Stigma and Health

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Significant Other Family Members and Their Experiences of COVID-19 in Pakistan: A Qualitative Study With Implications for Social Policy

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To the best of our knowledge, there is no research about the challenges faced by significant others of coronavirus patients in Pakistan, including spouses, children, siblings, and parents. We aimed to discover through an open-ended semistructured questionnaire the main challenges and coping strategies of significant others since the time their relative have been tested positive for coronavirus and taken to quarantine or admitted to the hospital. Sampling was done using contact information from three hospitals of Lahore with the largest quarantine facilities for COVID-19 patients. We used NVIVO to analyze the interviews of 20 participants through content analysis approach. The findings included three broad themes of experiences of stigma, struggles, and strengths and a total of 9, 6, and 8 subthemes under each theme, respectively. We conclude with key social policy recommendations to support families of coronavirus-infected people through salient areas of criminalization laws, therapy and counseling, surveillance and monitoring, employee protection, and accountability of government, health workers, and police.

Keywords: family, coronavirus, stigma, struggles, social policy

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Significant others are defined as close relatives with whom an individual has a deep emotional connection and lifelong attachment (Jakoby, 2015). Disease, pain, and public stigma suffered by an individual affects the life circumstances, social acceptance, and psychological health of significant others, such as spouses, parents, children, and siblings. Human behavior and social interaction play an important role on the impact of disease, the course of seeking treatment, and the ability to return to wellbeing for both patients and their families (Bohle, 2013). Stigma and mistreatment can contribute to health and social inequalities and also compromise national objectives for public health and safety (Helman, 2008). Studies have investigated the significant spillover stigma or courtesy stigma that family members can face (Goffman, 1963). Although stigma can lead to discreditable status for significant others, social psychologists have highlighted that because this status is created by social constructions, there is hope for social reform (Chaudoir, Earnshaw, & Andel, 2013).

There has been a lot of research on the stigma faced by people suffering from mental illness (Larson & Corrigan, 2008), plague and cholera (Hamlin, 2012), tuberculosis (Macq, Solis, & Martinez, 2006), HIV/AIDS (Bond & Nyblade, 2006), and the Zika virus (Howells & Pieters, 2018). However, less research has been done on the stigma and challenges faced by family members of people suffering from illness (Fischer, Mansergh, Lynch, & Santibanez, 2019). There is even little scholarship on stigma and psychosocial changes on family during infectious pandemics because most research agendas during emergency health pandemics start prioritizing diagnosis and clinic prevention (Huremović, 2019). Despite stigma being recognized as universal and ubiquitous (Murthy, 2002), we have to identify local and regional realities that create stigma to plan better interventions for antistigma.

Significance of Study

To the best of our knowledge, no research has yet been done on the family challenges faced by significant others of coronavirus patients in Pakistan. Our aim in this study was to understand the changed life circumstances of close relatives affected by coronavirus 2019 (COVID-19) patients in Pakistan to recommend better social and state support for them. The broad research questions for this study included identification of: (a) the main challenges and (b) coping strategies of significant others since the time their relative have been tested positive for coronavirus and taken to quarantine or admitted to the hospital.

Editor's Note. This article received rapid review due to the time-sensitive nature of the content. Our standard high-quality peer review process was upheld throughout.—PWC

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Methodology

This was a qualitative study using a semistructured open-ended survey (see online supplemental material). Ethics approval was taken from the Institutional Review Board of Forman Christian College University (Lahore, Pakistan) for this study. All ethics were observed during the research process, including anonymity, confidentiality, and seeking of informed consent. Participants were communicated the availability of free services from a trained psychologist if needed.

Sample

The authors were able to retrieve a contact list of the family nominees of 72 coronavirus-affected families who had been admitted at three government-allocated hospital quarantine wards of Lahore during February 2020 to April 2020. Names of the hospitals have been kept anonymous for confidentiality and because of lack of permission from the government. The selection criterion for this study was significant others who at the time of the study are COVID-19 negative and have close relatives who have tested positive for coronavirus. Furthermore, we aimed to sample significant others with relatives who are currently in quarantine, currently admitted in the hospital, or discharged for home in the last 3 months (March 2020 through May 2020).

Survey

A semistructured open-ended survey was developed by the authors based on past experience of qualitative research with marginalized populations and a literature review of previous scholarship on stigma. The survey included nine questions and explored areas of: (a) challenges faced by significant others, (b) experiences of support from state and society, and (c) coping strategies for survival. Use of the word stigma in the interviews was not used by the interviewer to avoid leading questions (Agee, 2009).

Data Collection

Data were collected in the month of May 2020 by the authors. All 72 cell numbers were contacted. The phone call was preceded by a text message communicating the purpose of the call, the aim of the research, and researcher information. Twenty-seven people did not answer, 15 declined participation, and 30 were willing to participate in the study. A total of 20 interviews were conducted. The response rate was 41.6%, which is a satisfactory response for social science research (Nulty, 2008). Data were collected telephonically and all conversations were audiotaped with permission of participants only for data analysis purposes.

Data Analysis

The data were analyzed using NVIVO software. A content analysis approach was pursued through which themes and subthemes of relevance and importance were generated (Bazeley & Jackson, 2013; Welsh, 2002). Transcription into Microsoft Word and theme generation occurred simultaneously. Interviews were translated from Urdu to the English language by the authors who are bilingual and fluent in both languages. After 14 interviews no new themes emerged. We conducted another six interviews to confirm final themes. Reliability was assured through manual coding and author discussions with senior researchers (Saldaña, 2015). Final themes (Table 2) were also shared with two significant others who had a loved one quarantined because of coronavirus, but had not participated in the study, to further ensure reliability of findings (Leung, 2015).

