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Nurses Experiences and Coping Styles About Stigma During Covid-19: A Qualitative Study

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Abstract

It is of great importance to take necessary measures to reduce and prevent stigma, and plan protective psychosocial interventions for the healthcare workers, especially for the nurses who are in contact with high-risk patients. This study was conducted to solicit nurses' views on social stigmatization in the process of combating COVID-19. A descriptive qualitative method was utilized on the nurses in a training and research hospital between June and September 2020. The sample of the study consisted of 15 nurses who worked in a designated pandemic hospital during the COVID-19 outbreak. The research data was gathered via Socio-Demographic Information Form and Semi-Structured Interview Form. Subsequently, content analysis was registered. This study was based on COREQ (consolidated criteria for reporting qualitative research) which is known to establish explicit guidelines in reporting qualitative research. The average age of the participants was 38 (min: 24–max: 54), of which 10 were women, 10 were single, 9 had children, 10 had a graduate degree. Participants had an average of 12.9 years of work experience (min: 1- max:30) of which 7.1 years was clinical work (min: 1- max:17). Three main themes were identified for the analysis of data, namely, the experiences of stigma, coping with stigma, and psychological-social results of stigma. It was determined that nurses, who were exposed to stigmatized attitudes in their clinical and social environments, mainly had recourse to employ passive coping methods during the process which later posed psychosocial adverse effects. Evaluation of the research results in theoretical, clinical, academic, and administrative settings shows necessity. Health care professionals can make use of proactive anti-stigma programs to sustain their effective work environment.

Keywords: *COVID-19, Mental Health, Nursing, Stigmatization.*

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Hemşirelerin Covid-19 Sürecinde Stigma ile İlgili Deneyimleri ve Başetme Yöntemleri: Kalitatif Bir Çalışma

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Öz

Damgalanmayı azaltmak ve önlemek için gerekli tedbirlerin alınması ve koruyucu psikososyal müdahalelerin planlanması özellikle yüksek riskli hastalarla temas halinde olan hemşireler için büyük önem taşımaktadır.COVID-19 ile mücadele sürecinde hemşirelerin sosyal damgalanma konusundaki deneyimlerini belirlemektir. Tanımlayıcı nitel araştırma tasarımı uygulanan çalışma, bir eğitim ve araştırma hastanesinde Haziran ve Eylül 2020 tarihleri arasında gerçekleştirilmiştir. Çalışmanın örneklemini COVID-19 salgını sırasında bir pandemi hastanesinde çalışan 15 hemşire oluşturmuştur. Araştırma verileri, Sosyo-Demografik Bilgi Formu ve Yarı Yapılandırılmış Görüşme Formu ile toplanmıştır. Araştırma kalitatif çalışmalar için rehber niteliğindeki Kalitatif Araştırma Raporlama Konsolide Kriterleri kontrol listesi (COREQ) temel alınarak nitel araştırma paradigmasına göre planlanmıştır. Katılımcıların yaş ortalaması 38 (min: 24-maks: 54) olup 10'u kadın, 10'u bekar, 9'u çocuk, 10'u yüksek lisans mezunudur. Katılımcıların ortalama 12.9 yıllık iş tecrübesine (min: 1 - maks: 30), 7.1 yıl klinik çalışma (min: 1 - maks: 17) deneyimine sahip oldukları belirlenmiştir. Verilerin analizinde damgalanma deneyimleri, damgalanma ile baş etme ve damgalanmanın psikolojik-sosyal sonuçları olmak üzere üç ana tema belirlenmiştir. Klinik ve sosyal ortamlarında damgalanmış tutumlara maruz kalan hemşirelerin, daha sonra psikososyal olumsuz etkilere yol açan süreçte ağırlıklı olarak pasif başa çıkma yöntemlerine başvurdukları belirlenmiştir. Araştırma sonuçlarının teorik, klinik, akademik ve idari alanda değerlendirilmesi önem taşımaktadır. Sağlık bakım uzmanlarına yönelik proaktif anti-stigma programlarının planlanması önemlidir.

