to the decision to refrain from wearing a mask. A high value of independence in congruence with government mandates emerged as the leading motivation behind their health behavior. In the United States, federal and local entities mandated the use of self-protection masks within public

settings such as grocery stores and restaurants – failure to comply to this mandate had the potential to deny citizen’s access to an establishment.

In the following anecdotes, the participants were asked to recall their thoughts when they first heard messages surrounding the government-supported mask mandates. Person reflects on their first time hearing about the mask mandate and their impression of the risk communication. According to Person A,

The mandate was by the governor and my first thought was, you don't have the right to tell us these things. You don't have the right to mandate anything to the people. This is a government of the people, by the people, for the people. Not of the government, by the government, for the government. We are your boss, you don't tell us what to do. That's how it works for the United States of America. If it's for my own safety, then I will determine whether or not I want to do something for my safety. Okay, I won't wear a seatbelt. Just because you say I should or will fine me if I don't, well it's my vehicle, my life, my choice. And me not wearing a seatbelt isn't going to affect anyone else. I was just watching our governor's press conference and in the comments, people are saying.. “Please lift the mandate! Please lift the mandate!” And I'm like, no he doesn't have to lift anything - just stop obeying him. You are under no obligation to obey a government official. Your civil rights, your constitutional rights, your human rights don't end when anyone says there's an emergency. As a matter of fact, they get stronger. It's all political. They believe that this mask is some magic shield, but it really just makes them sick. These people who have prohibited me, well

they're going to get lawsuits. You can't violate my rights; you can't violate anyone else's rights.

Person A's depiction of how they fall under the government's expected regulatory code is repeated in the interview with Person B. One key component throughout the findings within the value of human rights and freedom emerges as the interviewees explain their perception of their human rights as it clashes with other's perception of the same mandate. Person B further explains how they communicate their choice to not wear a mask by describing,

I typically say you know, "It's not a law, no one really has the right to force you to wear a mask. This is America at the end of the day, we're a free country." And I feel like it's a choice. Store policies and people's personal beliefs are not above the mandate and they're not above the law so.. I know my rights and I'm not rude and I'm not a jerk about it. If people really are perturbed about it, I'll just leave the establishment. I don't fight with them because if that's how they are going to act I don't want to give them any money.

This instance of a form of peaceful protest is a cohesive theme throughout the interviews. Every individual spoke on their desire for peace and intention to steer away from public conflict. Person C considers what their response would be if asked why they was not wearing a mask. Person C concludes,

If I was to have that confrontation, I would just say that I'm exempt. And if they ask why I'm except - well they can't actually say that. They don't have a right to ask. At the end of the day, I'm doing it for my mental health.

Person C continued on to describe their disdain for how the government mandate began to play a massive role in her mental state. After nearly a year of fretting over which mask to

purchase and wear, and constantly staying up to date with risk communication surrounding the type of number of masks to wear – they stopped wearing one. Confrontation on their mask choice has not been a leading issue for Person F. They recall when they first heard of the mask mandate. Initially, the government instruction was not perceived as a threat to them. But the evolution of misinformation eventually swayed them stance on mask-wearing. Person F recalls,

I think the mandate came out when things were a little dire, so I thought, “Okay.” But at the same time because of my political beliefs - I wasn’t against not wearing masks, I mean I thought it was a good thing at that time, but I wasn’t so much in agreement that the government should be forcing people and that you have to. At that point I feel like everyone was on the same page and people were doing it willingly. I don’t have a problem with them saying “We highly suggest you doing that,” but the idea that it’s a law and required of you? To me, kind of was overstepping their reach. I just see it as my freedom to have a choice and based off of what I’ve read, I just don’t think it’s that big of a deal. I’m not judging you for your choices, why are you judging me?

There appears to be an evolution of perception gleaned from Person F’s recollection of their first memory of the mask mandate communication. Initially, the mandate served as a necessary tactic to dampen the health threat, yet as time went on Person F perceived the mandate infringed about their rights. The consistent thread of libertarian rights rooted in the American culture is extensively reiterated throughout the narrative of each participant. Political ideals suggest a massive factor of one’s self-identity, freedom - a seemingly integral component to what drives and motivates decision making.