Findings

Sociodemographics. Table 1 presents the sociodemographic characteristics of the sample. The majority of the significant others were from Lahore city ($n = 15$). An equal number of participants were male and female ($n = 10$). The majority of the significant others were spouses ($n = 11$), and almost all had recovered family members from COVID-19 at the time of the interview ($n = 18$).

Table 1
Sociodemographic Characteristics of Significant Others Who Have Participated in the Study (N = 20)

Variable	Frequency
City	
Lahore	15
Faisalabad	2
Nankana Sab	1
Rawalpindi	1
Manan Wala	1
Gender	
Female	10
Male	10
Relation	
Wife	6
Husband	5
Mother	3
Sister	2
Brother	2
Daughter	1
Father	1
Age group (years)	
21–26	4
32–36	6
40–45	5
50–55	3
61–62	2
Wealth group based on household locality	
Low	9
Middle	9
High	2
Religion	
Muslim	19
Christian	1
Literacy	
Illiterate	3
Primary/secondary	5
Graduate	12
Current status of relative	
Recovered and home now	18
Deceased	1
Still admitted in quarantine	1
Number of HH members	
Between 2 and 5	8
Between 6 and 16	12
Number of children	
None	3
2	6
3–7	11

Note. HH = household.

Table 2
Summary of Themes and Subthemes for the Study

Theme	Subtheme
Stigma	- Police and health department harassment
	- Maltreatment by hospital administration and health care practitioners
	- Fear of hospitalization because of bad conditions, fear of hospitalization because of bad conditions, and ill treatment
	- Falsifying test results for revenge or as a precaution
	- Blame and rejection by neighbors and relatives
	- Doctors facing stigma from other doctors
	- Discrimination by employer
	- Having to shift locality
	- Difficulty in commuting for necessities because of mistreatment
Struggles	- Not being able to fully adopt social isolation and physical distancing
	- Inadequate knowledge and information about coronavirus
	- Having to substitute for mothers in the care for children
	- Suffering from depression and irregular sleep patterns
	- Difficulty in dealing with the new corona life
	- Anxiety for children, unborn child, and daughters specifically
Strengths	- Praying and patience
	- Time spent in reading religious text and fasting
	- Support and assistance from daughters
	- Counting blessings in difficult times
	- Spending time in household activities never done before
	- Planning for the future with regard to immunity and diet
	- Turning to media as a source of information and awareness
	- Physical exercise

The majority of the participants were graduates ($n = 12$), and nearly all were Muslims ($n = 19$). The wealth status of majority, based on household locality, was either low or middle class ($n = 18$) and the majority lived with 6–16 household members ($n = 12$) and had three to seven children ($n = 11$).

Themes of Stigma

Police and health department harassment. Significant others described the misbehavior of the police and health department as harassment and abuse during the course of detection, hospitalization of patient, and lockdown of home. A 62-year-old husband from the lower middle class, whose wife had been admitted for coronavirus, described his family's ordeal:

> We got a call from the health department at 12:00 AM in the night to come to the hospital immediately or else they would come to take us by force. All of us (family members) felt humiliated and scared by their tone and behavior.

A 55-year-old wife from a middle-class family with two children, shared her experience after her husband had tested positive:

> The police and health department people came to our house repeatedly, and always at night, to check whether any of us had gotten sick. At home alone with the children and without my husband, I was so afraid that I didn't used to put on the house or gate lights after dark.

Maltreatment by hospital administration and health care practitioners (HCPs). Participants described how there were maltreatment, neglect, and abuse by hospital staff and HCPs with regard to treatment support and dealing with comorbidities. A husband described how he had to visit the hospital daily to ensure his wife was provided the insulin she needed to survive:

> My wife was diabetic and needed to inject insulin. There was no provision in the hospital. I told this to the Medical superintendents of the hospital but received no help. I had to buy the insulin from the market. However, a bigger problem became asking for refrigeration for the insulin. I used to visit in the morning at 8:00 AM to help inject my wife. After repeated requests, the staff would eventually give us the insulin around 3:00 PM. Many times they threw it at me like it was something dirty. I tried to ask doctors for help, but everyone I approached during the stay behaved very badly with us.

A 45-year-old wife with four children from a lower-class locality described her experiences:

> When my husband was admitted, I was unable to find him at the hospital. They (doctors) would not talk to me or tell me where he was. The doctors literally took the peace out of our life and shredded it like paper. They (HCPs) treated us as if we were not humans.

Fear of hospitalization because of bad conditions. Significant others described the unsatisfactory conditions of the hospital and quarantine centers. A husband from a middle-class neighborhood shared that he knew of relatives who were experiencing symptoms but were not getting tested because of fear of hospitalization:

> Many of my relatives have symptoms, but they do not get tested because of the terror of what might happen with them if they were hospitalized.

In a 42-year-old husband, the fear is so great that he has recurring bad dreams of hospitalization and consequently faces paranoia in making contact with things and catching infection:

> I am afraid of going to sleep at night. I have bad dreams that I am admitted in the hospital. I am afraid of touching anything. We have all

> become overconscious about our health. It is not pleasant to be afraid like this from the inside.

Falsifying test results for revenge or as a precaution. Disturbingly, participants also shared how negative COVID-19 test results were being conveyed as positive by society members. Reasons for falsifying test results were described. A 62-year-old participant described how employers used falsification of laboratory reports as a means to take corporate revenge against his daughter:

> My daughter was asked to get tested for coronavirus by her office. The results were negative. Because of some office quarrel they (her employer) had, the test result changed to positive. The laboratory gave the negative test online, and in the evening, they changed the test result to positive.

