

The “Untold” Side of COVID-19: Social Stigma and Its Consequences in India

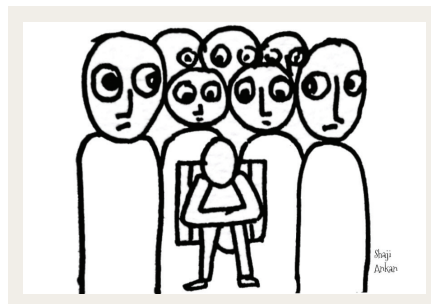
Prama Bhattacharya¹, Debanjan Banerjee², TS Sathyanarayana Rao³

Imagine a society of saints, a perfect cloister of exemplary individuals. Crimes or deviance, properly so-called, will there be unknown; but faults, which appear venial to the layman, will there create the same scandal that the ordinary offense does in ordinary consciousnesses. If then, this society has the power to judge and punish, it will define these acts as criminal (or deviant) and will treat them as such.”

—Émile Durkheim, *Rules of Sociological Methods*, 1895, p. 123¹

The Canadian sociologist Erving Goffman theorized that social stigma is an attribute or behaviour that socially discredit an individual by virtue of them being classified as the “undesirable other” by society.² There has been a long association of social stigma with illness. Through the process of othering, social stigma segregates the healthy from the ill. It creates stereotypes and prejudice. “Othering,” originally a philosophical concept given by Edmund Husserl, describes the reductive action of labeling and defining a person as a subordinate in terms of category.³ This generates a “we versus they” dichotomy that helps

in the establishment of a socioeconomic hierarchy. During times of social crisis (pandemics in this case), it can lead to discrimination and blame. Those who have any association with the illness are discriminated against and socially isolated, with their human rights being violated. The unknown factors about illness create fear, myths, and rumours around



them that heighten social stigma. This can negatively affect the treatment and prevention of the illness. Especially, pandemics of infectious disease outbreaks have had a historical relationship with stigma and prejudice. Mary Malon, in the 18th-Century England, became infamous as “Typhoid Mary,” guilty of spreading the infection amongst affluent families, though she was unaffected. The concept

of “asymptomatic carriers” came quite later; however, the textbooks still bear her name associated with an illness.⁴ Transmission of infections has always been associated with “poverty, filth, and class,” to maintain a false sense of assurance and safety for the higher sections of society. The “pestilences” of bubonic plague, Asiatic flu and cholera, Middle East respiratory syndrome, and Ebola outbreak in Africa, all have been associated with polarization, racism, blame against certain ethnicities, and resultant psychological distress.^{5,6} The concept of naming illnesses by the country or place of origin has been termed as “epidemic orientalism” and is considered to be a form of social labelling.⁵ Even acquired immunodeficiency syndrome (AIDS) had been termed as the “Gay Plague,” being theorized as a “divine punishment” for homosexuality.⁷ The tradition is reflected in the legislation of many countries that still prevent homosexual men from donating organs and blood. Research has shown that the fear and uncertainty of unknown infections affect human behavior significantly. Panic, illogical beliefs, aggression, blame, and “othering”

¹Dept. of Humanities and Social Sciences (HSS), Indian Institute of Technology Kanpur (IITK), Kanpur, Uttar Pradesh, India. ²Dept. of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Karnataka, India. ³Dept. of Psychiatry, JSS Medical College and Hospital & JSS Academy of Higher Education and Research, Mysuru, Karnataka, India.

HOW TO CITE THIS ARTICLE: Bhattacharya P, Banerjee D, Rao TSS. The “untold” side of COVID-19: Social stigma and its consequences in India. *Indian J Psychol Med.* 2020;42(4): 382–386.

Address for correspondence: Debanjan Banerjee, Dept. of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, Karnataka, India. E-mail: dr.Djan88@gmail.com

Submitted: 20 May 2020
Accepted: 31 May 2020
Published Online: 14 Jul. 2020



Copyright © 2020 Indian Psychiatric Society - South Zonal Branch

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620935578

are some of the unhealthy offshoots.⁸ The need to hold someone accountable based on power and social hierarchy has been explained by the social attributional theories.⁹ Through decades, humans have paid the price for being “social beings” by fostering hate-mongering as an inevitable accompaniment of biological disasters.

