A Qualitative Study on Stigmatization Associated With COVID-19

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ABSTRACT

Objective: To survey and analyze the experience of stigma among patients with coronavirus disease 2019 (COVID-19) in Iran.

Methods: This qualitative study was conducted from September to December 2020 in the Fars, Khorasan Razavi, and Yazd provinces of Iran. Sampling was done via the snowball method. Based on data saturation criteria, 24 adults aged > 18 years who had been diagnosed with COVID-19 were recruited. Semi-structured telephone interviews were conducted with each patient. Data were analyzed following the conventional content analysis method.

Results: The results showed that during their illness with COVID-19, the participants experienced a difficult and anxious course, with rejection and alienation from their first-degree relatives taking them by surprise. The 3 main themes extracted from this study were (1) fear and rejection, (2) discrimination, and (3) loneliness. These experiences changed the attitudes of the participants toward life and themselves.

Conclusions: The results show the importance of being aware of social stigma among patients and that primary care physicians play an integral role in addressing this issue, especially during pandemics. Psychological counseling sessions for those afflicted is recommended, and education and training should be provided to the public regarding the proper treatment of patients with COVID-19. Quantitative studies in this field are highly recommended.

Prim Care Companion CNS Disord 2022;24(2):21m03174

To cite: Sadati AK, Parvizi MM, Forouhari S, et al. A qualitative study on stigmatization associated with COVID-19. *Prim Care Companion CNS Disord.* 2022;24(2):21m03174.

To share: https://doi.org/10.4088/PCC.21m03174

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A new strain of coronavirus emerged toward the end of 2019 in Wuhan, China, giving rise to coronavirus disease 2019 (COVID-19) and spreading a wave of concern across China.[1] This health issue soon became a pandemic, placing an immense burden on populations worldwide.[2] According to data from the World Health Organization (WHO), Iran is one of the countries that has been highly affected by COVID-19, ranked only behind the United States, Italy, France, Spain, Germany, and Switzerland.[3] Kalantari et al[4] found that up to one-third of patient deaths due to COVID-19 in Iran occurred in individuals aged > 70 years, while the highest recovery rate was seen in those aged 30–39 years. Everyone was encouraged to practice preventive behaviors including wearing face masks and gloves, washing their hands, and social distancing.[5,6] However, the literature indicates that several factors played a role in the application of preventive behaviors.[7]

A key issue raised from the beginning of the pandemic was social stigma.[8] The term *stigma* refers to a social process that results in devaluation and discrediting.[9] According to Goffman,[9] stigma creates a dichotomy between the states of "being normal and acceptable" and the state of "being tainted and undesirable" or a dichotomy between "normal" and "undesirable" states in general. It is usually associated with an attribute that is deeply discrediting, reducing an individual "from a whole and usual person" to a "tainted, discounted one."[9,10] In the process of stigmatization, people are pushed to the margins of society.[11] Stigma may not only affect the mental health[12] and behavior of those who are stigmatized but also change and reconstruct their feelings and beliefs.[13,14] Furthermore, stigma can cause depression in the short or long term due to the social disrespect that accompanies it.[15]

Since the beginning of the COVID-19 crisis, infected individuals have at times been labeled, stereotyped, and discriminated against. Such stigma can represent a critical issue, threatening both the personal and social lives of health care workers, patients, and survivors.[8] In Italy, Ramaci et al[16] found that the social stigma associated with COVID-19 had a high impact on health care workers' psychological and physical needs, professional quality of life, and self-esteem. Moreover, reports have claimed that some people refuse to bury the corpses of COVID-19 victims in Egypt.[17] Gradually, the issue of COVID-19–associated stigma went beyond personal and social aspects and turned into an international stigma against races and countries. For example, anti-Asian stigma was generated by certain groups and even politicians given the supposed geographical origin of COVID-19.[18] Stigma and discrimination lead to social exclusion, which affects mental health.[19] Stigma does not stop at illness: it