A 32-year-old husband with three children explained that people from their neighborhood had been calling the health department and claiming that other members of his household also have coronavirus so that his family is removed from the neighborhood for safety:

> After my wife was admitted, the health department called us again that they have been informed by neighbors that there is another coronavirus patient in our house . . . and that we are hiding the case. I pleaded that this is not true and people are lying to you. All my family members have tested negative. We had to repeat the tests to make them believe us.

Blame and rejection by neighbors and relatives. Participants expressed sadness and shock at the treatment of neighbors since their family member had been detected with coronavirus. A 50-year-old mother with five children described how neighbors had become hostile and wanted them to leave the neighborhood:

> We were shocked by the behavior of our neighbors; it was horrible. Not only did they not want to see us, even when we exited for groceries with masks, . . . but they began to spread rumors about us. Some were seeking out ways so that the police or the army might arrest us.

A 32-year-old husband from a lower-class locality described how because of his wife testing positive, their neighborhood was forced into strict lockdown, with neighbors losing daily wages:

> People living around us were affected because of strict lockdown after my wife tested positive. There were people in our locality who sold milk for business. During lockdown police didn't allow them to sell anything or earn an income. There was blame on us for this!

Some participants mentioned their hurt feelings about family relatives not wanting to meet them. A husband whose wife had coronavirus described that even though he had tested negative, family members were reluctant to meet him:

> Close family members were reluctant in seeing us, as they always used to do after discovering that my wife had coronavirus. Although we were following the protocols of social distancing, I still see fear in their eyes. This shift in behavior was a very difficult to handle and upsetting for us.

Doctors facing stigma from other doctors. There was also the stigma faced by significant other doctors from the medical fraternity and the consequent humiliation felt. A 55-year-old doctor, whose wife had contracted coronavirus, described how, although he had tested negative and was following protective measures at work, he was treated as if he was an infection carrier:

> My colleagues are suspicious of me, despite my negative test results and strict observance of a PPE [personal protective equipment]kit. This has been painful since my colleagues know that I would not jeopardize them or my patients. . . . We are doctors. I am upset that this behavior has been shown to me by the medical fraternity.

Discrimination by employer. The economic consequences to coronavirus-affected patients and their families was a significant theme, specifically with regard to job security and continuation of contractual jobs. A wife with four children shared that even though her husband's reports were now negative, people did not believe them and he was not allowed to return to work:

> I am worried about my husband's job and our household income. My husband's boss at work is not accepting the fact that his reports are negative now.

Having caught coronavirus at the workplace and then facing discrimination because of it was also a concern. A 62-year-old father complained that instead of getting compensated, his son's contract was rescinded:

> As a security officer at a bank, my son got it (coronavirus) on duty. Now that he has recovered, his contract has not been resumed. We cannot complain to the government as the employers draft 3-month contracts. This way they can dismiss us without explanations when it is convenient for them.

Having to shift locality. Some participants shared that the stigma and discrimination faced in their locality was so great that they were planning to shift houses. A newly married 26-year-old woman elaborated on how she had shifted temporarily to her parent's home because of lack of safety until they could find a permanent residence:

> Since people in that area knew that my husband is admitted in hospital, horrible things started happening. One night I heard gunshots. In the morning I got to know that they were fired by the neighbor's security guards at intruders who were spying on my home. Thank God my husband has returned, but I can never live in that neighborhood. We have now shifted to my parent's house until we find another home.

Difficulty in commuting for necessities due to mistreatment. Participants also described the difficulty of facing self-quarantine and managing mandatory visits out of the home because of discrimination. A 35-year-old mother with two children described how she experienced pain and humiliation from neighbors when taking her children to the doctor:

> When my husband was admitted in the hospital, both of my kids got sick. Their pediatrician lives near my mother's home. Leaving the house and finding an auto rickshaw was very painful for me. People in my locality gave us bad looks and an old uncle gave me a lecture on leaving the house.

A 45-year-old wife with four children described how she was unable to leave the house to buy groceries or borrow money for essentials because of mistreatment and stigma:

> It was a huge crisis for us. It felt like my husband had died and our children had become orphans. There was no financial support or anyone to bring us groceries. No one talked to us in the neighborhood and everyone treated us with hatred. They treated us as if we were not humans.

Struggles

Not being able to fully adopt social isolation and physical distancing. Participants described the challenge of maintaining self-isolation and adopting preventive behavior because they had to visit the hospital daily to check on their family member because of unsatisfactory management of coronavirus patients and fear of maltreatment by HCPs. A husband described his difficulties while his wife was hospitalized and the fear for his children:

> I had to go to hospital daily to check on my wife, as things were not good at the hospital. . . . I asked my sister came to our home and look after my children. The child wept all day at home. I too used to weep upon return for fear that I might get sick and leave my children orphaned or bring the infection to them.

A wife shared that she had to leave the house to visit the bank, pay bills and school fees, and buy groceries, and consequently experienced great fear about catching the virus:

> There is so much confusion. We are in lockdown. Yet we have to go out daily . . . to the bank, the stores, to pay the school fees and utility bills. I am perpetually afraid of catching the virus despite wearing a mask and gloves.

Inadequate knowledge and information about coronavirus. An important theme was lack of knowledge and information about coronavirus prevention and management. Participants felt isolated and helpless in how to manage disease and protect their families. A 26-year-old wife stated:

> No one has shared proper information about prevention with me. You have no idea how much stress we accumulated because of this.