The outbreak of coronavirus disease 2019 (COVID-19) has created social stigma and discriminatory behavior towards individuals who are perceived to have any contact with the disease. This is one of the most large-scale outbreaks known to the modern world. It has affected more than 10 million globally and killed nearly 516,000—the numbers rising as we speak.¹⁰ Pandemics such as these are much beyond just biological phenomena. They create lasting psychosocial consequences that persist longer than the infection itself. Besides the direct psychological impact of stress, fear, anxiety, and mass hysteria, COVID-19 has led to the emergence of significant stigma, “othering,” prejudice, and blame that have strained both inter-regional and international relations. From the very time of its origin at Wuhan, China, the infection has been termed as “Chinese virus” or “Kung Flu,” which later fostered conspiracy theories about biological warfare, which strained international relations. Ironically, social stigma has spread faster than the virus itself. This commentary briefly glances at the resultant social stigma of COVID-19 pandemic in India, the vulnerable populations, and the impact of it on the society at large. It then highlights the ways forward to mitigate this “social evil” associated with the outbreak.

The Victims of Social Stigma During the COVID-19 Pandemic

The stigma around COVID-19 stems from the fact that a lot is unknown about it. Scientists, researchers, and medical professionals around the globe are still working at a breakneck pace to figure out the strategies to deal with the novelty of this virus. The fear of the unknown has overwhelmed humankind evolutionarily. Human beings tend to distance

and segregate themselves from the unknown. Deviant has been branded and stigmatized in all eras of human history, particularly in the history of medical science. Whenever there has been a lack of explanation, be it scientific or supernatural, the affected individuals have been segregated, labelled, and stigmatized, and therefore, ostracized as a consequence.

Social stigma towards the segregated appears to be normal behavior to the common mass. It gains social acceptance amidst the chaos of the unknown. Institutional segregation of those who are affected by a disease, at present COVID-19, further strengthens the stigma. We are aware of the social stigma experienced by those who are admitted to institutions for mental illness, leprosy, HIV Aids, or tuberculosis, even today.^{11,12} Even the prevention of COVID-19 demands segregation; terms like quarantine, social distancing, and isolation have become an integral part of the household vocabulary. Hospitals have been allocated particularly for the treatment of COVID-19, separate laboratories been assigned, quarantine zones been set, containment zones have been created, and the country has been divided into color zones depending on the incidence rate. Indeed, these are steps to flatten the ever-rising graph. However, since a pandemic is much more than a biomedical phenomenon, all these steps have their own social implications as well. For example, the Air India crew members who brought hundreds of stranded Indians back home experienced being stigmatized by their neighbors when their homes were stamped “quarantined.”¹³ Similar experiences have been reported by home-quarantined individuals when the Delhi Government decided to put up notices outside their home.¹¹

Incidents of social stigmatization towards those who are affected with COVID-19, including their family members, have been rampant. Individuals who have succumbed to the illness have been denied their last rites. In many cases, the families have refused to accept the bodies, and the state governments have performed the cremations instead.^{14,15} As an action towards such ostracizing behaviors, some states of India even is-

sued orders to bring criminal charges against anyone obstructing the performance of the last rites.¹⁶ Many incidents have come to light where the survivors have been isolated by the neighborhood, forcing them to live a life that is far from ordinary. Being labelled with multiple tags like “super-spreader” only worsens their suffering.¹⁷ The medical symptoms of COVID-19 subside, leaving behind the society to ostracize the survivors for days innumerable.

The stigma is directed not only towards those who have recovered from COVID-19, those who are undergoing treatment, or who are presumed to be affected or who have succumbed to it or their families. The brunt of social stigma is also faced by frontline workers, medical practitioners, nurses, police personnel, etc. They have been forced to leave the neighborhood and denied access to their houses and the families have been threatened. The insurmountable atrocities that they have been undergoing to win this race against the virus have been ignored. Instead, social stigma has overpowered the goodwill of those for whom they are fighting.¹¹ The way mental health practitioners are labelled as *paagolon ka doctor* (doctor for the mad person), the frontline workers who are tending to those affected by COVID-19 are being stereotyped against.