Clinical Points

- The most important psychosocial issue concerning COVID-19 is that associated fear and rejection may continue even after disease resolution.
- The atmosphere of fear and rejection, discrimination, and loneliness among patients with COVID-19 may have caused some to hide the disease, especially during the first and second waves of the pandemic.
- Psychological and mental support from clinicians, clinical staff, and relatives could be considered a primary aspect of care in the treatment of patients with COVID-19.

affects those who are ill, their families across generations, institutions that provide treatment such as psychotropic drugs, and mental health workers.[20] The stigma associated with COVID-19 poses a serious threat to those involved directly or indirectly with the disease.[8] The effects of COVID-19–related stigma on the health and social lives of individuals and societal functioning are enormous.[21] A study conducted by Banks et al[22] showed that poverty exacerbation due to COVID-19 could represent a key social problem among individuals who reside in low- and middle-income countries. The results revealed that people with disabilities faced several personal, economic, and social challenges during the COVID-19 pandemic, with the researchers[22] concluding that social protection and financial support are necessary to shield such individuals from social stigma. Moreover, a study by Gupta et al[23] revealed that some protective measures against COVID-19 had negative social effects on low-income individuals (including those residing in poor areas) due to inadequate access to health facilities and lack of financial support and that some of these social effects may be stronger than the negative health effects of COVID-19. On the other hand, frustration and anxiety were reported as the predominant social theme among both specific and general populations, particularly among health care workers on the front lines of COVID-19 management.[24,25]

Few studies, to the best of our knowledge, are available on COVID-19–associated stigma in Iran, especially those that are qualitative in nature. Therefore, this study was conducted to assess COVID-19–associated stigma among the Iranian population through a qualitative survey.

METHODS

Study Design, Participants, and Sampling

This qualitative study was conducted from September to December 2020. The study area was the Fars, Yazd, and Khorasan Razavi provinces of Iran. These provinces were selected by dividing Iran into 3 zones, including the southern, central, and northern areas, then selecting 1 province in each zone. Data were obtained through interviews with 24 individuals who had fully recovered from COVID-19 after treatment. The snowball sampling method was employed, and sampling was continued until data saturation was achieved. Table 1 provides the characteristics of the study participants.

Table 1. Demographic Characteristics of the Participants

Participant No.	Sex	Province	Age, y	Occupation
1	Male	Yazd	43	Miner
2	Female	Fars	39	Nurse
3	Female	Yazd	34	Tailor
4	Male	Fars	34	Lawyer
5	Woman	Fars	43	Housewife
6	Male	Fars	58	Freelancer
7	Male	Fars	43	Sports coach
8	Male	Yazd	23	Student
9	Female	Yazd	18	Student
10	Female	Yazd	38	Housewife
11	Female	Yazd	22	Student
12	Female	Yazd	26	Hospital social worker
13	Male	Yazd	34	Faculty member
14	Male	Yazd	34	Freelancer
15	Female	Yazd	17	Housewife
16	Female	Yazd	39	Nurse
17	Female	Yazd	34	Housewife
18	Female	Yazd	20	Medical student
19	Female	Yazd	38	Housewife
20	Female	Yazd	43	Housewife
21	Female	Yazd	23	Housewife
22	Female	Yazd	48	Housewife
23	Male	Khorasan Razavi	42	Executive manager
24	Male	Khorasan Razavi	77	Retired

Data Collection

The interview protocol was based on the following questions:

Can you tell us how you felt about getting COVID-19 and what you did in response?

Did people around you and your relatives change their attitude toward you after you tested positive for COVID-19?

How did people treat you in other environments, such as the workplace or hospital?

Can you describe your perception and understanding of the behaviors of those around you?

The semistructured interviews were transcribed after being conducted via telephone by an expert sociologist. The use of telephone interviews in qualitative research has proved useful in recent decades.[26,27] The transcribed data were analyzed via conventional content analysis.[28] For this purpose, the data were read several times by the researchers to obtain an overview of what the participants were talking about. Condensed meaning units were labeled by formulating codes that were subsequently grouped into categories. The interviews were analyzed with the aim of taking the categories to the highest level of abstraction, ie, arriving at specific themes. The reflexive method was used during this process. Researchers went back and forth several times between the data and the generated themes to identify those that were most appropriate.

