Why don't people wear masks?

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The vast majority of scientists believe that masking and social distancing confer some protection against COVID-19 infection. Yet, despite violating mandates, guidelines or common sense, many Americans continue to increase the risk of contagion by flocking unmasked to crowded political rallies, bars or large parties.

We all know that many non-maskers oppose social distancing mandates, guidelines or community pressure as attacks on personal autonomy, abrogation of embedded constitutional rights, unbridled government control of individual behavior as well as challenging self-control of one's life. Some critics of non-maskers decry this behavior as selfish, reckless, impulsive denials of science and a failure of civic responsibility. Many commentators oversimplify this controversy as a partisan political issue exemplified by the report that as few as one third of conservative-leaning Fox viewers always wear masks in public compared to two-thirds of liberal-leaning MSNBC/CNN viewers.[1] But, it's more complicated and nuanced.

There is danger in accepting the stereotype of a "Blue state versus Red state" mentality, an assessment which exaggerates the magnitude to which specific party affiliation determines adherence to masking and social distancing.[2] What other influences help explain masking behavior?

How do we decide if a risk is acceptable?

We live in a risky, uncertain world complicated by a harmful national controversy about COVID-19-related risks. Risk perception reflects a subjective interpretation of the world.[3] Individual tolerance for both risk and uncertainty vary widely. Non-maskers may believe that danger from COVID-19 is lower than maskers do and that the threat is exaggerated, sometimes purposefully. Thus, non-maskers are not uncaring or ignoring their civic duty; they may conclude that the virus is less threatening or that mask protection is ineffective, thus, giving users a false sense of security. Also, many Americans support opening the economy as more important than any public health consequences of not masking or social distancing. Previously innocent actions, such as a meal at a crowded eatery with friends, are difficult to abandon. "*COVID fatigue*" from prolonged adaptation to the complex new normal of isolation, quarantine and contagion may decrease compliance with preventive measures.[4]

Risk perception and group identity influence masking decisions.

Personal risk-taking perception may be a common component in decisions about distancing behavior. Risk perceptions can align poorly with actual, real-world risk, which may be unclear, misunderstood, controversial or manipulated. Sudden or dramatic increases in rates of infection or personal experience with infected persons may induce us to overestimate risk. Some non-maskers may downplay social distancing because their personal costs of lost revenue or connections to others are greater or the perceived advantages of distancing are lower. Other influences, including group affiliations, affect risk perception. It is important to note that existing beliefs tend to be resistant to change.

Table. Potential biases in masking behavior[2,3,8,9]

Trust in personal beliefs over scientific evidence, expert opinion
Preference for explanations confirming existing beliefs; skepticism of disconfirming beliefs
Blind spot bias: easier to detect bias in others than in oneself
Illusion of control: mistaken belief we control or influence outcomes we cannot
Overconfidence bias: inappropriate confidence inflating real-world accuracy
Denial of scary or unwelcome information (ostrich effect)
Overvaluation of short-term consequences (discomfort of masks) versus long-term outcomes (masking reduces contagion)
Ambiguity aversion: preference for choices minimizing uncertainty and sense of risk
Voluntary risks (non-masking) preferred to imposed risks (masking)
Faith in successful past actions ("I never mask, never had COVID")

What factors influence *"following the crowd"*?

Risk has a social context. Masking is a collective choice as well as an individual one. Our self-identity is linked to the social groups and values with which we align**.** Shared solidarity in crowds such as at sports events can satisfy a human wish for closeness, belonging, camaraderie and trust. In crowds, we tend to feel less vulnerable to disease when we identify strongly with fellow attendees.[5] In social settings, data suggests that potential COVID-19-related threats arising from in-group members will be rated as less risky and tend to elicit enhanced risk-taking behavior compared to potential threats from non-group members.[6]

Herd behavior in groups tends to homogenize attitudes or actions. Thus, non-masking and rejection of social distancing may satisfy a human drive for consensus, collaboration, inclusiveness as well as avoidance of rejection, stigma and loss of status when one's group identity is impaired or threatened.[7] A strong group identity reinforces the subjective assumption that in-group members will act in principled, safe ways and are thus less likely to be COVID-infected.[4] A bystander effect in large groups may inhibit active, individual choice- the more people present, the less likely an individual will make an active decision, believing that "*Someone else will do it!*"

Why do those we trust sometimes pose the *greatest* risk?

"*I'm less at risk if maskless with kindred spirits*" is a dangerous belief which may lead to increased risk-taking behavior with friends or colleagues.[8] Groupthink, a cognitive bias where pressure from oneself, peers, or leaders to achieve consensus may interfere with choices because potential dissenters self-censor, revise or suppress a contrary opinion or evidence despite underlying disagreement.[9] Adherence to unhealthy "Wisdom of the Crowd" beliefs (smoking, non-masking) increases the probability of bad outcomes. Examples from experimental studies include widespread beliefs that risk of a car crash is lower when driven home by a friend who drank too much vs. a stranger and there is less risk shaking hands with a co-worker with dirt on her hand if she's a member of our political party.[10,11] Of course, experimental studies may create artificial distinctions rather than mirror real-life behavior.

Conclusion

The COVID-19 pandemic has spawned an infodemic of disagreement, information and misinformation. Controversy about personal and community prevention has challenged

Historical Footnote: Masks from the Past

Masking as protection from contagion was noted as far back as 23–79 AD when Pliny the Elder, a Roman philosopher and naturalist, advocated wearing animal bladder skins to prevent dust from being inhaled while crushing toxic mercury compounds. In the 1500s, Leonardo da Vinci used wet cloths to protect the mouth and nose from inhaling dangerous particles.

During the Spanish flu of 1917–1918, some cities mandated masking in public, at times with heavy fines for scofflaws. During that period, a partisan political group formed the Anti-Mask League.

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Letter carrier in New York City wearing mask,1918.

To prevent the spread of Spanish Influenza, Cincinnati barbers wore masks.

Female clerks in New York City wearing masks at work to prevent the spread of the flu,1918.

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our ability to make effective, reasoned choices – including masking and social distancing decisions. These preventive interventions remain contentious and unresolved despite the weight of robust evidence supporting them.

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