Anahtar Kelimeler: *COVID-19, Ruh Sağlığı, Hemşirelik, Damgalama.*

Introduction

The concept of stigmatization is defined as "the unfair treatment of a person or a group for a dissimilar characteristic they have" (Abioye, Omotayo and Alakija, 2011; Goffman, 2014). The stigmatized person develops emotional and reactive responses such as avoiding social relationships, shame, and guilt by internalizing the feeling of worthlessness (Courtwright and Turner 2010). The risk of social stigma has been peculiarly on the rise due to the current COVID-19 pandemic that affected the whole world. Owing to its rapid spreading nature, Coronavirus Disease 2019 (COVID-19) became a world-wide health crisis which shortly brisked the World Health Organization (WHO) to declare the matter as a public health emergency of international concern on 30th January 2020 (WHO, 2019). The sudden and uncharted nature of the incident has led to distress, unease, and various psychological problems (Cai, Tu, Chen, Fu, Jiang and Zhuang, 2020). As such, according to a study in China, the psychological impact of fear from COVID-19 was found to be more dangerous than the disease itself (Yu, Li, Li, Xiang, Yuan, Liu, Li, and Xiong, 2020). Moreover, several sources ascertained that patients diagnosed with COVID-19 and their relatives, people close to the patients, healthcare professionals, healthcare institutions, countries, regions, neighborhoods, individuals returning from abroad, and specific races such as Asians had been subject to stigma and microaggression in particular (Canada Center For Occupational Health And Safety, 2020; Centers for Disease Control and Prevention, 2019; Shigemura et al., 2020). The concept of microaggression entails daily verbal and non-verbal, hostile, humiliating, or negative messages which target individuals according to which group the other person perceives him to belong. (Canada Center for Occupational Health and Safety, 2020). Gradually, the stigmatized individuals may start to think that they are no longer a member of the society they feel being part of and may begin to feel rather lonely and ultimately end up turning in on themselves. Prolonged exposure to thoughts such as social isolation, guilt, inadequacy, pessimism, hopelessness, and despair can trigger mental illnesses. Likewise, stigma against healthcare professionals contains many challenges such as the spread of demotivation among frontline healthcare professionals, augmented anxiety, and reduced work-place efficacy, which may increase the odds of suicide, though it has remained a low

possibility. As most of the stigmatized people can take the social prejudices and stereotypes on themselves, it is merely a matter of time to observe guilt development, embarrassment, worries about the future, arise in intense feelings of anger and harming thoughts against themselves and those around them (TPA, 2020; Yaman and Güngör, 2013).

Healthcare professionals are often a primary target of stigmatization in their communities in the event of a pandemic disease that they are often regarded as the source of infection that needs to be feared or abstained from (Bagcchi, 2020; Taylor, 2019). This exclusively propagates an unnecessary burden to the lives of healthcare professionals which could be accounted for the increased burnout levels (Lai et al., 2020; Ramaci, Barattucci, Ledda, and Rapisarda, 2020).

On the other hand, stigma and aggression against healthcare professionals are on escalation (Ganapathy, 2020). For instance, stigma against infectious diseases had proven to pose a perpetual concern by several recorded incidents in forms of healthcare personal being forced to evection from their homes (Kolkata, 2020), acts of violence against healthcare personal on the field (Sakhadeo, 2020) and not admitting healthcare workers to burial grounds who died on duty (Lobo, 2020). As Menon (2020) quotes, more common forms of stigmatization were isolations originating within residential communities, local stores, as well as amongst friends and relatives (Menon, 2020).

Alternatively, a study in Egypt assessing burnout perceptions amongst the physicians during the COVID-19 outbreak affirmed that stigma against healthcare professionals traced to harassment by patients' families was ranked the highest by registering more than three-quarters of the physicians' consensus (Abdelhafiz and Alorabi, 2020). Bearing the fact that some incidents remained unreported or underreported, the extend of the problem and its effect remained understated (CDC, 2019). Respectively, WHO published a document recognizing mental health and psychological aspects of stigma during the COVID-19 outbreak followed by recommendations to put the issue on the bed (WHO, 2020).