Role of Advocacy

Self-identity encapsulates a dynamic facet of constructive perceptions both looking into oneself and outwardly into the environment around them. Role identities revolve around the action taking place, and therefore serve as one's set of expectations as to what the appropriate behavior is for that given role (Terry et al., 1999). In an effort to uncover how each individual perceived their role to society, they were asked to speak on how they believed their choice to refrain from wearing a mask impacted their social environment. Across the board, participants revealed a hope that their public display of divergent behavior would spark enlightenment in those watching. Person A's underlying theme in his narrative was the importance of research. According to Person A,

I am going to speak out against the practice and share whatever scientific data I can - I guess you could consider that a role in a way. If you know better, then let me know.

Similar to a beacon of information, Person A continued to reveal their value of truth seeking and continually being a critical analyzer of media and research. Person C spoke on this notion of acting against the cultural norms, specifically on the way they expect others to view their choice to not wear a mask. Interestingly, Person A's role of information sharing is parallel to Person C's narrative which elevates a value of sharing her lack of trust in the use of facemasks. Person C states,

I hope that when people when they see me now, they question why they are wearing a mask. Because obviously it's like a thing now. It's like if some celebrity gets something and everyone wants to follow that celebrity – it's almost like that for me. And we've just gone into something so blindly and people have

just been like a sheep. You follow everyone in front of you. I hope that if someone sees me and question me like, “Why are you not wearing a mask?” I’ll just be like “I’m just not. Because it’s not worth it. My mental health is more important.” I hope that it makes people question why they’re making that choice.

In the plight to inform others of the lack of efficacy of face masks, Person D states,

I would have to say, if there is a role, it is to point out the lies and hypocrisies that is being perpetuated upon the American public - and the public around the world. Because again, I don’t believe that its effective - I believe it’s all being done to keep people scared, to keep them afraid, to put people in a position where people in power have control because we’re being told we need to wear masks. So, I guess my viewpoint would be that as a person who isn’t interested in wearing a mask and will only wear a one when I absolutely have to wear one to go into a store - I hope I can at least bring up ideas and bring up things for people to think about when it comes to the mask. And people will start to be able to say, “Alright maybe he’s got a point here. We need to investigate, and we need to look into this.” So, I just lay out my opinions and point people to some of the directions where I get my information from then say please investigate for myself.

This plight to inspire others to change their mask habits reveals an evident value of advocacy for others within one’s self-identity. Both Person D and Person G share the goal of leading others towards enlightenment and empowerment. Person G explains,

Because I don’t wear a mask I feel like it empowers other people not to wear a mask and not walk in fear. But also, to take care of their bodies and be stewards. It’s a strong belief of mine to be proactive instead of reactive. So, if I can

empower someone not to be fearful but to be healthful and take care of their bodies then that's how I see it. Empowering others to not walk in fear and exercise my right as an American and not take it for granted.

The above narratives pointing to a perceived role of advocacy illuminate a self-identity characteristic of value and elevation of others. A common advertising theme amidst risk communication surrounding risk mitigation tactics during Covid-19 revolves around caring for others and putting others above your personal comfort. Ironically, the individuals revealed in their descriptions the willingness and plight to communicate perceived empowerment. From this finding, there is a noticeable shift from the original label of “risk-bearer” to a “risk advocate.” The narrative paradigm offers insight into the different characters amidst risk situations, pointing towards the role of risk advocates who serve as the agents seeking to resolve conflict based upon their research and information from the risk researchers (Palenchar, Heath, Robert, Levenshus, Lemon, 2017).

Perception of Fear Tactics

An evident theme trickled throughout the interviews was the participant's perception of tainted risk communication efforts. In the same vein of one's rights and freedom – participants spoke on how they viewed the government's mandate to wear face masks in public areas. During the year 2020, an abundant amount of local and federal government and corporate organizations communicated the important of wearing a mask – typically revolving around a collective mindset of protecting oneself and those around you. The collective interviews provided a major finding that the risk communication efforts to wear a mask was perceived as a fear tactic to keep individuals and the United States of America stagnant. Person A's commentary reveals their

dismissive tone of the health crisis as well as the reasoning behind the faulty claims of the supposed health crisis at hand. Person A reveals,

First of all, I have to disagree that there's a pandemic. That's based off of science, critical thought, and deductive reasoning. I never doubt things unless my questions cannot be answered. I'm not one of those tinfoil hat wearing conspiracy people, I just have questions that have never been answered. I'm pulling my hair out because I'm seeing blatant propaganda. I'm frustrated. People don't take the time to do their own research. I question everything someone says on the TV. When I hear something on the TV, now I know automatically if it's a lie or if it's the truth. So it makes you wonder you know, before all this stuff happened, when I was believing what people said on TV, were they lying to me then? Because I wasn't doing any research then. You've got to ask that question - how long have they been lying to us?