Another 45-year-old wife from a lower-class locality complained that although the government and health department were in contact to detect disease, there was no information sharing about prevention:

> Awareness about prevention is lacking in this pandemic. I did receive a phone call once or twice from the health department. However, they didn't provide any educational material regarding coronavirus; . . . they only asked about test results and if I had symptoms.

Having to substitute for mothers in the care for children. A compelling theme was that of the displacement and separation of mother and child. A 32-year-old husband with fiver children described the struggles of managing children who cried relentlessly without their mother:

> Taking care of children without their mother is the most difficult thing. Our children wept all the time while my wife was at the hospital. We have an 8-month-old baby, who was used to mother's feed. I began to give him bottled milk, but he still wept all through the nights.

Suffering from depression and irregular sleep patterns. Participants shared feelings of depression because of the fear of losing a loved one and also because of the lack of support from society and the experience of social isolation. A 40-year-old wife with four children shared that she had to resort to medication:

> I was unable to manage (house and children). All I did was cry. I later on contacted a doctor who prescribed antidepressants to me.

It was found that significant others struggled with being able to sleep. Much of this inability to sleep was due to fear of the unknown for loved ones and self, an uncertain future, and not knowing what to do in home isolation. An elderly father whose wife had contracted the virus described:

> I felt very depressed when my daughter went to the hospital to look after my wife. I feared losing both. I was unable to sleep because of this.

A 35-year-old wife shared that she slept almost all the time as a way of distracting herself from the fear of losing her husband to coronavirus:

> I did nothing but sleep for 10 days until my husband returned. I still sleep a lot now that he (husband) has returned.

Difficulty in adapting to the new corona life. There was an important theme of difficulty faced in adapting to the new way of life, consisting of social isolation, fear of catching coronavirus, and social stigma. A young wife without any children shared how the unexpected change in life has led to hysteria:

> Being left alone (without my husband) was the biggest problem. I was so disturbed that I didn't even go into the bedroom I shared with my husband. Now that he has returned, I am not the same. I am always afraid about the future. I never expected our married life to be like this. I do not watch TV as the news of coronavirus terrified me. I feel hopeless and I cry all day.

Anxiety for children, unborn child, and daughters specifically. A salient theme was the immense fear parents had for their children. Most of the worry was in case children caught the virus or how they would be impacted if a parent died because of the virus. A wife whose husband had been hospitalized emphatically stated:

> The children will die without their father.

One of the biggest fears for women of reproductive years was pregnancy and risk to an unborn child. A newly wedded wife shared her fears about her possible pregnancy and complications:

> I think that my pregnancy has started. I felt nausea and kept fainting while my husband was hospitalized. My (pregnancy) test reports are not here yet. What if I am pregnant? Could I test corona positive in the future? How would I be able to continue this (pregnancy), and will my baby be effected by this?

Many participants shared how because of the pandemic-induced lockdown and health burden, much of the weight of responsibilities had shifted to the daughters of the house. A 50-year-old mother shared how her daughter, who should be pursuing applications for an undergraduate degree, is now responsible for household duties:

> My daughter who has completed Faculty Of Sciences- Intermediate level degree has started taking care of the cleaning, cooking, and sanitation while I care for my husband. I fear the burden on her when I too get sick someday.

Strengths

Prayer and patience. There was a strong current of religiosity and worship across all the participants in the study. All declared that their main coping strategy since the time that loved ones were diagnosed with coronavirus was turning to prayer and practicing patience. A 50-year-old mother shared that she and her husband prayed continuously for their son:

> We worship Allah day and night and wept in front of Him to relieve us from this pain. We were able to handle everything well due to our strong faith in God.

A 32-year-old husband with three children confessed that although he did not pray regularly in the past, he now prayed steadfastly and that prayer was his only refuge during his wife's illness:

> I started praying regularly—five times a day. God was my only asylum. If we are patient, God will reward us eventually.

Time spent in reading religious text and fasting. It was discussed by most participants that they spend their time in social isolation and awaiting recovery of loved ones by reading religious texts and fasting. An elderly mother described how reading the Quran helped her cope during the pandemic:

> I did not go to the school. However, I read the Quran, and it has been the only comfort for me.

A middle-aged wife with five children shared how she was able to deal with her helplessness in her husband's recovery by keeping fasts for 3 days and reading the Quran:

> I was unable to do anything for him (husband). So while I was locked at home, I began reading the Quran for long hours and fasting. I used to fast for 3 days . . . then take a 1-day break and then fast again for 3 days.

Support and assistance from daughters. Significant others highlighted that of family relations and household members, it was daughters who were of the greatest support and assistance for them during challenging times. An elderly mother with an affected daughter described how her other daughter was a great solace and help for her:

> My other daughter makes meals for us and helps to look after the children (of the daughter with coronavirus). God has blessed me with my daughters.

An elderly father with an infected son shared how his daughter was only a phone call away and he would not have been able to manage on a daily basis without her:

> Luckily my daughter lives in our neighborhood. On one phone call, she brings things for us and passes it through the roof. Otherwise, I do not know what I would do.

Counting blessings in difficult times. Many have stayed positive by counting their blessings during difficult times. A roof over the head, food to eat, and other members of family members testing negative for coronavirus were some of the things listed by participants as things they were extremely grateful for. A mother whose son had contracted the virus was thankful that her four grandchildren were healthy:

> God has been so kind. They (my grandchildren) didn't get a fever or feel even a slight flue. Due to the grace of God, our grandchildren were spared and I cannot thank Him enough.