Aptly, a study on the hemodialysis staff accounted stigma (54.6%) as the leading perceived factor affecting staff's day-to-day work compared to job-related stress (36.1%) which was in concordance with other studies carried

out among healthcare workers (Uvais, Aziz and Hafeeq, 2020). In furtherance, a recent study carried out in India contemplating physicians in the presence of the COVID-19 pandemic reported relatively higher levels of stigma (62.1%) and stress (63.8%) (Uvais, Shihabudheen, Bishurul Hafi, 2020). These findings are valuable as its implications in clinical, policy-making, and research settings are inevitable.

In this context, it is of great importance to take necessary measures to reduce and prevent stigma, and plan protective psychosocial interventions for the healthcare workers, especially for the nurses who are in contact with high-risk patients. It should be provided a guideline about the types of stress triggering conditions, how it could be coped with, early signs of distress, and how to attain collegial help (Mental Health Foundation, 2020). In fact, as per the checklist published by the United States Centers for Disease Control and Prevention (CDC) following issues are suggested:

- The media should take uttermost care not to broadcast content that includes stigmatization risks and points to a single target audience,
- Establishing systems where people can quickly access information when necessary, thus preventing misinformation,
- Establishing or supporting independent organizations that monitor the stigmatization risk on a regular basis,
- In case stigmatization cannot be prevented, the suffering people and groups should receive psychosocial support promptly,
- It is recommended to hold focus group discussions with the stigmatized groups to determine in what situation and through what channels they are affected and which necessary measures should be taken for the future (CDC, 2019).

Thus, this research was carried out as a qualitative study based on descriptive analysis to seek nurses' views on social stigmatization in the process of combating COVID-19.

Methods

Type of Research

This study employed a descriptive qualitative approach.

Study Design and Participants

This study utilized a descriptive qualitative method in order to solicit the viewpoint of the participants in an attempt to understand the underlying events and experiences (Sandelowski, 2010). Within this scope, the investigation is limited to the stigma experiences of nurses who work with COVID-19 diagnosed patients. This study was conducted in a training and research hospital in Western Turkey between June and September 2020.

Population and Sampling

The sample size in qualitative research is set by the saturation point, which is designated by continuing data collection to the point where the concepts begin reduplicating themselves (Yıldırım & Şimşek, 2011; Boddy, 2016). In this study, maximum diversity sampling method (one of the purposeful sampling methods) was used and the sample size was determined by carrying on individual in-depth interviews with nurses until the data started to repeat itself.

The sample of the study consisted of 15 nurses who worked in a pandemic hospital during the COVID-19 pandemic. The data was collected via the Socio-Demographic Information Form and Semi-Structured Interview Form and analyzed by content analysis.

Inclusion Criteria

Inclusion criteria are as follows:

- Working as a nurse in one of the departments: Anesthesia Intensive Care, Emergency Service, Infection Service, Pandemic Services of the hospital,
- Caring for individuals diagnosed with COVID-19
- Volunteering to participate in the study.

Data Collection Process

Consolidated Criteria For Reporting Qualitative Research (COREQ) was employed in this study which established guidelines to report qualitative research (Tong, Sainsbury, and Craig, 2007). Besides, standards of validity, transferability, consistency, and con-firmability were utilized for validity and reliability analysis (Pandey and Patnaik, 2014). Similar to other studies

in the literature, data was collected thru face-to-face half-structured in-depth individual interviews. Interviews were conducted between June and September 2020 at either the meeting room or the private office of the nurses' service unit with an average duration of 40 minutes. As the data collected from the nurse was of sufficient depth, no subsequent interviews were pursued. The research aim was explained to each nurse, and isolated interviews were performed by utilizing an in-depth meet strategy with the volunteers. A voice recorder was utilized to record the interviews. After getting authorization from the nurses, the notes were held. The meet rooms were calm, shinning, well ventilated, and reasonable for a private discussion. Depth-oriented data collection was exercised throughout the interviews per the purpose of the research (Pandey and Patnaik, 2014). The theoretical saturation was reached when 28 interviews had been completed. Data were initially classified into emerging themes without fine adjustments. Interviews were conducted by the same researcher for internal reliability. Interviews were kept consistent throughout the data collection such as the same voice recorder was used, and notes were taken thru the interviewing process. Emerging themes were then refined into more uniform subthemes. The author has carried out the initial analysis of the interview data thru content analysis. Subsequently, an independent analyst with qualitative research background had reanalyzed all the materials (sound recordings, raw data, codes, and themes created during initial analysis) for external reliability (Colorafi and Evans, 2016). Each interview data was transcribed and briefly analyzed within a week after conducting the interview.

