REVIEW



Social stigma at the time of CoViD-19 and strategies to counter it: remembering and networking.

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Abstract - The social stigma associated with mental distress and, more specifically in recent years, the social discrimination and stigma associated with the CoViD-19 pandemic represent an emergency with a high psychosocial and economic impact on the global community. Indeed, some research shows that CoViD-19 sufferers and their families may have experienced a sense of shame, guilt and isolation because of their disease, and may have been discriminated against and labelled as having a kind of 'second disease'. In order to learn from history and avoid making the same mistakes as in the past, it is important to 'remember' what happened in previous epidemic crises as a result of stigmatisation of different social groups. In addition, it may be useful to be clear about the processes of countering stigma, such as 'networking' around people affected by stigma, promoting processes of pro-sociality and collective solidarity, and also changing communication models and the language used to talk about certain issues. The aim of this review is to describe the state of the art within the phenomenon of stigma related to CoViD-19 and to propose prevention and support strategies for the population affected by this phenomenon.

Keywords: Social stigma, CoViD-19, Discrimination.

Key messages:

- Changing communication patterns related to illness and mental health reduces stigma.
- Promoting pro-social processes and collective solidarity reduces discrimination.

Introduction

CoViD-19 has profoundly undermined people's mental wellbeing, triggering a pandemic wave of psychological distress manifested in depression, anxiety and self-harm, hitting women and young people particularly hard and not sparing children. The first global estimates reported in *The Lancet* (1) point to 53 million more cases of major depression (+28%) and 76 million more cases of anxiety disorders (+26%) in 2020, directly linked to the pandemic. This grim picture emerges on World Mental Health Day showing that, with the pandemic, mental problems affect the most vulnerable segments of the population the most.

More than one million people die each year from substance abuse, and in conjunction with Covid, the picture may even have worsened. In fact, one in four (25%) 18-24 year olds reported increased substance use to cope with the stress of CoViD-19. Someone takes their own life every 40 seconds, and suicides are on the rise. There was a 16% increase in suicides in Japan from June to October 2020, compared to the same period in 2019. According to *The Lancet*, without CoViD-19, there would have been 193 million cases of depression

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worldwide in 2020. The actual number of cases was 246 million, an increase of 53 million, including 35 million in women. As for anxiety disorders, without the pandemic there would have been 298 million cases in 2020. Instead, there were 374 million cases, 76 million more, including 52 million in women. Another paper published in *The Lancet* (2) shows that depression rates more than tripled and symptoms worsened in one year of the pandemic: 32.8% of US adults reported major depressive symptoms in March-April 2021, compared with 27.8% in the first months of the pandemic (March-April 2020) and 8.5% before the pandemic.

The pandemic is not sparing children: according to Save the Children, 83% of the world's children are experiencing an increase in negative feelings, and levels of depression, anxiety, loneliness and self-harm among minors are on the rise. In countries where schools were closed for 17-19 weeks, mental distress increased in 96% of cases. The data comes from a World Health Organization survey of more than 13,000 children in 46 countries. Those living in poverty or in disadvantaged or vulnerable situations are even more exposed to the harmful effects of prolonged lockdowns. The lack of social stimulation may have had a serious impact on their mental health.

The pandemic has immediately led to an exacerbation of the already existing inequalities, with a higher incidence and outcome of the disease in the weaker segments of the population— say Massimo di Giannantonio and Enrico Zanalda, co-chairs of the Italian Society of Psychiatry. The inequalities generated by CoViD-19 have also had repercussions on mental health, increasing mental distress especially among the most fragile segments of the population, with less access to treatment and services.

Materials and Methods

The aim of this article is to describe the state of the art concerning the impact of social stigma related to CoViD-19 in different communities around the world, through the analysis of recent scientific publications.

This narrative review of scientific literature included a number of studies considered the most relevant. A total of 8 articles were selected from the following databases: Sapienza Psycinfo Databases and specifically Psychology and Behavioural Sciences, E-Journals, Apa Psycinfo Ebook Academic Collection (Ebsco Host), Apa Psycarticles, Ebook Collection (Ebsco Host) and Pubmed.

The terms used in the research were the following: mesh*((((social stigma) AND (social health)) AND (health)) AND (discrimination)) AND (covid 19) Filters: Free full text, Adult: 19+ years.*

Results

Table 1 reports the articles according to the PICO process.

An analysis of the selected articles shows that CoVid-19 stigma has affected various social groups, especially the most vulnerable or disadvantaged, with enormous consequences both in terms of access to treatment and social reintegration.

Stigma is a kind of stain of shame that lasts for a long time, even when, for example, a disorder has been cured. Stigma comes in two main forms: external stigma and self-stigma. Almost all people who have been labelled in some way, such as having a mental disorder, have to deal with the prejudice and discrimination associated with having a 'deviant identity', which is brought back to them by the negative reactions of the general population towards them.