Person A further explains that the propaganda he refers to is the insistence from government officials of the critical health concern in the United States. From his vantage point, the mask mandate is solely an intimidation tool used to quench the strength and resources of the United States. Person G too, explains how fear is driving people to wear masks. Person G states,

I'm over the fear factor from all different party lines. I'm just tired of the combativeness and divisiveness that it causes. And I'm part of that, you know. I say I'm tired of it but I'm also part of it so it's a little hypocritical. When you see someone in their car alone wearing their mask you pretty much know their party line. It's kind of comical to me. I really see a great divide - I see people who are still so pro-mask even still at this point although the vaccine is coming out and

becoming a central focus. But I see a fear factor - there's just such fear in wearing the mask and I even find it in myself that when I wear it, I feel more nervous.

The notion that the media is purposefully driving a narrative of risk due to the virus is an exhaustively held perception among participants. The election year of 2020 created a perfect storm. One's choice to wear a mask or not wear a mask was assumed to reveal one's political identity, and the arguments for or against blended effortlessly into the perception of self-identity. Understanding the aspects and themes pertaining to the individual-self allow further examination into the collective identities that inevitably form out of behavior, and eventually reinforce one's individual perception of illness and health (Spini, 2001). The perception of fear is linked with political schemes as explained by Person E's quote,

I also feel like the mask mandate was more of a political agenda more than anything. I think they pushed it on people to achieve some goals and make some money. I mean that's my view on it - I don't buy into it at all. I mean, why is it that after millions of years of human beings living on earth, letting our bodies build antibodies to the common cold and the flu – really any disease or infection - and exposing ourselves to it, then continuing on with normal life? And now all of a sudden, this virus is “completely different” and we have to wear a mask everywhere we go. It's giving people this power trip - refusing people to come inside stores and to shop and stuff. I think the whole thing is ridiculous – it's all a big theatre.

This notion of a theatre perpetuated in the media is a shared assumption of Person B. Person B recalls when the mask mandate was first communicated, where they first heard of the protocol, and how they perceived this risk communication. Person B reveals,

It was definitely from CNN. They were very, uh, I'm trying to think of the right word - confusing. What they were putting out in the media was very misleading. One day it would be you need to wear a mask, and the next day they would have a doctor on there saying healthy people should not be wearing masks. So, I remember that very early on - the misinformation that was being put out by the mainstream news. To me, it was the first step of trying to get people, you know, I think it's a control tactic. It's a fear tactic at the same time. I feel like they don't really know what to do. And that's one of the things that they're trying to force because they know people will do it and not ask questions. It also makes me sad because people are still so afraid of it, and it definitely is a security thing. It's just sad that the country is living in that much fear, and not that it's not all warranted because it is a scary virus and all sorts of things. Not that it's all false fear, just that people are living in so much fear.

Person B revealed during his interview that they had in fact had Covid-19, a re-occurring factoid in participant conversations. Therefore, several individuals attested the validity of the virus yet explained their perception of the disproportionate communication and expectation surrounding the need to wear a face mask.

Individual Responsibility

In an effort to uncover the perceptions associated with health behavior perceptions, participants were asked how they viewed mask-wearing behavior. The Health Belief Model suggests that a person's beliefs about the effective course of risk mitigation action aside from objective facts about the effectiveness of the action determines what course of direction one will take (Rosenstock, 1974). When recalling the model's three beliefs motivating health behavior, it

becomes apparent that the subject interviewed demonstrated a low perception of susceptibility paired with an individualistic rather than collectivist value on health responsibility. The overarching response revealed both the notion of independent responsibility for one's level of health and a respect for other people's decision. Person E responded to the interview question probing what their perception of mask-wearers was and elevates an individualistic mindset.

Person E states,

If that's what makes you feel better and that's what you do to protect yourself - by all means, go right ahead. It doesn't bother me when people wear a mask. But it does bother me when someone tries to force me to do something that I don't want to do.

Most narratives elevated a value of respect for the choice to refrain from wearing a mask. The concept of "you do you" was an echoed stance throughout. Person G's perception on the questioned health behavior is closely linked to their self-identity value of individual responsibility. Person G recalls,

Honestly, I was angry when they said we had to wear masks because I don't believe in them. I think people should be responsible for their own health and if you are concerned with getting sick there are lots of options for you to continue to live a life and have all the services, groceries, and all the things you need to have done. But I feel like it infringed on my right as a human being to make choices for my own body. When I say my own body, I mean my own health - I don't mean that in a pro-abortion way. I mean it in a "This is my own body and I'm taking care of it." It is my responsibility to take care of me. And I take care of my body -

I feed it healthful foods and supplements and I make sure that I maintain a certain standard of health.