The Dependent Variable

It is a phenomenological study, hence there are no variables.

Data Collection Tools

The data was collected via the Socio-Demographic Information Form and Semi-Structured Interview Form.

Personal Information Form: The form aims to gather Socio-Demographic attributes of the participants such as age, gender, marital status, experience level, and vice versa. This form was prepared by the researcher and each nurse filled out the forms on their own.

Semi-structured Interview Form: This form included semi-structured questions prepared for interviews with the participants. The form is structured by the researcher to evaluate the stigma perceptions and its effects. Principally, all interviews were conducted on the premises of these questions while additional questions based on the nurses' responses were also solicited during the interview process.

Data Analysis

The sociodemographic data of nurses' were analyzed using percentages and numbers. Individual interviews were written word-by-word. The data were analyzed using content analysis by the researcher and an independent analyst with a qualitative research background. The responses that fell into a meaningful category were labeled by a name and code. A separate list of codes was created for the participants. Later, codes obtained from all interviews were cross-examined to identify similarities and differences. Finally, similar codes were grouped to create a specific theme. Subsequently, proximate themes were reworked into a few as they best fit for the described findings (Elo and Kyngäs, 2008).

Researcher Experience

This study was conducted by an academician who held a Ph.D. degree. The author participated courses on subjective work and had several past experiences on the matters of stigma and psychosocial studies. There was no prior relationship between the research participants and the researcher.

Ethical Consideration

Before the study, ethics committee approval was obtained from the Ministry of Health (2020_09_07T14_47_23) and Non Invasive Clinical Research Ethics Committee (2020/829). The purpose of the study was communicated to each participant nurse. The study was conducted in full accordance with the ethical standards established in the 1964 Helsinki Declaration and its

later amendments, or other, similar ethical guidelines. Verbal and written informed consent of the participants were solicited. All the participants were explicitly informed thru consent forms that they might choose to opt-out from this research study at any stage of the interview(s).

Results

Socio-demographic Characteristic of Nurses

The sample population was comprised of 15 nurses. The average age of the participants was 38 (min: 24–max: 54), of which 10 were women, 10 were single, 9 had children, 10 had a graduate degree. Moreover, participants had an average of 12.9 years of work experience (min: 1- max:30) of which 7.1 years was clinical work (min: 1- max:17) (Table 1).

Table 1. Socio-demographic characteristic of nurses

Participant No	Age	Gender	Marital Status	Having children	Education Status	Professional Work Experience (Year)	Clinical Work Experience (Year)
N1	32	Male	Married	No	Postgraduate	6	3
N2	27	Female	Single	No	Graduate	2	2
N3	25	Female	Single	Yes	Graduate	2	2
N4	41	Female	Married	Yes	High school	20	8
N5	47	Female	Married	Yes	Postgraduate	18	12
N6	52	Female	Married	Yes	High school	29	11
N7	29	Male	Married	Yes	Graduate	5	5
N8	24	Male	Single	No	Graduate	1	1
N9	49	Male	Married	Yes	Graduate	24	9
N10	45	Female	Married	Yes	Graduate	19	15
N11	54	Female	Married	Yes	High school	30	17
N12	37	Female	Married	No	Graduate	12	7
N13	35	Female	Single	No	Graduate	5	4
N14	40	Female	Married	Yes	Graduate	13	8
N15	33	Male	Single	No	Graduate	8	3

N: Nurse

Themes of the study

Three main themes were identified for the data analysis. These themes are experiences of stigma (a), coping with stigma (b), and psychological-social results of stigma (c).