Research Validity

Given its significance, we attempted to ensure the validity of the work by following the model of Lincoln and Guba.[29] To this end, designing a suitable qualitative research model,

Table 2. Concepts, Categories, and Themes Identified Among Patients With COVID-19

Theme	Category	Meaning Units	Sample Statements
Fear and rejection	Fear and distance The unpleasant feeling of rejection The continuation of rejection	Extreme fear Distancing of strangers Distancing of colleagues Distancing of hospital personnel Feeling distant from family members Feeling rejected by colleagues Fear and hope of those around you Rejection of rural laborers Continuation of fear and distancing among colleagues Continuation of fear among friends	*In the first wave, people had extreme fear and stress about COVID-19 and assumed that whoever acquired it would die. Everyone distanced themselves from me as soon as my test returned positive. I told a woman on the bus that I might be afflicted, and she immediately pulled herself away from me. I saw my colleagues moving away from me in the dressing room as if I was dirty. I went to a general hospital, and as soon as I said that I might be afflicted, the nurses ordered me to leave and visit a COVID-19 hospital.* *You feel like you have to leave since your family is afraid of you.* *It's a unique feeling; you realize you have to distance yourself.* *You feel like they are afraid of you, yet they also want to help you.* *Their view was that rural workers who commute from their homes should not enter the factory.* *I returned to the hospital after 21 days, but everyone was still moving away from me.* *Even now that a year has passed, I jokingly or seriously tell any of my colleagues who go on trips across cities that I wish they had not returned immediately to work; we are still really scared.* *I returned to work after 2 weeks, but I saw that my colleagues would become scared when they came near me, and this was not pleasant.*
Discrimination	Occupational Familial Social	Loss of employment, forced leave, fear of getting fired Neglect of the patient, indifference, and/or discrimination by the family Verbal indifference, social distance, and physical distance	*I went for a job interview. The employer asked me to pull my mask down. I said that I am suspicious [for COVID-19]. He asked what I was doing there!* *The employer would immediately send those who were suspicious on leave.* *The workers were afraid even to cough.* *Nobody paid attention to me; I took care of myself.* *The family did not say anything, but I felt they were paying more attention to other members.* *When I got sick, my family left me and went to their village, but they called me and said that I should not leave the room at all. Even my mother would not let me out of the room, and I was coughing very badly and was short of breath. I was constantly in tears because of their behavior.* *In the factory, people who have passed the disease course are ignored. The expectation is that we should never come back to the workplace. We are ignored, and others distance themselves from us.* *On the bus, I told a lady to keep her distance because I was suspicious.* *After my affliction, I saw our neighbors pass by us very quickly while ignoring us.*
Loneliness	Loss of psychosocial support Self-disgust Loneliness	Feeling forgotten Distancing of the closest relatives Feeling bad Feeling danger from the disease Feeling dirty Lack of establishing communications Feeling lonely Experiencing the reality of loneliness	*I felt that everything about love and affection was lies, and I felt severely left out.* *Not even my brother came to visit me.* *It's an unpleasant feeling—as if you have HIV or plague. I said, "Do I have leprosy?!"* *Among the workers, if someone tested positive, it was like they had al [mythological demons of childbirth that interfere with reproduction].* *I felt dirty; it gave me a very bad feeling.* *You see that you cannot have a relationship with anyone.* *We were quarantined and felt introverted and lonely.* *My sister called and told me not to leave my room.* *It was very difficult to be alone and away from my wife and children.* *During the quarantine, you are completely lonely, and all you have is your thoughts and imagination.*

selecting the right participants, choosing accurate interview questions, and employing appropriate methods for data analysis were the most important concerns of our research group. We used member check[30] during the data analysis process to assess if the identified categories and themes were satisfactory. Assessment of the transferability of concepts and themes was also one of our priorities. Ultimately, our research group aimed to base the concepts and themes on the actual data rather than rely on individual preconceptions and assumptions.