Similar to Person G's expectation of owning your health state, several other conversations revealed a perception of flawed argumentation continuously repeated in risk communication – wearing masks to protect others. This negation of a collectivist mindset is revealed in Person E's personal way of navigating dissent from mask-wearers. Person E states,

People say, "Oh you're murdering someone because you're not wearing a mask."
 laughs Ha, no I didn't make their blood pressure high - I didn't make them have diabetes – that's not me murdering somebody, that's just living life. That's natural selection in my opinion. The weak die, the strong survive. I mean, that's the way it's always been. That's a very dark, morbid way of looking at it but at the same time that's also just life. If I get cancer tomorrow and die because of correlations to my high blood pressure, that's no one's fault but my own. It's not my responsibility to coddle someone else because they've made bad decisions throughout their life.

The leading value of individual responsibility is illuminated in Person F's response to how they perceive mask-wearing behavior. Furthermore, they describes an environment in which they yields to their value of individual responsibility for the sake of respecting a perceived authority in their social life. Person F explains,

But also, I think that there are some people that genuinely believe that what they are doing is the right thing and I totally respect that. I would never want to look down or make anyone feel bad about not wearing a mask. The way I see it it's

your personal choice to wear one or not. Even though I don't think they help and I'm not personally going to wear them. I'm not going to look at people who are wearing them and say, "Oh you're such an idiot." Especially with my church, even though I wasn't super excited, I knew the place where they are coming from is a place of caring and to be sympathetic to our neighbors and such. So, in that case I'm much more willing if that's what the leadership is asking me even if I personally don't think that we should or that they actually help that much. I just take a very libertarian view - it's a free country, it's a free will. If that's what you want to do and that makes you feel safe, then go for it.

From Person F's comment there is evidence pointing to the catalyst capable of provoking divergent behavior from one's desired risk behavior. Their self-identity value of supporting the congregation's security reveals a noteworthy divergence from their overarching belief in individual responsibility within health behavior. Individual beliefs are inevitably influenced by the social norms and pressures within one's groups. This creates a conflict between perception of susceptibility to what others regard as a serious threat and in independently held conviction that the promoted risk mitigation method is useful (Rosenstock, 1974). Further discussion allows a tangible glance into how individualism collides with the collective values of one's culture.

Chapter 5

Discussion

The findings from this thesis provide further insight into the self-identity themes contributing to risk bearer's perception of risk mitigation behavior. The interview questions analyzed involve both interpersonal and social perceptions illustrated by (Stets & Burke, 2000)

identity motivations. Their (2002) theory is echoed in this study's findings that our social identities motivate individuals to perform risk mitigation tactics which help people (a) feel like they are part of a group, (b) behave in accordance with a desired role in the group, and (c) increase one's evaluation of identity of chosen group association. The interviews elicited one's perception of self, alongside their perception of how others may view their behavior. The dynamic perceptions within self-identity revealed ample supply of how the participants noted their interpersonal values amidst neglecting to wear a face mask as well as how they perceived their health behavior on a social level.

Political Polarization Impact on Risk Communication

Fowler and Gollust (2015) promote that the politicization of health manifests while political cues or symbols dynamically weave into the public narrative of the politicized health issue. This thesis reveals the extensive lengths to which the symbols of a face mask has surpassed a mere risk-mitigation tool, and into a threat of one's interpersonal values, political beliefs, and human right. From this, we recognize how Americans interpret the politized risk mitigation tactic of wearing a face mask heuristically through this lens of a political motivation. Interpersonal behavior motivated to bolster and reinforce one's social identity is a conceptual notion supported by self-identity literature and abundantly evident in the findings from participant interviews. The health communication crisis imploding during Covid-19 suggest the identity-driven decision making dictating an individual's risk prevention strategy. The political disparity has been heightened by social and cultural differentiation in the United States, and therefore party members grow increasingly homogenous in order to bolster one's self-identity values. The ideological health spirals model (Young & Bleakley, 2020) echoes this understanding by promoting a framework integrating political and health communication to

account for health behavior within a politically divisive social construct. The extensive media coverage surrounding the pandemic evolved as uncertainty of the virus began to rest in the projected truths from party narratives. This model suggests that the process is cyclical – understanding how beliefs result from reinforcing identity values through interpersonal networks and media selection (Young & Bleakley, 2020). The ever-growing chasm of political party divide surpasses policy dissention – but transforms into factors correlating with one’s social identity. Social identity theory (Tajfel & Turner, 1979) lends credence to the conversation of political science and the ways in which individuals categorize themselves inside groups which they belong.