Theme 1: Experiences of Stigma

The majority of the participants (n = 12) affirmed that they had been exposed to stigma from the work environment and/or social circles since the COVID-19 pandemic. Experiences of Stigma encompassed two sub-themes: work-environment related stigma and social circle related stigma.

Experiences of Stigma in the Workplace Setting

Nurses expressed that they could be exposed to stigmatization from their colleagues, patients/patient relatives in the hospital environment during the pandemic process. Likewise, nurses exclaimed that other healthcare professionals exhibited a discriminatory attitude especially towards nurses and physicians serving COVID-19 diagnosed patients and that they preferred to keep their distance in the hospital environment with the thought that they might also infect them. Moreover, these healthcare professionals refused to provide clinical support to healthcare professionals working in pandemic services and even share the same shuttle service.

- N2: "When I went out for a break while working in the intensive care, my other colleagues were leaving that environment quietly even without keeping eye contact. This was a shame hence I might be caring also their relatives",
- N11: "The treatment we received from our colleagues was truly disappointing. I requested two nurses from other units to support the clinic, but they only conveyed that the nurses in the pandemic service should carry out this work and they do not want to work with our team.…"
- N8: "... I suggested to a nurse friend, whom I knew well for a long time, to drink coffee together per the rules of the distance after the shift. However, my friend said that it would not be appropriate for us to meet even at a distance under these conditions as I worked in the pandemic service. It disappointed me to hear this when I needed a friendly chat and environment the most under these stressful working conditions..."

Experiences of Stigma in the Social Setting

Nurses, who were the subject of stigmatization and discriminatory attitudes from their social circles during this period, disclosed that stigmatizing attitudes were mostly displayed by their neighbors and familiar shopkeepers.

- N1: "…Indeed, you need serious support during this period. However, on top of all unease associated with the intense work environment, the fear of catching a virus after every shift, the uncertainty of the future, etc., I had seen reactions even from our closest folks outside the work. Unfortunately, many of my colleagues had experienced this."
- N5: "…. When I got on the subway after work in my clean uniform, I saw other passengers switch to the next compartment immediately as I hop in. I traveled along with a homeless person in that compartment..."
- N3: "…When I went to the market across my house where I constantly go shopping, the shopkeeper told me that they would not allow the healthcare professionals in the market for the time being, but offered to send items to my homes with a phone order. They conveyed this in such a polite way that I felt like I should accept it. On the way back home, I thought it was a discriminatory approach and this attitude bothered me a lot. Do you know why? Because people who entered the market for shopping after me could have been COVID-19 positive."
- N7: "…. One day, when I came to my house after work, I found a letter posted by the apartment manager on the flat door writing this: Our residents who are healthcare workers, please wear masks when entering the apartment, do not touch the elevator with bare hands and do not hold on to the support areas, enter and exit without talking to anyone. welcome, apartment management…"
- N10: "… One day when I was at work, I got a phone call from my landlord. He told me that I had to evacuate the house urgently and that he would refund me the last payment I made. When I asked why he said that I could not live in my house because I was working in the pandemic hospital and I had a high risk of bringing the COVID-19 microbe to his house and therefore he refrained from getting reactions from other residents in the apartment. I felt so bad at that moment that I can barely describe. During my hectic shift, I constantly thought about how we would find a new home, the situation of our children, the discriminatory attitude of the landlord like a cyclic film strip …"
- N6: "… While working in the pandemic service, my caregiver who looked after my children at home said that she wanted to take a break for a while and I have compelled to understand this. As you know, finding a new caregiver is not an easy and fast process. In the meantime,

> our upstairs neighbor wanted to support me and she offered to look after my children for a while. One day when I was at work, she told me that she presumed I was working in normal service and not a pandemic service and that is why she agreed to look after my children. She concluded that I have to take care of myself from now on. I could have made sense if my neighbor was in the risky group, but she wasn't. It was just a rude awakening..."

Theme 2: Coping with Stigma

There are two sub-themes of 'Coping with Stigma', namely: passive and active coping.