A husband with five children shared that despite his wife contracting the coronavirus and there being a total of 16 family members living in the house, no one else got sick:

> There was no effect on our health. We didn't even feel the regular flu. We had a stock of food to eat without any problems. There is much to be grateful for. If we have survived so far, we will manage in the future also.

Spending time in household activities never done before. For many significant others, an adult partner getting quarantined meant more household work duties for them. However, the added work was seen as a positive distraction and solace in times of distress. A husband with four children shared that time spent looking after children prevented him from negative thoughts:

> I kept myself occupied doing several difficult tasks like changing the children's pampers, boiling milk for the children, putting them to sleep, and consoling them when they missed their mother during the night.

A wife from an upper-class locality with three children shared that since the lockdown her maids could not visit the house and this gave her the opportunity to immerse herself in cooking and cleaning duties until her husband recovered and returned home:

> As we were afraid of the maids transmitting the virus, we did not allow them in. My elder daughter and I started doing all the cooking and cleaning, and this kept us sane and busy until my husband returned.

Planning for the future with regard to immunity and diet. Another way that significant others were able to cope with their changed life circumstances was by looking ahead and planning for the future. Participants explained that food management and nutrition was something that they could control. One wife shared that reading and planning to improve her husband's nutrition and immunity was helping to make her feel happy that she could protect him in the future:

> I am studying about how to improve my husband's immune system. It gives me something to do. . . . I am happy that I can work on modifying our lifestyle and eating habits upon his return.

Turning to media as a source of information and awareness. Information about prevention and recovery provided relief and comfort to significant others and gave them back some measure of control in their lives. A wife with three children shared that while her husband was hospitalized, she was able to get the information she needed from social media and Google:

> We got our educational material regarding coronavirus from social media and Google. It helped to know that there was high probability of my husband returning home.

A 26-year-old wife described how she felt more confident after gathering information and awareness about preventive protocols for when her husband returned:

> I was able to gather information on [World Health Organization]'s website. I also used their WhatsApp health alert number. It was the Internet basically that helped me to become aware of how to sanitize and disinfect my house.

Physical exercise. Some participants shared that although since the lockdown they had more time for physical exercise inside including, spot jogging, walking in the garden or in their home compound area, or by using an indoor cycle. A brother of an affected coronavirus patient shared:

> I used to go outside for exercise. But now I've shifted to an indoor cycling machine.

Another brother mentioned that he was going for a walk or jog outside the home while practicing social distancing:

> Working from home has now given us the time to go for walks around the neighborhood. I am now even able to jog for 30 min at a time and am looking forward to increasing this.

Discussion

There are limitations to this study, such as a small sample size and inability to sample other cities of Pakistan. We were also unable to sample more significant others with loved ones still in quarantine or who had died. It may be that the stigma and challenges faced by such people are considerably more intense than our findings report. However, this research has strengths, such as identification of experiences of stigma, struggles, and strengths of coronavirus family members—an area that has been unexplored in Pakistan. We have also been able to bring to attention that public stigma is not only embedded in fear of contamination, as confirmed by previous research on infection stigma (Holzemer et al., 2009), but also that with regard to coronavirus specifically, public stigma is accentuated by: (a) anxiety because of the novelty of the infection and radical change in social order because of social distancing, (b) uncertain epidemiology and recovery, (c) fears of not having a vaccine, (d) increased vulnerability of patients with comorbidity, and (e) risk of quarantine and separation from family members.

Stigma communication and support to build and enact stigma (Smith, 2011) in the age of coronavirus is made easier because of enforcement of lockdown and social isolation. Family members of infected patients are easily identifiable because of lockdown of neighborhood and social isolation in homes, and this may increase build-up of stigma against them. We find in our study that with the stigma of infectious disease, it is the uninfected population that is perpetrating stigma against infected families. The reasons are not necessarily sinister but are a part of the self-constructed perception of precaution against coronavirus. The fear is that this justification of combining practice of stigma with preventive behavior against coronavirus may contribute to sustenance of labeling, discrimination, and hostility in society (Adler-Nissen, 2014). Most especially, when this stigma comes from institutions and care authorities, like the government, police, health sector, employer, health practitioners, and work colleagues, there is cause for worry with regard to social equality, health access, and financial security.

In this study we find that both the lower and upper class face stigma and challenges. Other research has identified that both victims and perpetrators of stigma may belong to the educated and upper class groups in society (Des Jarlais, Galea, Tracy, Tross, & Vlahov, 2006). We found that authorities that people depend on for support and protection in times of national emergencies—like the government, health sector, and police—are imposing stigma and harassment against family members of coronavirus patients. This is contributing to feelings of fear and marginalization in significant others. International research adds that that when populations face stigma and abuse from the health sector and constitutional bodies they are also unable to access health rights, civic freedom, and public resources (Frost, 2011). Theorists have explained that stigma-related stressful life events can stem from an isolated event (Meyer, 2003). In our study we find that because of maltreatment by health care administration and practitioners, there is great fear of hospitalization, such that people are reluctant to get tested and diagnosed for coronavirus. Other scholarship contributes that when stigmatization is high, families may adopt hiding and passing as a coping strategy to avoid public shaming and institutional discrimination (Newheiser & Barreto, 2014). Hiding of infections and avoiding testing is a grave problem and may contribute to an increase in infection risks and decline in protective behavior (Fischer et al., 2019).