The interviews illuminated participant perception of political over-step within risk and crisis communication. Over and over again the intrinsic self-identity value of freedom and liberty were perceived to be increasingly threatened by a political agenda. This has phenomena is analyzed in the New England Journal of Medicine as Dr. Rosenbaum speaks on bridging the partisan divide amidst the Covid-19 communication discrepancy. In their recollection of the federal government’s initial failure to unanimously inform the United States public on the efficacy of facemasks, she remarks on the massive toll such initial risk communication impacted divergent health behavior. “As easy as it is, then, to retrospectively criticize the initial lack of transparency regarding mask wearing, could even the most crisis-savvy communication have changed the outcome? Probably not” (2020, p. 1683). The political turmoil toppling the risk management of the Covid-19 pandemic is a sharp contrast to the partisan advice found during the 2009 epidemic. The previous health crisis of the H1N1 influenza has been retrospectively integral in understanding the degree to which the Covid-19 crisis communication has caused widespread distrust. “Masks have become a flash point in our culture wars; a symbol of either a

commitment to public health or an infringement on basic liberties, the mask encapsulates the politicization of science” (Rosenbaum, 2020, p. 1683). The risk communication associated with face masks has been absent of consistent, nonpartisan expert advice – only serving to ignite the fire of perceiving the fear tactic narrative elicited in earlier interviews.

Libertarian Ideology within Health Behavior

The libertarian attitude argues that state’s laws and government solely exist for the benefit of the citizens which they serve – an individual person is considered the unit of value, and one’s liberty as the factor contributing to thriving (Iyer, Koleva, Graham, Ditto, Haidt, 2012). This moral mentality can be associated with the differentiation between an individualistic versus a collectivist predisposition. Anecdotal insight gleaned from participant interviews elevate a value of individualism which clearly plays a massive role in determining risk mitigation behavior. Social psychology is keenly attuned to which factors serve as a catalyst strong enough to provoke deviance from a perceived collectively held norm in society. The widely communicated and obeyed mandate of face masks during Covid-19 has elicited a socially poignant conversation on the perception of one’s health behavior. Those who have made the choice to refrain from wearing facemasks during the pandemic have been widely criticized for their seemingly selfish choice. When the divergent behavior in question violates a shared expectation, the individual is often perceived as endangering the collective values of the community or social environment (Marques, Paez, & Abrams, 1998). The self-identity value of maintaining an individualistic construct of meaning suggests a saturated theme illustrated by anti-maskers in the United States. Typically criticized for their individualistic value system, those who refrain from wearing face masks have been met with massive disapproval from the majority of institutions and businesses driving the narrative of a collective responsibility. Yet,

the anecdotal evidence previously shared reveals how the libertarian self-identity value is used as shield from those acting against the tide. The elevation of individual liberty and personal freedom appears to be a strong enough identity value to withstand the pressure and disapproval of the collective.

The theme of elevating one's health as an individual responsibility further bolsters the finding of how the libertarian ideology may dictate health behavior. "Libertarianism has historically rejected the idea that the needs of one person impose a moral duty upon others" (Iyer et. al., 2012, p. 2). This self-identity characterization is widely visible within the narratives elicited in the previous findings. The individual's studied revealed a consistent aversion to the government forcing moral standards onto its citizens, and perceived advertisements projecting every American's mandate to wear a mask for the sake of others as massive concern threatening one's individual liberty. The role of the libertarian attitude is an example of an individual's ideological self-identification; the intertwined themes of personality, values and political ideology of a libertarian revolve around the notion of endorsing the principle of liberty as an end, and devaluing the typical, normative moral concerns endorsed socially (Iyer, et. al., 2012). From this it becomes apparent how individually held assumptions of personal freedom play a tangible role in how one chooses to mitigate risk for the sake of a collective body.

Insight for Practitioners

An individual's self-identity values play an integral role in shaping perception and motivation behind health behavior (Rosenstock, 1974) as revealed by this thesis. The illustration of narratives displayed within the interviews provide insight into the how the industry of public relations seeks to manage the relationships between publics and stakeholders. The following

suggestions provide insight for practitioners whose role involves risk communication and health behavior.