Study Ethics

The study protocol was approved by the Ethics Committee of Shiraz University of Medical Sciences (ethics code: IR.SUMS.REC.1399.419). Informed consent was obtained from all participants. Patients were also assured that their personal information would remain confidential with the researchers.

RESULTS

Data analysis revealed that the experience of COVID-19 was quite difficult for the study participants. This was particularly prominent in the first 2 waves of the disease in Iran, wherein the participants were under severe psychological pressure. Fear of transmitting the disease to other family members, fear of illness and death, rejection by family members, and loneliness comprised the most common experiences. The 3 main themes were fear and rejection, discrimination, and loneliness (Table 2).

Fear and Rejection

From the time of diagnosis, COVID-19 creates a pervasive fear among patients and possibly more so among those around them. Such fear arises when the test returns positive, and the patients implicitly or explicitly start noticing dramatic changes in the behaviors of those around them, as the fear is

accompanied by rejection. The most common experience of the study participants was the behavioral changes that they witnessed in those around them after receiving a positive test result. These changes are shaped by a combination of fear, concern, suspense, and compassion, though mostly due to fear of being infected with the disease. Usually, fear first arises in those around the patient, such as first-degree relatives or colleagues. The behavior that stems from fear is understandable to the patient. However, while patients give those around them the right to be fearful, witnessing such extreme fear adds to their concerns. Rejection begins with the initial distancing from the patient. "Testing positive" in this context means fear, concern, anxiety, rejection, and seclusion. Patients understand these meanings from the behaviors and attitudes of those around them and attempt to manage the reactions, as ensuring the well-being of those around them is important. The patients realize that family, friends, and colleagues are reluctant to approach them and may be trying to maintain their distance. In this situation, everyone is afraid of illness and death, which are seen as embodied by the patient. The fear is such that even patients in the COVID-19 wards were afraid of one another. Moreover, 4 participants drew similarities to stigmatized diseases such as AIDS and leprosy and cultural beliefs such as *al* (mythological demons of childbirth that interfere with human reproduction) due to the intense atmosphere of fear following a positive result.

> *See, the disease was so scary that I remember, for instance, when my test result returned positive, everyone around me became anxious even though I didn't have a very bad feeling (participant 6).*

> *It seems that you have AIDS or leprosy because a very discomforting feeling touches you and everyone tries to distance themselves from you (participant 5).*

The most important psychosocial issue concerning COVID-19 is that this fear and rejection may continue even after disease resolution. One participant still spoke of feeling fear and rejection. He believed that 14 months after the start of the COVID-19 pandemic, laborers in cities such as Mashhad, Tehran, and Tabriz who go on leave to their towns and villages are still avoided by others upon their return.

> *You know, we're still scared. We are afraid of those who return after going on leave. We assume that they were gone due to testing positive or that they are returning from another area with the virus (participant 1).*

The atmosphere of fear and rejection made some prefer to hide the disease, especially during the first and second waves. Stigmatization of COVID-19 patients and victims was the main reason for such concealment. One of the participants, a 34-year-old single man, described telling a cousin to keep it secret after he tested positive.

> *When I tested positive, I didn't tell anyone. No one in the neighborhood was aware of my disease. I didn't even tell my family members, except for my cousin, whom I told so that if my situation worsened, he would be prepared to take me to the hospital (participant 4).*

Discrimination

Another key experience among the participants was discrimination, which they saw either in themselves or their relatives. Fear and exclusion lead to the construction of an atmosphere of discrimination. Several participants described their experiences with occupational discrimination. At the beginning of the pandemic, when intense fear prevailed throughout society, occupational discrimination became prominent. In the workplace, anyone who coughed or sneezed was labeled as infected or suspicious, leading to their rejection by others. Notably, people who became infected continued to experience a sense of discrimination even after returning to work. The discrimination seems to be involuntary; it may be a social compulsion influenced by the atmosphere of fear, wherein the pandemic appears to have led to such discrimination against COVID-19 patients.