Our findings show that significant others are deeply shocked and hurt by the stigmatization of relatives and neighbors whom they trusted and to whom they were close. In fact, infection disease stigma has been argued to be one of the first forms of stigma practiced by close community members (Park, Faulkner, & Schaller, 2003). A reason for stigma and discrimination against family members has been identified as blame on the family for the ill health of the infected person (Corrigan & Watson, 2007; Larson & Corrigan, 2008). The fear in relatives and neighbors may also have been because of the symptomless nature of infections and the invisibility of communicable disease (Smith & Hughes, 2014). We also found that families are now reluctant to move outside and some are even contemplating changing neighborhoods because of maltreatment and abuse. Previous research on stigma alerted us that family members may anticipate stigma after initial experiences and thus make decisions for the future to avoid interaction with society (Girma et al., 2014). Professional participants, like doctors, highlighted their hurt at the stigma faced by colleagues and on being questioned about their protective behavior and professional integrity in putting others in danger. Past research on pandemics confirms that HCPs who work on the frontlines with infected patients or interact with infected groups face stigma from their colleagues (Verma et al., 2004).

It was also found that employer stigmatization is contributing to great financial insecurities in significant others. Other scholars have confirmed that stigma can lead to structural discrimination and employment disadvantaged within communities (Yang et al., 2007). Adding to the dilemma is the fear that employers, state, and society may allow stigma to prevail as a means of deterrence and infection control (Williams & Gonzalez-Medina, 2011). Findings also reveal that because of uncertainties of disease, death, and

financial security, people are experiencing irregular sleep pattern and depression in significant others. Previous scholarship confirms that stigma can become a cause of mental health deterioration and emotional instability in people (Siu, 2008). In addition, it can also contribute to feelings of humiliation and shame (Hawryluck et al., 2004) and physical health problems (Basrur, Yaffe, & Henry, 2004). We also found that families were finding it difficult to adapt to the new corona life comprising of social distancing and home isolation. At the same time, we also discovered that many were unable to adhere to isolation protocols because of having to leave home to monitor the health of hospitalized loved ones and management of house affairs like grocery buying and bill payments. This finding aligns with other scholarship that confirms the new normal during corona is causing adjustment difficulties for people (Zeegen, Yates, & Jevsevar, 2020) and that in developing nations strict lockdown is not being enforced because of governance inefficiencies (Mukhtar, 2020).

Misrepresentation and falsification of laboratory reports is a disturbing finding in this study. We also found that families were being forced to leave their homes through different criminal tactics, like threats of encroachment, lying to the police, and harassment outside the home by neighbors. Other research confirms that fear of infection and coinfections of coronavirus (Cox, Loman, Bogaert, & O'grady, 2020) may lead to extreme forms of stigma and even abuse or violence as a defense mechanism to protect family members, especially children and aging parents (Balmer & Tanner, 2011). Findings revealed that one of the biggest problems was the inability to substitute a mother's care and nurture for young children during a mother's illness and quarantine. Immense fear was shared by all participants for their children, unborn children, and daughters specifically. The reasons were multifold including fear that children would get the infection and be separated from family during quarantine and what would happen to them if a parent or both parents died. Other research confirms that parents fear for the consequences of stigma and illness on children's education and future prospects for marriage and employability (Raguram, Raghu, Vounatsou, & Weiss, 2004). Our findings also show overdependency on information from media and the Internet in the absence of comprehensive communication from the government and health sector. Overdependency on social media for news and communication about coronavirus may not be ideal, and there may be issues of sensationalization, panic spreading, and misrepresentation (Depoux et al., 2020).

Overall, research suggests that when significant others face stigma and discrimination, they may resort to unsafe attitudes and behaviors like not seeking health care services and not reaching out to family and friends for support (Östman & Kjellin, 2002). There is also risk to the quality of life of family members and the care provided to the ill within the family setup. On a positive note, we also found that many families affected by coronavirus are adopting healthy coping strategies and showing great strength and resilience in difficult and uncertain times. This includes turning to religion and spirituality, staying active with housework and physical exercise, planning for dietary changes, and counting their blessings. Other research confirms that in the midst of marginalization and stigma, resilient people are known to adopt positivity and social creativity to secure their well-being and survival (Dovidio, 2010; Jewkes, 2006).

Concluding Recommendations for Social Policy

We have to make a swift cultural and structural shift toward destigmatization of coronavirus-infected individuals and their families. Mitigating stigma will help improve detection, reporting, and protective behavior, thus, reducing disease burden and hospitalization rates. The challenge for coronavirus stigma now is how to maintain social distancing without imposing stigma. We recommend the monitoring and tracking of stigmatization behavior at individual, community, and institutional level. Surveillance systems can include a combination of record keeping by police, the health sector, the government, and independent researchers. Support groups and neighborhood watch groups must be created to create an informal culture of observation and deterrence against stigmatization within communities.

There needs to be improved and realistic communication for awareness and prevention by state and health sector (Thornicroft, 2006). We also recommend education interventions and social awareness campaigns through community leaders, clinicians, the health sector, religious notable, and media to increase support for family members who are practicing social-distancing protocols. Campaigns with informative public service messages to reduce myths and misinformation about infection and the consequences of public stigma would reduce fears and anxiety in the public and improve behavior and interaction. Improvement in access to digital banking and delivery of supplies to home for social distance maintenance will also help build trust and security across communities. We urgently recommend laws on public stigmatization at the federal and provincial level to deter the build-up of a culture of stigmatization as a justified form of prevention against coronavirus infection. Two kinds of criminalization laws need amendment, implementation, and enforcement for Pakistan at the moment (United Nations Development Programme [UNDP], 2014): (a) laws to criminalize stigmatization and discrimination at individual and institutional levels and (b) laws to criminalize breaches in protective protocols for infection containment.