The proliferation of health and science narratives that have inevitably become an increasingly politicized topic in the United States has required communication scholars to begin to address both the nature and implications of this phenomenon. Specifically speaking, practitioners would be advised to assess “how partisan message frames surrounding health and science shape new coverage as a result of journalism’s bias toward drama and conflict.” (Gollust, Baum, Niederdeppe, Barry, & Fowler, 2017). Practitioners would be advised to prioritize environmental scanning for an organization – consistently soaking up the current environment of publics and stakeholders with a futuristic glance at potential issues down the pike. The ability for public relations practitioners and health communication strategist to recognize the interloping phenomena of how self-identity perceptions potentially clash with cultural norms will better suit message strategist to design campaigns that offer a more fine-tune approach to relationship management.

Additionally, a developed understanding of how the ideological health spirals model (Young & Bleakely, 2020) manifest in the public relations and health field will encourage practitioners to think holistically about the relationship between individual-level characteristics on the one hand, and political, media, and sociological context on the other, in shaping an individual's likelihood of engaging in discrete health-related behaviors. Contributors to the industry must elicit a willingness to anticipate and manage stakeholder perceptions in a way that caters to how an interpersonally constructed phenomenon compares and contrasts with the collective group associations. Tom Nichols authored a book *The Death of Expertise*, highlighting the rejection of science that has shaped a culture of advocating for autonomy. In her 2020

writings, Doctor Rosenbaum recalls a conversation with Nichols and his statement, “Once beliefs become fused to your sense of personal identity, they become very difficult to shake” (2020, p. 1683). From this understanding, it is imperative for practitioners to recognize how the psychology of an audience (Ferguson, 1999) considers the hierarchy of how beliefs, attitudes, values, and needs crucially impact how an individual perceives and responds to a given message. Practitioners must therefore take into consideration that identity values of their given audience and construct messages and campaigns based off of their attentive environmental scanning not only to examine the environment of today – but also to predict the audience’s tomorrow.

Chapter 6

Conclusion

This thesis reveals the intricacies of thematic schemes within self-identity, which illuminate under the context of how individuals perceive themselves and other’s health beliefs and choices. Since the proliferation of face-mask mandates in the United States and globally, an ample number of perspectives await researchers and industry professionals will inevitably

account for data providing further understanding into how publics warrant decision making. Specifically, the industry of public relations and health behavior will progress with a heightened sensitivity towards how people's experiences amidst risk communication dictate meaning making interpersonally and from one's social environment. Findings suggest that the self-identity themes associated with how one perceived health behavior is determined by perception of the risk, the perceived efficacy of the suggested risk mitigation tactic, their value of individuality, and their construction of social role.

These findings mimic literature from Syngg and Combs (1949) suggesting that self-identity be understood as a nucleus of an individual - dynamically weaving one's values within the broader realms of groups and the culture at large. The study's finding pointing towards a value of individuality is parallel to the (Stets & Burke, 2000) paradigm which qualifies self-identity as the "me-identifications" which construct an individual's personal values and ultimately their behavior. Several of the participants revealed this type of strongly held value as seen in their libertarian ideology. This explicit "me-identification" provides an example to how the construction of their perception of the mask mandate contributed to their decision to refrain from wearing one. Additionally, the findings reveal that those with a high value of independence and individuality in regard to their libertarian value system do not assume the public at large will share their beliefs. The participants consistently communicated a mantra of individuality which remained constant in their suggestion that others be allowed to carry out their own form of risk mitigation tactics without shame or retribution.

Additionally, the narratives provided during the study demonstrate the participants' uncertainty regarding the risk of Covid-19 and the efficacy of face masks. The degree to which these individuals perceived a low threat is bolstered by the foundation of the health belief

model's (Rosenstock, 1974) literature suggesting individual behavior is based upon the perceived susceptibility, perceived seriousness, and perceived benefits of taking action and barriers to taking action amidst a health risk. Ultimately, those interviewed perceived very low risk of Covid-19 alongside a very low confidence in the effectiveness of face masks. Moreover, the participants overwhelmingly emitted a belief that one's personal health and safety is solely dependent on that individual's willingness to seek after their own health and wellness – not the responsibility of a collective whole.

Limitations and Future Research

While this thesis certainly contributes to the connection amidst self-identity and perceived risk within health behavior, it does have some limitations. The first limitation is that no interviews took place in person. The health risk of Covid-19 during the study resulted in a requirement for solely remote research, and while interviews were easier to set-up due to the Zoom or phone method, there are mixed perceptions on the researcher's ability to provide a personal rapport to suit the qualitative research remotely. Previous literature by Patton (2002) imply that the personal nature of qualitative methodology is strengthened by an ease of conversation. And while the stipulations of the study required remote interviews, the process of phone and Zoom conversations were positive in their ability to build a rapport through technological channels. Yet inevitably the limitation of technological devices played a role in the degree to which the participant's meaning making was captured.