Social stigma towards certain marginalized groups like the homeless or the migrant laborers has also been witnessed. On returning home after months of being stranded in various parts of the country, the workers and their families have been singled out, sneered at, and harassed by the community members. At some places, they have been cast off even after completing the mandatory 14 days’ quarantine.¹⁸ Similarly, in the wake of the spurt of cases following a religious gathering in Delhi, the social media was flooded with communalistic and provocative sentiments.¹⁹ In a country like India, with a history of multiple communal riots, such stigmatization might bear significant consequences. The Government of India issued an advisory on April 8, 2020, asking its citizens to act more responsibly in such a critical time and to refrain from stigmatizing any community or area.²⁰

The “Dual” Burden: Struggle with COVID-19 and Related Social Stigma

Social stigma towards different stakeholders during a pandemic like COVID-19 might play a significant role in undermining social cohesiveness, enforcing social segregation.²¹ The International Federation of Red Cross, WHO, and UNICEF issued guidance to prevent and address the social stigma around COVID-19.²¹ The report identifies the impact social stigma might have on both treatment and prevention of the disease.

There have been multiple instances reported in various states of India where individuals have not reported their history of foreign travel or symptoms of COVID-19 due to the fear of facing social boycott and discrimination, leading to low testing and high mortality rates.^{22,23} According to public health experts, the social stigma associated with being diagnosed is creating a fear among the public and is acting as a deterrent to the effective management of the disease, particularly in the urban setup.

The stigmatization is taking a heavy toll on the mental health of the frontline workers as well as those who are recovering or have survived the disease. Media has reported the influence of isolation and discrimination on suicides in India.²⁴ Experiencing isolation and stigma from social boycotting and religious discrimination can increase the risk of loneliness and self-harm.²⁵ Data related to suicides during the COVID-19 period in India is scarce. As per the cases reported in the media, 168 out of 326 non-coronavirus-related deaths in India (data till May 9, 2020) are due to suicide²⁶; however, the source of this statistics has not been clearly mentioned. Reverse migration, the two-months-long lockdowns, and fear of job loss are making individuals vulnerable to self-harm and depression. Social stigma, as well as the self-inflicted stigma associated with the pandemic, is further catalyzing the process. However, these are largely media reports that can have their inherent bias. Systematic population-based studies over the next few months after the pandemic will help us estimate the actual risk of suicide attributable to COVID-19.

In an unprecedented event, hundreds of nurses (more than 350, as on May 17, 2020) quit their job from multiple private hospitals in West Bengal in two days.²⁷ Most of these nurses belong to other states, and they started returning to their native states. While the experts are still at a loss in understanding what led to such a mass resignation, fear of treating those who are affected with COVID-19 and the social stigma associated might have encouraged such unfortunate behavior.

Mitigating the Social Stigma: The Way Forward

Social stigma might threaten the basic structure based on which a society grows. In times like this, when “physical distancing” and “physical isolation” are much-required steps to keep oneself and the loved ones safe and healthy, society might need to act together to stand against all things, be it COVID-19 or the stigma associated, that challenge its cohesiveness.

Wording Sensitively

Historically, it has been seen that the terms that are used in connection to a disease, *pagal* (mad) for individuals with mental illness or *pagalkhana* for hospitals treating mental illness, can possibly shape the lens through which society is likely to perceive that disease. Illness creates othering. Coining terms to address those who are affected with COVID-19, or for that matter, any illness, widens the gap between self and others, instead of bridging it. It thus becomes critical to consider the words that are used in relevance to COVID-19 by not only medical professionals but also organizations like WHO and UNICEF, public directives and notices, promotional campaigns and advertisements, and media.²⁰ For example, “a person suffering from COVID” is more appealing than “COVID positive.” Terms like “coronized,” used in casual humor, can be perceived as labelling. Acknowledging the affected as victims of the pandemic, rather than the source, is helpful. Also, the frontline COVID warriors need community support and encouragement rather than discrimination.