Much of the public stigma would also be reduced if quality of services and treatment by HCPs improves. We strongly recommend training of HCPs, government officers, and police during the evaluation, testing, and quarantine process of patients and how to deal with family attendants. Patient and family attendant satisfaction surveys are also important, and feedback must be linked to officer evaluation, promotion, and bonus. There has to be state pressure and accountability to ensure contractual and informal sector employees are compensated if infected with both health and life insurance. Assurance of job security upon recovery is also needed. Additionally, instead of punitive blame against infected employees who contract the virus at the workplace, the employment sector must improve infection control and workplace safety through regular sanitation and sterilization. There is also a critical need to ensure confidential and secure testing for diagnosis to build trust. We also need free telephonic and digital counseling and therapy for families afflicted by coronavirus to secure mental health and emotional needs in times of health crises. Utilization of subsidiary health care team like Lady health Worker and Health Social Worker could be helpful for this.

References

Adler-Nissen, R. (2014). Stigma management in international relations: Transgressive identities, norms, and order in international society. *J International Organization, 68,* 143–176. http://dx.doi.org/10.1017/S0020818313000337

Agee, J. (2009). Developing qualitative research questions: A reflective process. *International Journal of Qualitative Studies in Education: QSE, 22,* 431–447. http://dx.doi.org/10.1080/09518390902736512

Balmer, O., & Tanner, M. (2011). Prevalence and implications of multiple-strain infections. *Lancet Infectious Diseases, 11,* 868–878. http://dx.doi.org/10.1016/S1473-3099(11)70241-9

Basrur, S. V., Yaffe, B., & Henry, B. (2004). SARS: A local public health perspective. *J Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique, 95,* 22–24.

Bazeley, P., & Jackson, K. (Eds.). (2013). Qualitative data analysis with NVivo. London, UK: SAGE publications limited.

Bohle, L. F. (2013). *Stigmatization, discrimination and illness*. Göttingen, Germany: Universitätsverlag Göttingen. http://dx.doi.org/10.17875/gup2013-289

Bond, V., & Nyblade, L. (2006). The importance of addressing the unfolding TB-HIV stigma in high HIV prevalence settings. *Journal of Community Applied Social Psychology, 16,* 452–461. http://dx.doi.org/10.1002/casp.893

Chaudoir, S. R., Earnshaw, V. A., & Andel, S. (2013). "Discredited" versus "discreditable": Understanding how shared and unique stigma mechanisms affect psychological and physical health disparities. *J. Basic and Applied Social Psychology, 35,* 75–87. http://dx.doi.org/10.1080/01973533.2012.746612

Corrigan, P. W., & Watson, A. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal, 43,* 439–458. http://dx.doi.org/10.1007/s10597-007-9084-9

Cox, M. J., Loman, N., Bogaert, D., & O'grady, J. (2020). Co-infections: Potentially lethal and unexplored in COVID-19. *Lancet Microbe, 1,* e11. http://dx.doi.org/10.1016/S2666-5247(20)30009-4

Depoux, A., Martin, S., Karafillakis, E., Preet, R., Wilder-Smith, A., & Larson, H. (2020). *The pandemic of social media panic travels faster than the COVID-19 outbreak*. New York, NY: Oxford University Press. http://dx.doi.org/10.1093/jtm/taaa031

Des Jarlais, D. C., Galea, S., Tracy, M., Tross, S., & Vlahov, D. (2006). Stigmatization of newly emerging infectious diseases: AIDS and SARS. *American Journal of Public Health, 96,* 561–567. http://dx.doi.org/10.2105/AJPH.2004.054742

Dovidio, J. F. (2010). *The SAGE handbook of prejudice, stereotyping and discrimination*. New York, NY: Sage.

Fischer, L. S., Mansergh, G., Lynch, J., & Santibanez, S. (2019). Addressing disease-related stigma during infectious disease outbreaks. *Disaster Medicine and Public Health Preparedness, 13,* 989–994. http://dx.doi.org/10.1017/dmp.2018.157

Frost, D. M. (2011). Social stigma and its consequences for the socially stigmatized. *Social Personality Psychology Compass, 5,* 824–839. http://dx.doi.org/10.1111/j.1751-9004.2011.00394.x

Girma, E., Möller-Leimkühler, A. M., Müller, N., Dehning, S., Froeschl, G., & Tesfaye, M. (2014). Public stigma against family members of people with mental illness: Findings from the Gilgel Gibe Field Research Center (GGFRC), Southwest Ethiopia. *BMC International Health and Human Rights, 14,* 2. http://dx.doi.org/10.1186/1472-698X-14-2

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New Jersey: Prentice Hall.

Hamlin, C. (2012). The cholera stigma and the challenge of interdisciplinary epistemology: From Bengal to Haiti. *Science as Culture, 21,* 445–474. http://dx.doi.org/10.1080/09505431.2011.652082

Hawryluck, L., Gold, W. L., Robinson, S., Pogorski, S., Galea, S., & Styra, R. (2004). SARS control and psychological effects of quarantine, Toronto, Canada. *Journal of Emerging Infectious Diseases, 10,* 1206–1212. http://dx.doi.org/10.3201/eid1007.030703

Helman, C. (2008). *Medical anthropology*. Surrey, United Kingdom: Ashgate Publishing Company.