The second limitation was the limited amount of participation in the study. As noted in the findings and literature – the symbol of a face mask during the Covid-19 pandemic has evolved into a symbol of one's identity. Whether you wear a mask or chose not to wear a mask – this health behavior, or lack thereof, is often perceived to reveal one's values and beliefs.

Therefore, the amount of individual's who showed a willingness to participate in the study were far and few between – most likely due to their uncertainty of whether I shared their beliefs.

The final limitation is evident within the variation of interview times. The longest interview ranged above forty minutes, while the shortest capped at eight minutes. While these times do not point the rigor in data derived from the interview, the range of time serves as a pertinent factor in the ability to fully glean findings from the shorter narratives when administering a phenomenological approach.

The implementation of a phenomenological perspective in the study served to elevate a holistic perspective of one's experience on a broad scale – future study would benefit from examining which factors served as a major catalyst to health behavior change. Face masks in the United States are such a polarizing symbol often closely associated with an individual's political beliefs, therefore future research should consider studying those who elicited an evolutionary health behavior change worthy of distinction and the factors at play to provoke such a change. Participant's narratives provided examples of instances to which they changed their preferred mask-wearing to submit to an additionally held value – whether that be the respect of a religious organization or a support for business continuity in their community. Future research would be beneficial for public relations practitioners and health communication strategist to understand the perceptions of one's self-identity which hold enough gravity to shift a contrasting identity factor. When two values collide – how does an individual choose which value determines behavior?

While the context of the study manifest in the timeliness of the health crisis of Covid-19, the findings and implications from the research would be well suited when drawn into further contexts. The variables of self-identity revealing choices to mitigate risk during a natural disaster would be an additional context of study along with how women's self-identity is perceived

internally and externally amidst their choice of birth control. While the Covid-19 pandemic and mandate of face masks was a timely study worthy of investigation, the thematic schemes which emerged would dynamically manifest in several other health and environment crisis.

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Appendices

Appendix I. Interview Questions / Script

Thank you for your willingness to participate in the following study. If at any point you choose to conclude our interview before you answer the following questions you may do so.

1. How are you doing considering the COVID-19 pandemic?
2. How has that affected your life?
3. From what source did you hear about wearing face masks?
(Family, News Outlets, Friends, or Other)
4. Describe your thoughts when the mask-mandate was first communicated.
5. Describe your daily life outside the home?
6. In what locations do you wear masks and why?
7. How do you communicate your choice to refrain from wearing a mask?
8. Did your mask-wearing behavior change at all between the Spring of 2020 and Thanksgiving/Christmas holidays?
9. How do you view mask-wearing behavior?
10. How would you describe your role as someone who chooses not to wear a mask?

Thank you for your willingness and time to participate in the study. Your identity will remain anonymous at the time of publication. If you have any questions feel free to email me at flk324@vols.utk.edu. Our interview is complete - have a great day.

Appendix II. IRB Approval



March 22, 2021

Mallory Leigh Denning

UTK - College of Communication and Inf - Communication Studies

Re: UTK IRB-21-06332-XM

Study Title: Copy of Self-Identity and Risk Mitigation Behavior: Self-Protecting Masks Mandate

Dear Mallory Leigh Denning:

The Human Research Protections Program (HRPP) reviewed your application for the above referenced project and determined that your application is eligible for **exempt** review under 45 CFR 46.101, Category 2: Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if the information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by .111(a)(7).

Your application has been determined to comply with proper consideration for the rights and welfare of human subjects and the regulatory requirements for the protection of human subjects. Therefore, this letter constitutes full approval of your application (version 1.1) as submitted, and the following study documents:

- Consent for research participation v. 1.2
- Denning recruitment statement v. 1.2
- Zoom interview session questions v. 1.0

You are approved to enroll a maximum of 20 participants. Approval of this study will be valid from 03/22/2021.

The requirement to secure a signed consent form is waived; willingness of the subject to participate will constitute adequate documentation of consent.

Any revisions in the approved application, consent forms, instruments, recruitment materials, etc., must be submitted to and approved by the IRB prior to implementation. In addition, you are responsible for reporting any unanticipated serious adverse events or other problems involving risks to subjects or others in the manner required by the local IRB policy.