According to social psychology, external stigma consists of three elements: stereotypes, prejudice, and discrimination. Stereotypes usually become labels. These stereotypes stimulate negative emotions such as anger, fear, guilt and prejudice, which lead to discriminatory behaviour that has three consequences: loss of opportunity, coercion and segregation, which then reduce the quality of life by undermining social inclusion. As a result, discriminatory practices make it difficult for these stigmatised people to achieve their life goals, and sometimes they do not seek appropriate treatment from health services for fear of being stigmatised.

For these same stigmatised individuals, a process of self-stigmatisation (self-stigma) is triggered, whereby they internalise the social stigma associated with their discomfort, as they have unconsciously adopted the cultural stereotypes typical of this form of discomfort. The result is a decrease in self-esteem and self-efficacy, as the person agrees with the negative social and cultural beliefs about himself or herself and helps to reinforce them by adhering to them.

Sometimes members of stigmatised groups may be more susceptible to discriminatory pressures against them and may end up believing that the consequences of stigma are just and legitimate. In contrast, identification with a group of people who share a stigmatised identity is a crucial variable and a protective factor against the

internalisation of stigma. Through interaction with a stigmatised peer group, a positive identity can be developed that reduces the likelihood of agreeing with social stigma and applying it to oneself.

According to labelling theory, the demoralisation caused by self-stigma reduces self-esteem, hinders the

Tab. 1 - Results from articles according to the PICO process

Author/Year	Title of the article	Source
Campo-Arias A., Jiménez-Villamizar MP, Caballero-Domínguez CC., 2021	Healthcare workers' distress and perceived discrimination related to COVID-19 in Colombia	Nurs Health Sci. 2021; 23:763–767. DOI: 10.1111/nhs.12854
Fahim C. , CooperJ, Theivendrampillai S., Phma B., Straus S. 2023	Exploring Canadian perceptions and experiences of stigma during the COVID-19 pandemic	Frontier in Public Health 10.3389/fpubh.2023.1068268
Nochaiwong S. et al.2021	COVID-19 Public Stigma Scale (COVID-PSS): development, validation, psychometric analysis and interpretation.	BMJ Open 2021; 11:e048241.doi:10.1136/bmjopen-2020-048241
Lasalvia A. 2020	Emergenze epidemiche e stigma sociale. Quali insegnamenti trarre dale precedent epidemie di SARS ed Ebola da applicare nell'attuale pandemia CoViD-19?	Rivista di Psichiatria 2020; 55 (4); 250-253
Peters L., Burkert S., Brenner C., Grüner B. 2022	Experienced stigma and applied coping strategies during the COVID-19 pandemic in Germany: a mixed- methods study	BMJ Open 2022;12:e059472. doi:10.1136/bmjopen-2021-059472
Reinius M. et al 2023	COVID-19-related stigma among infected people in Sweden; psychometric properties and levels of stigma in two cohorts as measured by a COVID-19 stigma scale	PLOS ONE 18(6): e0287341. https://doi.org/10.1371/journal.pone.0287341
Saiz J. et al. 2021	Effects of COVID-19 Lockdown on Perceived Discrimination and Internalized Stigma in People with Previous Mental Disorder Diagnoses in Spain.	American Journal of Orthopsychiatry 2021;91(3):407-411. doi: 10.1037/ort0000542.
Sumesh S.,Nitish Gogoi 2022	Collecting the 'Thick Descriptions': A Pandemic Ethnography of the Lived Experiences of Covid-19 Induced Stigma and Social Discrimination in India	Journal Of Loss And Trauma 2022, VOL. 27, NO. 3, 271–284https://doi.org/10.1080/15325024.2021.1947019

achievement of personal goals, undermines quality of life in key areas such as work, housing and economic satisfaction, physical health, also reducing the ability to seek help (3). Not only would people not seek help for their distress, but self-stigma would also affect the effectiveness of evidence-based practices, i.e. those treatments that have been shown to be effective for their health. People would ask themselves, "Why bother?" And this, together with low levels of self-esteem and self-efficacy, would limit people's participation in treatments in which they would not invest because of certain questions: "Why should I engage in treatment if I am not capable?" or "Why should I continue my studies if I do not deserve anything?"

On the other hand, if there are acceptable levels of self-esteem and self-efficacy, and support and encouragement from the social networks in which the person is immersed, or from the carers who follow them, one is encouraged to use services to achieve personal goals, thus creating a 'virtuous circle'. The person feels empowered to define his or her own goals and to seize the opportunities that life offers. In this way, early successes increase motivation for treatment and hope for the future, as well as levels of self-efficacy and empowerment.

Stigma also affects people who do not yet have a history that can lead them to be 'stigmatised', as they avoid the treatment services they should be seeking in order to avoid being stigmatised. However, the avoidance of care due to the desire to avoid the label that leads to stigma and discrimination appears to be one of the most important factors explaining the underuse of services. There seems to be a concern about what others might think and a desire to solve problems alone.