Holzemer, W. L., Human, S., Arudo, J., Rosa, M. E., Hamilton, M. J., Corless, I., . . . Maryland, M. (2009). Exploring HIV stigma and quality of life for persons living with HIV infection. *Journal of the Association of Nurses in AIDS Care, 20,* 161–168. http://dx.doi.org/10.1016/j.jana.2009.02.002

Howells, M. E., & Pieters, M. M. (Eds.). (2018). *The mosquito brings the sickness": Local knowledge, stigma, and barriers to zika prevention in rural Guatemala. In Maternal death and pregnancy-related morbidity among indigenous women of Mexico and Central America, in maternal death and pregnancy-related morbidity among indigenous women of Mexico and Central America*. Switzerland: Springer.

Huremović, D. (2019). *Psychiatry of pandemics: A mental health response to infection outbreak*. Switzerland: Springer. http://dx.doi.org/10.1007/978-3-030-15346-5

Jakoby, N. R. (2015). The self and significant others: Toward a sociology of loss. *Illness, Crisis Loss, 23,* 129–174.

Jewkes, R. (2006). Beyond stigma: Social responses to HIV in South Africa. *Lancet, 368,* 430–431. http://dx.doi.org/10.1016/S0140-6736(06)69130-7

Larson, J. E., & Corrigan, P. (2008). The stigma of families with mental illness. *Academic Psychiatry, 32,* 87–91. http://dx.doi.org/10.1176/appi.ap.32.2.87

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4,* 324–327. http://dx.doi.org/10.4103/2249-4863.161306

Macq, J., Solis, A., & Martinez, G. (2006). Assessing the stigma of tuberculosis. *J Psychology, Health Medicine, 11,* 346–352.

Meyer, I. H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93,* 262–265. http://dx.doi.org/10.2105/AJPH.93.2.262

Mukhtar, S. (2020). Preparedness and proactive infection control measures of Pakistan during COVID-19 pandemic outbreak. *Research in Social & Administrative Pharmacy*. Advance online publication. http://dx.doi.org/10.1016/j.mehy.2020.109919

Murthy, R. S. (2002). Stigma is universal but experiences are local. *World Psychiatry, 1,* 28.

Newheiser, A. K., & Barreto, M. (2014). Hidden costs of hiding stigma: Ironic interpersonal consequences of concealing a stigmatized identity in social interactions. *Journal of Experimental Social Psychology, 52,* 58–70. http://dx.doi.org/10.1016/j.jesp.2014.01.002

Nulty, D. D. (2008). The adequacy of response rates to online and paper surveys: What can be done? *Assessment & Evaluation in Higher Education, 33,* 301–314. http://dx.doi.org/10.1080/02602930701293231

Östman, M., & Kjellin, L. (2002). Stigma by association: Psychological factors in relatives of people with mental illness. *British Journal of Psychiatry, 181,* 494–498. http://dx.doi.org/10.1192/bjp.181.6.494

Park, J. H., Faulkner, J., & Schaller, M. (2003). Evolved disease-avoidance processes and contemporary anti-social behavior: Prejudicial attitudes and avoidance of people with physical disabilities. *Journal of Nonverbal Behavior, 27,* 65–87. http://dx.doi.org/10.1023/A:1023910408854

Raguram, R., Raghu, T. M., Vounatsou, P., & Weiss, M. G. (2004). Schizophrenia and the cultural epidemiology of stigma in Bangalore, India. *Journal of Nervous and Mental Disease, 192,* 734–744. http://dx.doi.org/10.1097/01.nmd.0000144692.24993.1b

Saldaña, J. (2015). The coding manual for qualitative researchers. Atlanta, GA: Sage.

Siu, J. Y. (2008). The SARS-associated stigma of SARS victims in the post-SARS era of Hong Kong. *Qualitative Health Research, 18,* 729–738. http://dx.doi.org/10.1177/1049732308318372

Smith, R. A. (2011). Stigma, communication, and health. In *The Routledge handbook of health communication* (pp. 480–493). Milton Park, England: Routledge.

Smith, R. A., & Hughes, D. (2014). Infectious disease stigmas: Maladaptive in modern society. *Communication Studies, 65,* 132–138. http://dx.doi.org/10.1080/10510974.2013.851096

Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness* (Vol. 301). New York, NY: Oxford University Press.

UNDP. (2014). Scan of Law and Policies Affecting Human Rights, Discrimination and Access to HIV and Health Services by Key Populations in Pakistan, United Nations Development Programme. Retrieved from https://hivlawcommission.org/wp-content/uploads/2017/06/rbap-hhd-2014-scan-of-laws-policies-hiv-key-populations-1.pdf

Verma, S., Mythily, S., Chan, Y. H., Deslypere, J. P., Teo, E. K., & Chong, S. A. (2004). Post-SARS psychological morbidity and stigma among general practitioners and traditional Chinese medicine practitioners in Singapore. *Ann Acad Med Singapore, 33,* 743–748.

Welsh, E. (2002). Dealing with data: Using NVivo in the qualitative data analysis process. *Forum qualitative sozialforschung/Forum: Qualitative Social Research, 3,* 1–9. http://dx.doi.org/10.17169/fqs-3.2.865

Williams, J., & Gonzalez-Medina, D. (2011). Infectious diseases and social stigma. *Applied Innovations Technologies, 4,* 58–70. http://dx.doi.org/10.15208/ati.2011.7

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine, 64,* 1524–1535. http://dx.doi.org/10.1016/j.socscimed.2006.11.013

Zeegen, E. N., Yates, A. J., & Jevsevar, D. S. (2020). After the COVID-19 pandemic: returning to normalcy or returning to a new normal? *The Journal of Arthroplasty, 35,* S37–S41.

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