Please note that restrictions are in place due to the COVID-19 pandemic, and all in-person contact with research participants is on hold until further notice.

- Newly-approved studies with in-person interactions may not begin enrollment until further notice from the IRB/HRPP.
- Newly-approved studies with no in-person participant interaction may begin after receiving IRB approval.

Please monitor the COVID-19 Updates at <https://www.utk.edu/coronavirus/faq/> for the latest information. Human Subjects Research updates are being filed under Information for Instructors/Research.

Any alterations (revisions) in the protocol or study documents must be promptly submitted to and approved by the UTK Institutional Review Board prior to implementation of these revisions.

Sincerely,

Lora Beebe, Ph.D., PMHNP-BC, FAAN

Chair

Institutional Review Board | Office of Research & Engagement
1534 White Avenue Knoxville, TN 37996-1529
865-974-7897 865-974-7400 fax irb@utk.edu

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*Appendix III. IRB-Approved Informed Consent***Consent for Research Participation**

Research Study Title: Social distancing during a pandemic: How attitudes, norms, and control can impact health behaviors.

Researcher(s): Mallory Denning, University of Tennessee, Knoxville

We are asking you to be in this research study because you are over the age of 18. The information in this consent form is to help you decide if you want to be in this research study. Please take your time reading this form and contact the researcher(s) to ask questions if there is anything you do not understand.

Why is the research being done?

The purpose of the research study is to understand how attitudes, perceived norms, and levels of control can impact health behaviors like washing hands, socially distancing, and staying home. This study is being conducted by researchers at the University of Tennessee, Knoxville.

What will I do in this study?

If you agree to be in this study, you will be interviewed for no longer than thirty minutes with questions that ask about your attitudes, perceived norms, and levels of control about specific health behaviors. Your interview will be audio recorded through Zoom or a phone call, and you can skip questions that you do not want to answer.

Can I say “No”?

Being in this study is up to you. If at any time you request to leave the interview you are permitted to do so and your interview will not be used for analysis.

Are there any risks to me?

You will not experience no more risk than what you experience in everyday life.

What will happen with the information collected for this study?

The interview is anonymous, and no one will be able to link your responses back to you. Your responses to the interview will not be linked to your computer, email address or other electronic identifiers. Information provided in this study will be coded to retain your anonymity and the recording of your interview will be deleted after the transcription is complete.

Information collected for this study will be published and possibly presented at scientific meetings with anonymous names.

Will I be paid for being in this research study?

No.

What are the benefits to participating in the study?

By participating in the study, you are providing helpful insight for practitioners and researchers toward how individuals perceive risk and health behavior. The benefit to participation in the study is the understanding that your willingness to provide anecdotal evidence to your experience offers helpful knowledge to how individuals create meaning-making.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers, Mallory Denning, flk324@utk.edu, 865-696-5090.

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board

The University of Tennessee, Knoxville

1534 White Avenue

Blount Hall, Room 408

Knoxville, TN 37996-1529

Phone: 865-974-7697

Email: utkirb@utk.edu

Statement of Consent

I have heard this consent statement and have been given the chance to ask questions and have my questions answered. If I have more questions, I have been told who to contact. By stating, "I agree." I am agreeing to be in this study. I can print or save a copy of this consent information for future reference. If I do not want to be in this study, I can leave the Zoom interview.

*Appendix IV. Recruitment Statement***Recruitment Statement:**

As a masters student at The University of Tennessee, I am researching the self-identity and health behaviors surrounding the COVID-19 pandemic. As a part of the study, I am asking to interview people above the age of eighteen who choose to not wear self-protection masks. The interview will take no longer than thirty minutes and will be recorded through Zoom or over the phone. Prior to the interview, participants will be shown a consent form and verbally confirm their willingness to participate. You may decline to complete the interview at any time throughout the study. Any information that would expose your identity will not be used to ensure anonymity. Please contact me via Facebook messenger or through my email at flk324@vols.utk.edu if you have any questions.

Vita

Mallory L. Denning is a thesis candidate at The University of Tennessee in the School of Advertising and Public Relations in the College of Communication and Information. The culmination of her undergraduate degree at The University of Tennessee until her current endeavors as a graduate student have produced an interest in crisis communication and health behavior. Her background education in Child and Family Studies influences her study of divergent and convergent behavior elicited in environments of risk and crisis. During her two years as a graduate student, Mallory taught Public Speaking at the University of Tennessee – an experience which illuminated her passion for higher education and motivation disciplines.