> *My father was hospitalized and died in a COVID-19 ward for unknown reasons. You can't imagine the calamity that we went through. There was no one to participate in the funeral, and I was deprived of seeing my father for a final farewell, which is something that will forever hurt me (participant 22).*

> *I went to a company for a job interview. The employer asked me to pull my mask down. I said that I am suspicious [a possible contact of someone with COVID-19]. He asked what I was doing there and told me to leave immediately and to come back later. In my current workplace, my coworkers told the employer to prevent me from coming to work (participant 17).*

Another form of discrimination was familial discrimination in which the atmosphere of fear and rejection would prevent family members from paying appropriate attention to a person with or suspected of having COVID-19. The family is not interested in communicating with or caring for the individual, who then must minimize family expectations.

> *I saw my family behaving in such a way as if I no longer had a place in the house … they would treat me differently than other family members. That's why I moved out; I found living apart to be better. I've lived apart from them ever since (participant 8).*

Social discrimination also occurs in social interactions between healthy individuals and those with or suspected of having COVID-19, their families, and families who have lost members due to COVID-19. In these situations, minimal contact is made with these individuals, and even condolences are sparingly given, and they are shunned in social situations. Perhaps the reason for all this social discrimination is that people are afraid that as soon as they begin a conversation, they may be infected or will be forced to visit the affected person or family.

> *In our neighborhood, I remember that no one would even reply to the greeting of the first person who became infected; people would pass by him swiftly as if he had all sorts of faults. An old man fell victim to COVID-19. When he died, even the way that people offered their condolences to the family differed from the usual (participant 4).*

Someone had willed for their body to be taken to the family village after their death. However, the villagers blocked the ambulance from entering the village. Ultimately, the person was buried in a desert nearby the village (participant 23).

Loneliness

A prominent theme among COVID patients is the intense feeling of loneliness. The first issue associated with loneliness is the loss of social and psychological support from loved ones, which was experienced by over one-third of the participants. Families were living in a state of fear and rejection. In these situations, family members usually inadvertently change their behavior toward those suffering. Furthermore, some participants described that family members would specifically expose the patient to severe social pressure in demanding that they follow COVID protocols during isolation. Many participants who stayed home in self-quarantine and sent their family members elsewhere experienced extreme loneliness. The absence of close loved ones such as a spouse, children, or parents and the fear and concern of illness and death created an overwhelming situation. In a house with multiple family members, the patient was typically isolated in a room and given food and medicine. The participants described that the infected or suspected person was constantly warned by those around them. While some had sent their family members to live apart from them, others felt abandoned, as their family members made the decision to leave. The most difficult experiences were described by those who were suddenly living alone.

As soon as I got sick, my parents left me alone and went to the village. I became very sad. My sister would visit every day and put the food behind the door; she wouldn't even stop a moment to talk to me (participant 11).

My older sister kept calling and saying that if mom and dad got sick, it would be my fault (participant 17).

Another category of loneliness is a sort of biological-physical experience related to the first theme, ie, fear and rejection. In this situation, the sufferer is dominated by the components of fear, worry, uncertainty, feeling dirty, and feeling like they have a terrible illness, giving rise to an unpleasant feeling of disgust toward the individual's own body. Any physical symptom reinforces this feeling of self-disgust and strengthens the fear of getting worse and dying.

Due to the way my colleagues would treat me, I would be left feeling dirty. It was a very, very bad feeling (participant 17).

It was as if I had leprosy; it was a very unique situation (participant 5).

When you test positive, it's like you have al … it's not a good feeling (participant 1).

The final category of the loneliness theme reflects the most important phenomenon that patients have experienced during the COVID-19 era, which is being distant from friends, family, and society. In addition to the difficulties embedded in the disease process, the absence of first-degree relatives creates a psychologically challenging condition. Constantly feeling lonely, continuous worrying, fear of disease progression and death, and the absence of a first-degree relative are extremely troubling for the individual. The sufferer feels a deep sense of loneliness—as if it is the end of the world and there is no one left to come to their aid.

I realized something during this period: it is because of this loneliness that people get sicker and lose their spirit, or even pass away. Living alone is not part of human nature, and this phenomenon itself can hurt people a lot (participant 21).