Amplifying the Voices

It is relevant to involve and amplify the voices of those who are affected by COVID-19 the most, to develop stigma-mitigating strategies. It would involve those who have recovered from it, those who are undergoing treatment, their families, families of those who have succumbed to the disease, as well as frontline workers. Their lived experiences of COVID-19 and other intersecting stigmas can contextually inform public health strategies to mitigate stigma. Furthermore, the stories of recovery are likely to create hope in public that might help individuals come out with their symptoms instead of hiding them. As identified earlier, social stigma is deterrent to testing for the disease. Thus, learning from the survivors that recovery is possible would encourage people to deal with this stigma.

Furthermore, the everyday struggle of the frontline workers should also be focused on. Their experiences, when remaining unheard, might not generate the gratitude that they deserve from society. The life risk that is undertaken by them to provide us with a safe and healthy society stays in the background, while we express stigmatized behavior towards them.

Acting Responsibly

It is not only on the government and frontline workers to act responsibly in a critical circumstance like this. Apart from them, political leaders, media, and, most importantly, the citizens need to act responsibly and do their parts sincerely in fighting the pandemic and related stigma.

One must stay informed. Stigma can be heightened by insufficient knowledge. It is thus necessary to spread the knowledge about COVID-19 (e.g., what causes it, how it is transmitted, treatment, and prevention) without using medical jargons. While social media can be a useful platform to reach the maximum people while lockdown is practiced, its use must be done responsibly. In the past, the misuse of social media had created further stigma than reducing it.²⁸ At the same time, journalistic reports that focus on an individual’s behavior or role in

“spreading the virus” might create stigma among the public. Such publication must be dealt with sensitively, keeping in mind the disruption it might create in the life of those who are involuntarily forced under societal scrutiny. The Ministry of Health and Family Welfare, Government of India, has also issued a directive that highlights the importance of the responsible role the citizens need to play to empower the community to respond effectively and appropriately in the face of adversities.²⁹ Knowledge, attitudes, and practice (KAP) can actually be improved through community awareness. Based on the Zika outbreak model, Banerjee and Nair have proposed a community-based psychosocial toolkit that involves all levels of health care, with an active health-media liaison, to improve the information–education–communication (IEC) activities during the COVID-19 pandemic.³⁰

Engaging social influencers such as religious leaders and celebrated actors and cricketers, and their take on COVID-19 and stigma, might also be influential in fighting stigma. The recently launched “Break the Stigma” campaign, featuring Amitabh Bachchan, is one such initiative undertaken by the Government of India.³¹ Such steps would not only ease the struggle of the survivors against the stigma but would also deal with the infodemic of misinformation and rumor that is playing a crucial role in creating stigma and racism. Understanding the crisis in humanitarian perspectives is a collective responsibility. The “we versus they” dichotomy mentioned before can only add to a set of common processes and conditions that amplify group-based inequalities and marginality. Knowledge, awareness, care, and empathy are probably the generic but neglected pillars to change “othering” into inclusiveness, collectiveness, and belonging for better coping and resilience against the ongoing crisis.

Conclusion

At this juncture, when the number of individuals affected with COVID-19 has crossed six lakhs in India,¹⁰ we are in dire need of more than just information to reduce the tension related to the pandemic

and to mitigate the stigma surrounding it. Multilevel strategies are required to address the underlying stigma drivers and facilitators.³² An intersectional lens can improve the understanding of the ways in which COVID-19 stigma might be intersecting with gender, race, immigration status, and health status, among others.³³ We had long taken the shelter of science to understand diseases and their pathogenesis. But, unfortunately, stigma exists beyond scientific understanding of diseases, at all societal levels. This is aided by misinformation and xenophobia during pandemics. Certain sections of the society are already vulnerable—for them, being targeted by society is a “dual pandemic” apart from COVID-19 itself. Very few times in history has the human race faced such uncertainty about itself. The pandemic will eventually cease, but the resultant stigma might prevail in the society for times unknown. Historically, pandemics have flared up hate but not “caused” it. It is unfortunate to see a civilization dealing better with medical rather than social management of infectious outbreaks. As COVID-19 is still in its early stages, unchecked stigma can lead to dire psychosocial comorbidities, the risk of psychiatric disorders and suicidality being one of them.²¹ Pandemics or epidemics do not discriminate based on sociopolitical, ethnic, or economic divisions. More than ever, society requires its solidarity and cohesiveness to deal with this pandemic. By reducing the stigma around this pandemic, its prevention, and containment, we might be able to develop immediate and long-term strategies to build empathy and social justice for the days ahead. COVID-19 just gives us one more such opportunity to strengthen our social resilience

