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Culture, gender and health care stigma: Practitioners' response to facial masking experienced by people with Parkinson's disease

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ABSTRACT

Facial masking in Parkinson's disease is the reduction of automatic and controlled expressive movement of facial musculature, creating an appearance of apathy, social disengagement or compromised cognitive status. Research in western cultures demonstrates that practitioners form negatively biased impressions associated with patient masking. Socio-cultural norms about facial expressivity vary according to culture and gender, yet little research has studied the effect of these factors on practitioners' responses toward patients who vary in facial expressivity. This study evaluated the effect of masking, culture and gender on practitioners' impressions of patient psychological attributes. Practitioners ($N = 284$) in the United States and Taiwan judged 12 Caucasian American and 12 Asian Taiwanese women and men patients in video clips from interviews. Half of each patient group had a moderate degree of facial masking and the other half had near-normal expressivity. Practitioners in both countries judged patients with higher masking to be more depressed and less sociable, less socially supportive, and less cognitively competent than patients with lower masking. Practitioners were more biased by masking when judging the sociability of the American patients, and American practitioners' judgments of patient sociability were more negatively biased in response to masking than were those of Taiwanese practitioners. Practitioners were more biased by masking when judging the cognitive competence and social supportiveness of the Taiwanese patients, and Taiwanese practitioners' judgments of patient cognitive competence were more negatively biased in response to masking than were those of American practitioners. The negative response to higher masking was stronger in practitioner judgments of women than men patients, particularly American patients. The findings suggest local cultural values as well as ethnic and gender stereotypes operate on practitioners' use of facial expressivity in clinical impression formation.

Introduction

The global prevalence of Parkinson's disease (PD), one of the most common age-related neurodegenerative disorders, is increasing with the aging of the population (Global Parkinson's Disease Survey Steering Committee, 2002). This progressive disorder is diagnosed at the average age of 60 and is characterized by slowness, stiffness and difficulty in initiating, coordinating and maintaining movement throughout the body. The face can lose expressive speed, elasticity and coordinated expression in the brow, eyes, cheeks, and lips: a condition called *hypomimia or facial masking*. The frozen position of pressed or slack lips and an unbroken stare creates the impression, regardless of its accuracy, of an asocial, cold, incompetent or apathetic person who fails to reciprocate others' feelings of warmth, concern, interest or excitement (Brozgold et al., 1998; Smith, Smith, & Ellgring, 1996). The mask interferes with social observers' formation of accurate impressions regardless of whether the observer is a lay person (Borod et al., 1990; Brozgold et al., 1998; Hemmesch, Tickle-Degnen, & Zebrowitz, 2009) or a health care practitioner (Lyons, Tickle-Degnen, Henry, & Cohn, 2004; Pentland, Gray, Riddle, & Pitcairn, 1988, 1987; Tickle-Degnen & Lyons, 2004). The experience for people with masking has been characterized as an imprisonment of the self by an unresponsive body (Anonymous, 1999). Socially and mentally competent people with masking are confronted with the challenge of clearly presenting a self that overrides observers' automatic and confidently-formed impressions of incompetence (Lyons & Tickle-Degnen, 2003; Pentland, 1991).

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Previous research findings have suggested that the mask is stigmatizing, yet these findings are limited by being conducted in western countries with predominantly Caucasian ethnicity. There has been little investigation of the socio-cultural factors underlying this stigmatization and the implications for health care. Our specific purpose was to test the role of universal facial expressiveness norms, local cultural values, and ethnicity and gender stereotypes in the health care context of both western and eastern culture. We studied practitioners' first impressions of patients, a point in time that is critical to the subsequent development and effectiveness of the therapeutic relationship (Martin, Garske, & Davis, 2000).

Facial masking and stigma

Kurzban and Leary (2001) theorize that one of the origins of stigmatization lies in the importance of dyadic cooperation for human survival and the predictability of human behavior for this cooperation to occur. When individuals can quickly decipher one another's thoughts and actions, they are able to respond effectively as a unit to the task at hand and to predict social and task outcomes. Decipherability is contingent on visible and dynamic physical displays of emotion, thought and motivation. By reducing physical cues of psychological states and traits, facial masking makes it less possible for observers to form reliable impressions of people with PD. When patients are masked there is a smaller correlation between the patients' tested social attributes and observers' impressions of these attributes than when patients are more facially expressive (Hemmesch et al., 2009).