Psychologically, I felt completely torn apart for a while. Everyone avoided me and whoever had contracted the disease after seeing me even a long time beforehand would blame me. They would even call me up to condemn me (participant 20).

DISCUSSION

The present study revealed that stigma in patients with COVID-19 is not an individual or minor problem, but rather comprises a very serious social issue. According to our analysis, 3 major themes were identified: (1) fear and exclusion, (2) discrimination, and (3) loneliness. It is understandable that there is confusion, anxiety, and fear about this unknown and rapidly transmitted disease among the public. Therefore, addressing these themes could be the primary goal of supportive care for these patients.

The results of our study do not justify the deprivation of COVID-19 patients and their families from their human and social rights.[31,32] In the current pandemic, there has been a lot of social stigma and discrimination against individuals perceived to have been in contact with the virus.[8,16] However, this is not a new issue, as Davtyan et al[33] found that there were forms of stigma during the Ebola outbreak that were similar to those reported in HIV/AIDS studies. Also, Karamouzian and Hategekimana[34] pointed to the fear and stigma of Ebola as a barrier to preventing the disease from spreading. A study by Farag et al[35] also noted stigmatization during the Middle East respiratory syndrome pandemic in Qatar. However, we believe that stigmatization during the COVID-19 pandemic has been much more severe than in previous public health crises.

In line with our findings, other studies[36,37] have shown that social exclusion has created barriers between COVID-19 patients and society, influencing the physical and mental health and overall well-being of those who become infected. A study by Ornell et al[46] showed that negative social stigma is mostly due to rejection and fear of acquiring COVID-19. Some researchers have referred to a constant sense of anxiety in the general population.[38–40] Other researchers[41] have theorized the relationship between the disease and the prevalence of anxiety, while some have addressed the effects of lockdowns, self-isolation orders, and strict quarantine measures, emphasizing the importance of the potentially

neglected mental health outcomes of the pandemic.[42] The situation not only alters the attitudes of individuals but also transforms and reassembles their emotions, beliefs, and values.[16] In addition, habits and daily behaviors are strongly affected by the COVID-19 outbreak.[43]

Stigma may influence the actions of those who are stigmatized. Many of the participants in the present study described their social experiences with the central concept of discrimination. Discrimination is in fact a state of differentiation and stereotyping at the community level wherein an individual is made to feel that he or she does not belong to a certain class. In other words, in the process of social discrimination, a symbolic social order assigns an individual to a class that they do not belong to according to the individual's own criteria and to those of society in its normal state. The individual experiences verbal indifference, even from relatives and loved ones. Such discrimination also gives rise to a sense of injustice, which has been reflected in research in the field of COVID-19–associated stigma. Research from around the world has found that fear and anxiety about the virus has led to social stigma and discrimination.[18] Addressing fear, loneliness, and discrimination toward COVID-19 patients should be a priority for public health professionals.[44,45] Cooperation between all sections of society in dealing with negative social stigma is essential but represents a serious challenge.[46]

It seems that stigma and its psychosocial complications have been substantially embedded within the context of COVID-19. Patients have found the atmosphere of being rejected by those around them to be quite disturbing. The absence of others from their daily lives has added psychological and social strains to their health problems. Our interviewees described literally or figuratively the unique feeling of realizing they had to distance themselves from others. This unique feeling brings about a sense of rejection that increases the suffering of the patient. Feeling rejected may extend over time, with the individual feeling the stigma even after being assured by their doctor that they are no longer infectious (continuation of rejection).

Fear and rejection intervene and intersect with the meaning units of the third theme. A child's conceptual network may be disturbed in its mirror stage, as described in Lacan's psychoanalytic theories under the influence of Freud.[47,48] Normally, in the epistemological network of the individual, there is an overall conceptual framework that lacks any deep gaps.[47,48] When a person acquires COVID-19 and is faced with rejection from those around them, their conceptual framework is disrupted. The loneliness that comes with rejection is considered as a harm in the patient's cognitive network, as they expect the company of loved ones but instead become the subject of stigma and are avoided, similar to that which occurs in the mirror stage in a child's mental and psychological systems. Phenomenologically, this experience is rather unique, as reflected in the personal accounts of those infected with COVID-19 during the pandemic.[49,50] The social stigma of disease and stereotyping seen in the current pandemic should trigger radical changes in helping patients in terms of their social and psychological well-being.