References

1. Durkheim E. *Rules of sociological method*. New York, NY: Simon and Schuster, 1895.
2. Goffman E. Stigma and social identity. in Rainwater L (ed), *Deviance and Liberty, Social Problems and Public Policy 1974*. New York: Routledge; 1974.
3. Canales MK. Othering: Toward an understanding of difference. *Adv Nurs Sci* 2000 Jun 1; 22(4): 16–31.
4. Leavitt JW. *Typhoid Mary: captive to the public's health*. Boston, MA: Beacon Press, 2014 February 18.
5. Anderson W. Immunities of empire: Race, disease, and the new tropical medicine, 1900–1920. *Bull Hist Med* 1996 Apr 1; 70(1): 94–118.
6. Davtyan M, Brown B, and Folayan MO. Addressing Ebola-related stigma: Lessons learned from HIV/AIDS. *Global Health Action* 2014 Dec 1; 7(1): 26058.
7. Van Wyngaard A. Towards a theology of HIV/AIDS. *Verbum et Ecclesia* 2006 Jan 1; 27(1): 265–290.
8. Manfredi P, and D’Onofrio A, eds. *Modeling the interplay between human behavior and the spread of infectious diseases*. Berlin: Springer Science & Business Media, 2013 Jan 4.
9. Kelley HH. Attribution theory in social psychology. In: Levine D (ed), *Nebraska symposium on motivation 1967*. Lincoln: University of Nebraska Press, 1967.
10. World Health Organization. *Coronavirus disease 2019 (COVID-19). Situation Report 163*. Geneva: World Health Organization, 2020.
11. Bharat S. A systematic review of HIV/AIDS-related stigma and discrimination in India: Current understanding and future needs. *SAHARA J* 2011; 8(3): 138–149.
12. Trani JE, Bakhshi P, Kuhlberg J, et al. Mental illness, poverty and stigma in India: A case-control study. *BMJ Open* 2015 Feb 1; 5(2): e006355.
13. Krishnatray P. COVID-19 is leading to a new wave of social stigma. *The Wire* [Internet]. May 12, 2020 [cited May 17, 2020]. <https://thewire.in/society/covid-19-social-stigma>
14. Sharma S. Kin of COVID-19 dead in Punjab refuse to attend last rites. *DownToEarth* [Internet]. April 10, 2020 [cited May 17, 2020]. <https://www.downtoearth.org.in/news/health/kin-of-covid-19-dead-in-punjab-refuse-to-attend-last-rites-70379>
15. Bajpai N. Noida DM performs last rites of COVID-19 victim as relatives refuse to receive body. *The New Indian Express*. May 13, 2020. <https://www.newindianexpress.com/nation/2020/may/13/noida-dm-performs-last-rites-of-covid-19-victim-as-relatives-refuse-to-receive-body-2142919.html>
16. Chavan V. Obstruct last rites of COVID-19 victims, face criminal charges. *Pune Mirror* [Internet]. May 8, 2020 [cited May 17, 2020]. <https://punemirror.indiatimes.com/pune/civic/obstruct-last-rites-of-covid-19-victims-face-criminal-charges/articleshow/75610268.cms>
17. Ram T. Branded “super spreader,” family of Karnataka COVID-19 victim battles stigma. May 13, 2020 [cited May 17, 2020]. <https://www.thenewsminute.com/article/branded-super-spreeder-family-karnataka-covid-19-victim-battles-stigma-124482>