This indecipherability sets the stage for social response biases and stereotype activation as the social observer attempts to understand an ambiguous situation. In western populations, it has been found that people who are more nonverbally expressive are viewed more favorably than are less expressive individuals (Boone & Buck, 2003). Social observers are likely to perceive expressive individuals as having nothing to hide, of being open and worthy of trust, and less expressive individuals as being deceptive or untrustworthy. Poor ability to mobilize upper face muscles that produce the eye crinkling of genuine smiling can create a look of deceptive smiling in people with PD even though they are experiencing genuine happiness (Pitcairn, Clemie, Gray, & Pentland, 1990). The lack of predictability and the reduced perceived trustworthiness of the facially masked patient in comparison to more expressive patients may contribute to negative response biases among observers (Hemmesch et al., 2009; Pentland et al., 1988, 1987; Pitcairn et al., 1990; Tickle-Degnen & Lyons, 2004).

According to an ecological theory of social perception (McArthur & Baron, 1983; Zebrowitz & Collins, 1997), health care practitioners may automatically over-generalize their everyday social and implicit use of the face into the clinical context (Tickle-Degnen & Lyons, 2004). The practitioner may believe that the patient "is" what is perceived, and although this impression may change over time, it is unlikely to do so as rapidly as when the first impression was formed. A patient with facial masking may enter the health care relationship with, in the words of Goffman (1963), a "spoiled identity" created by a special kind of association between attribute and stereotype (p. 4). The attribute is the muting of facial expressivity and the stereotype is observers' preconceptions about the meaning of muted expressivity. Practitioners' impressions of patients can be unreliable indicators of patients' actual psychological attributes without being stigmatizing, leading to poor diagnostic discriminations (Burn, 2002). However if this unreliability is paired with a belief that inexpressive people have less favorable psychological attributes than expressive people, a systematic stigmatization can occur.

Facial masking and culture

There are commonalities in the social meaning of behavior across cultures. Regardless of culture people believe facial behavior indicates emotion, character, and health (Yu, 2001), and favor pleasant affect over negative affect (DePaulo, 1992). There is also systematic variation in the meaning of social behavior as groups develop specific methods for living within their social environments (Markus & Kitayama, 2010; Zebrowitz & Rhodes, 2002). Yang and Kleinman (2008) and Yang et al. (2007) have observed that individuals are stigmatized when others perceive them as failing to uphold important moral obligations and transactions of everyday social life. The stigmatized lose moral character in the eyes of the public and suffer diminished human value in domains that "matter most" to the local community.

We chose to study Taiwanese and American culture because of differing views of the social self in the world as related to expressive behavioral displays (Markus & Kitayama, 2010). East Asians construe the self as interdependent with others in one's group and value submission of self in favor of the greater good. Personal development and intellectual achievement is a moral obligation to family and social life (Yang & Kleinman, 2008). A humble muting of personal expressiveness is seen as supportive of harmonious relationships with others and is highly valued within the Confucian tradition (Chang & Holt, 1994). Americans on the other hand construe the self as independent of others and value autonomous action and individuation of self-identity. Personal skill at influencing others and drawing positive attention to the self and one's opinions are valued (Markus & Kitayama, 2010).

A common stereotype is that Asians are less openly expressive than Americans. Consistent with the stereotype, Asians have a stronger normative system of display rules that control facial expressivity in response to emotionally evocative stimuli (Ekman, 1972; Fernandez, Carrera, Sanchez, Paez, & Candia, 2000; Okazaki, Liu, Longworth, & Minn, 2002). Asians, compared to Americans, view themselves and are viewed by others as less extraverted and expressive, especially related to assertiveness, personal agency, and activity (Cheung et al., 2001; Kashima et al., 1995; McCrae, Yik, Trapnell, Bond, & Paulhus, 1998; Williams, Satterwhite, & Saiz, 1998; Zhang, Lee, Liu, & McCauley, 1999). Vibrant and expressive sociable behavior is favored over quiet retiring behavior in American culture (Williams et al., 1998; Zillig, Hemenover, & Dienstbier, 2002). The implications, tested for the first time in this study, are that facial masking would be more deviant for Americans on attributes related to sociability, whereas more deviant for Taiwanese on attributes related to social harmony or intelligence.

Facial masking and gender

Universally held stereotypes and norms expect women to be more expressive emotionally than men. In fact women as compared to men are more emotionally expressive generally; their behavior is more responsive to the emotions and behavior of others, and their social interactions in close relationships are characterized by more emotionally supportive behavior (Eagly, 2009; Fischer & Manstead, 2000; Hall, 2006). The implications are that facial masking would be more deviant for women than men and put them more at risk of stigmatization. Consistent with this implication, Hemmesch et al. (2009) found that older adult peers judged the social supportiveness and interpersonal appeal of Americans with PD more favorably with lower than higher masking, and this effect was larger for women than men with PD. The present study extends these findings by investigating cross-cultural judgments of men and women with PD by health care practitioners.

Although women have been found to be more expressive than men across cultures, gender differences are larger in western