The 'pandemic ethnography' of S.S. Sumesh and Nitish Gogoi (4) examines the 'lived experiences' of CoViD-19 in different countries around the world from December 2019 in Wuhan in China. It shows that the pandemic has contributed to the desire to stigmatise the 'different other'. The stigma of being uncomfortable with CoViD-19 is a global phenomenon that intersects with racial and ethnic prejudice. "Pandemic ethnography" is a process whereby researchers bring together people or groups of people, in this case affected by Covid, and address them with in-depth interviews to collect observations. The researcher's task is to both describe and interpret the social behaviour observed within its context.

In India, quarantine was reportedly the starting point for social stigma and discrimination, as the Ministry of Health put a 'red banner' outside the doors of people with CoViD-19 to isolate them from the community and their families for 15 days. As a result, neighbours and family members with whom these people had a good relationship stopped talking to them or offering to bring them food. These people felt humiliated and isolated, and their anxiety and depression increased because of the negative ideas about them circulating in the community. This process was then compounded in the post-covid period where they felt discriminated. Recent studies show an increase in suicide cases in India during the CoViD-19 period.

In Spain, a large increase in perceived discrimination and internalised stigma was found among people with a previous diagnosis of mental disorder, followed by people with lung problems and those diagnosed with cardiac or neurological problems. This may suggest that people diagnosed with a mental disorder are more vulnerable to perceived discrimination than people with a physical illness are. This should be taken into account on a similar future occasion. (5)

An Italian article (6) examines studies conducted in China and Canada and in West Africa at the time of the SARS epidemic in 2003 and the Ebola epidemic in 2014. These studies show that people affected by Ebola and SARS, once they went back to their normal lives, were stigmatised and discriminated against, shunned by friends and reported a decrease in invitations to social events. It took at least two years for acts of discrimination to decrease significantly. One of the effects of stigma was that people chose not to access services for early screening or to seek help or treatment in the early stages of the disease for fear of being labelled 'infected' and thus stigmatised.

According to Patrizia Carozza (7), three approaches are useful for decreasing the impact of social stigma: protest, education, and contact. Protest concerns opinion movements or individuals who challenge inaccurate and prejudiced opinions about the stigmatised group by sending two messages: the first addressed to the media and calling on them to 'stop reporting incorrect representations about the people in question'; the second addressed to the public to 'stop believing negative opinions about the group in question'. It has also been remarked that the media are less likely to convey a stigmatising message when they know that it will not

only be disapproved of by the public, but also by the stigmatised people themselves. Therefore, alarming and dramatizing headlines or broadcasts should be avoided, and instead objective and rational information should be given on the characteristics of the disease and measures to contain it. Language should not feed, but reduce stigma and prejudice. Using words such as 'suspect case' or 'isolation' can provoke negative reactions and should be rethought and replaced with other terms. The International Federation of the Red Cross (IFRC), UNICEF and the World Health Organization (WHO) have published a document with recommendations from the READY Network, Johns Hopkins Center for Communication Programs, entitled 'Social Stigma Associated with CoViD-19. A guide to preventing and addressing social stigma' to help media professionals use appropriate language. The original English version of the document can be downloaded from the WHO website (6, 19). The National Institute of Health has translated it into Italian (20).

Education, on the other hand, implies dispelling false myths about the stigmatised category, including through the production of informational material, such as video testimonies, in which people tell their stories in order to disseminate them to the public, with the aim of raising awareness of new issues and making people less likely to stigmatise and discriminate. Contact is based on the assumption that those who interact directly with people belonging to a particular category are less likely to hold stigmatising beliefs and more likely to form positive opinions about them. In this context, the role of professionals and service providers is to help stigmatised people strengthen their ability to resist social processes that undermine their identity by identifying and challenging the stigmatising effects of certain conscious and unconscious behaviours.

In the specific case of the pandemic, authorities should pay more attention to people who already belong to 'stigmatised' populations during confinement or quarantine, as they are even more vulnerable than other ones to discriminatory behaviour that may result from exposure to the disease.

Conclusions

It is now certain that there is a CoVid-19 stigma that has arisen out of fear of contagion, fear of the unknown and, in general, fear of 'the other than oneself' (8, 9, 10, 11, 12).

It would therefore be necessary to develop community strategies for dealing with serious discrimination that may arise in similar situations in the future, precisely in order to embrace and at the same time challenge this fear. It would be appropriate to create and maintain confidence in the health services and their health advice in the event of a recurrence of a pandemic. Replacing the climate of 'terror' with the possibility of 'networking' and 'pro-social' behaviour, through the sharing of experiences related to the pandemic itself and the implementation of solidarity behaviours, seems to be the only way to prepare for and manage similar events that may occur in the future, in the hope of avoiding stigmatisation processes.

Disclosures:

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