18. Kumar C and Mohanty D. Migrant workers battle stigma, bias back home. *Hindustan Times* [Internet]. May 11, 2020 [cited May 17, 2020]. <https://www.hindustantimes.com/india-news/migrant-workers-battle-stigma-bias-back-home/story-ouuRSEZfoickVOrPUzagGL.html>
19. Krishnan M. Indian Muslims face renewed stigma amid COVID-19 crisis. *Deutsche Welle: Made for Minds* [Internet]. May 14, 2020 [cited May 18, 2020]. <https://www.dw.com/en/indian-muslims-face-renewed-stigma-amid-covid-19-crisis/a-53436462>
20. *The Economic Times*. Do not label any community or area for spread of COVID-19: Government. *The Economic Times* [Internet]. Press Trust of India; 2020 Apr 8 [cited May 18, 2020]. <https://economictimes.indiatimes.com/news/politics-and-nation/do-not-label-any-community-or-area-for-spread-of-covid-19-government/articleshow/75051453.cms?from=mdr>
21. UNICEF. Social stigma associated with the coronavirus disease (COVID-19) [Internet]. UNICEF [cited May 18, 2020]. <https://www.unicef.org/documents/social-stigma-associated-coronavirus-disease-covid-19>
22. *Hindustan Times*. Social stigma, low testing behind WB's high Covid-19 mortality rate: Report. *Hindustan Times* [Internet]. 2020 May 8 [cited May 18, 2020]. <https://www.hindustantimes.com/kolkata/social-stigma-low-testing-behind-wb-s-high-covid-19-mortality-rate-report/story-VGGBAEy-2IXueEplUxOGX3N.html>
23. NDTV.com. Stigma reason for high COVID-19 mortality rate in Ahmedabad: AIIMS Chief. NDTV.com [Internet]. Press Trust of India; 2020 May 10. <https://www.ndtv.com/india-news/coronavirus-stigma-reason-for-high-covid-19-mortality-rate-in-ahmedabad-aiims-chief-2226177>
24. Banerjee A. Anxiety over COVID-19 leads to Phagwara woman's suicide. *The Tribune* [Internet]. 2020 Apr 6 [cited May 18, 2020]. <https://www.tribuneindia.com/news/punjab/anxiety-over-covid-19-leads-to-phagwara-womans-suicide-66466>
25. *The Times of India*. Madurai: Stigma over coronavirus testing blamed for man's suicide. *The Times of India* [Internet]. 2020 Apr 2 [cited May 18, 2020]. <https://timesofindia.indiatimes.com/city/madurai/stigma-over-covid-testing-blamed-for-mans-suicide/articleshow/74939681.cms>
26. Srivastav A. 168 of 326 non-coronavirus deaths till 9 May were suicides, finds report: COVID-19 lockdown may cost us dearer than economy, warn psychiatrists. *The First Post* [Internet]. 2020 May 13 [cited May 18, 2020]. <https://www.firstpost.com/health/coronavirus-outbreak-168-of-326-non-coronavirus-deaths-till-9-may-were-suicides-finds-report-covid-19-lockdown-may-cost-us-dearer-than-economy-warn-psychiatrists-8357451.html>
27. *India Blooms*. Kolkata nurse crisis: 169 more private-hospital nurses resign, leave West Bengal. *India Blooms* [Internet]. 2020 May 16 [cited May 17, 2020]. <https://indiablooms.com/news-details/N/61686/kolkata-nurse-crisis-169-more-private-hospital-nurses-resign-leave-west-bengal.html>
28. Betton V, Borschmann R, Docherty M, et al. The role of social media in reducing stigma and discrimination. *Br J Psychiatry* 2015 Jun; 206(6): 443-444.
29. MoHFW. Addressing social stigma associated with COVID-19 [Internet]. MoHFW. [cited May 18, 2020]. <https://www.mohfw.gov.in/pdf/AddressingSocialStigmaAssociatedwithCOVID19.pdf>
30. Banerjee D and Nair VS. Handling the COVID-19 pandemic: Proposing a community based toolkit for psycho-social management and preparedness. *Asian J Psychiatry* 2020 May 7; 51: 102152.
31. Tewari S. Govt launches #Breakthestigma campaign with Amitabh Bachchan for covid survivors. *livemint* [Internet]. 2020 May 12 [cited May 18, 2020]. <https://www.livemint.com/industry/media/govt-launches-breakthestigma-campaign-with-amitabh-bachchan-for-covid-survivors-11589274819182.html>
32. Stangl AL, Earnshaw VA, Logie CH, et al. The health stigma and discrimination framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Med* 2019 Dec 1; 17(1): 31.
33. Logie CH and Turan JM. How do we balance tensions between COVID-19 public health responses and stigma mitigation? Learning from HIV research. *AIDS Beh*. 2020 Apr 13: 1-4.