In their 2020 study, Grover et al[51] demonstrated an urgent need to understand and address the mental health issues of patients with COVID-19 during hospitalization or quarantine. Uncertainty about the illness, limited support from family, and fear of death of oneself or loved ones give rise to severe psychological stress, making mental health assessments and the provision of mental health support crucial. Bruns et al[52] showed that from the start of the COVID-19 pandemic, feelings of fear have encompassed patients. There are concerns that fear and stigma may be more severe during the current pandemic relative to other infectious disease outbreaks.[52]

In line with the literature, the findings of the present study revealed that the stigma caused by COVID-19 at the individual level may lead to delay or refusal of care, noncompliance with containment measures and treatment, and physical and psychological stress. In addition, Ren et al[53] found that stigma is associated with problems in diagnosing and controlling the disease, feelings of rejection and loneliness, and increased mortality and complications, consequently exerting negative effects on public health. Persistent discrimination and false beliefs associated with the disease may become major barriers to effective public health interventions such as vaccinations. Other studies[44,46] have rightly pointed out that for an infectious disease prevention program to be effective, the stigma associated with it must be actively addressed. Therefore, addressing the fears, loneliness, and discrimination felt by those afflicted with COVID-19 should be a priority for public health professionals.[44,45]

Combating COVID-19–associated stigma requires evidence-based cultural strategies. Lessons learned from successful experiences of dealing with past epidemics as well as WHO guidelines for dealing with such social stigma can help inform public health campaigns to address this issue. While emphasizing the importance of words, WHO recommends that those with COVID-19 should not be addressed as *COVID-19 cases* or *COVID-19 victims*. Furthermore, the patients' families should not be addressed using terms like *COVID-19 suspects* or *suspicious cases*, and conversations about patients should not include the use of phrases such as *carriers and transmitters of the disease* or *contaminants of others*. These recommendations are important because such words implicitly indicate intentional transmission and put blame on the patient, reinforcing attitudes of stigmatization and labeling.[54,55]

We selected 3 provinces of Iran and received acceptable data saturation from 3 different geographical areas of the county. However, this study included limitations. First, telephone interviews may possibly result in shorter conversations with the interviewee compared to face-to-face interviews. Second, the physical and spatial conditions of the interviewees may have varied at the time of the interview, possibly affecting the findings. Third, it seemed to be more difficult to gain a patient's trust in a telephone interview relative to a face-to-face interview. Nonetheless,

telephone-based interviews seemed to be more appropriate considering the urgent health situation caused by the pandemic. Finally, a larger study, enrolling patients from more provinces to gather samples with a richer ethnic and racial diversity, is warranted.

CONCLUSION

Familial, social, and occupational discrimination; embarrassment; social isolation; and disruption of social support systems and relationships affect the mental health of COVID-19 patients. These factors may negatively affect recovery from the disease, making it more difficult for health officials to curb the pandemic. We recommend that primary care physicians direct their attention toward the psychological needs of stigmatized patients and their families. Furthermore, efforts should be made to minimize stigmatization and its associated pressures through different cultural and educational programs. Finally, to understand the long-term mental health consequences of this devastating pandemic, prospective or retrospective multicenter studies with larger sample sizes should be conducted.

Submitted: October 14, 2021; accepted January 5, 2022.

Published online: March 24, 2022.

Relevant financial relationships: None.

Funding/support: This study was supported by Vice Chancellor of Research, Shiraz University of Medical Sciences, Shiraz, Iran (grant no. 20183).

Role of the sponsor: The supporters had no role in the design, analysis, interpretation, or publication of this study.

Acknowledgments: The authors thank all participants who helped with this study.

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