Passive Coping

The nurses participating in the study reported experiences of intense anxiety due to work and social environment related to discriminatory attitudes. This posed a certain difficulty in reacting rationally. Additionally, participants enumerated adopting some coping methods such as establishing social/online social isolation, preferring not going shopping at all, entering and leaving home unseen, preferring to get a coffee if the cafe is empty, having violent tendencies due to the inability to control excessive anger, displaying aggressive behavior, ignoring what was done and said, having constant crying jags.

- N2: "…. I remember once sitting down and crying because it was not my fault. This went on for 3 months till I started using antidepressants which I am still on…"
- N4: "… It hurts seeing people being mean. After a while, you start to think that no matter what I do for people, they will never give up their attitude, and when that is the case, you start to ignore many things. Doing this makes you feel comfortable for a while..."

Active Coping

During this pandemic process, it was found out that some nurses employed active coping methods to confront stigma. Meanwhile, the World Health Organization's (WHO) announcement of the year 2020 as the year of nurses and midwives not only helped nurses gain more public visibility amongst

the healthcare professionals but also a motivating, empowering, and comforting edge that provided a niche for transforming discriminatory attitudes towards positive attitudes. Hence, nurses notably appealed to engage in active attempts for "seeking social support" and "coping with stress effectively".

- N1 "…. When I was exposed to the discriminatory attitude of our colleagues who are healthcare professionals, I went to them keeping my social distance and clearly stated that I was extremely uncomfortable with this attitude. They had no right to do this. Hypothetically, the risk of getting infected from someone while shopping in a grocery store aisle is higher than contracting viruses from me as I take all the necessary precautions and strictly follow all the necessary hygiene protocols. After expressing my thoughts, I felt incredibly relieved as I always advocate open communication..."
- N3: "WHO's statement gave me a great honor. Frankly, I felt like a hero and conveyed this message to those who have discriminatory attitudes towards us. I said: we are an indispensable hero if we weren't here you would be ready to give up all your wealth to take a breath..."
- N5: "…. As soon as I felt like everything was coming upon me, I received expert support from our hospital's psychologist, it was really good for me, it changed my perspective…"
- N9: "…. I called the nursing association, we discussed what we could do in this process. We even had an action plan for "anti-stigma" on our agenda. Cooperating with my colleagues and fighting with the association made me feel more courageous..."
- N6: "…once I was constantly sharing posts on social media to prevent information pollution against nurses and other healthcare professionals, I think not intervening would not be right..."

Theme 3: Psychological-Social Results of Stigma

The psychosocial effects of stigma on nurses were addressed concerning physical, cognitive, social-family issues.

Physical Effects

The participants uttered that they experienced changes in eating habits and sleep patterns. Some of the participants reported physical complaints such

as migraine and stomach pain linked to stigmatization from their environment.

- N7: "... with this process, my stomach cramps have started, I go to the gastroenterologist regularly now..."
- N2: "…I was not able to go to sleep due to unresting thoughts of what awaits us tomorrow…"

Cognitive Effects

The participants reported facing some cognitive domain-related challenges such as attention and concentration difficulties, memory problems, difficulties in problem-solving skills, reasoning, and decision making. Interestingly, nurses adopting active coping methods reported facing lesser problems in the cognitive domain.

- N2: "…. The discriminatory attitudes towards us are so overwhelming that I could not provide full concentration to my work and patient."

Social & Familial Effects

Participants shared their point-of-views in the sub-theme of 'social & familial effects' by elaborating on the effect of stigma over familial roles, family dynamics, social relations, and social roles. Concordantly, participants predominantly emphasized the negative influence of stigma over those areas which could be traced to physical and cognitive characteristics.

- N2: "…. Some parents in my child's class demanded that our kids shall be isolated from the rest of their classmates by opening a separate class in the upcoming semester just because we work in the pandemic hospital. This hurt me very badly for which I wasn't able to sleep for days. It made me question whether I should continue my profession or just quit for the heck of it…"
- N7: "…. I thought that I could not spare enough time for my little child in such a busy schedule and that I failed to fulfill my fatherly roles as it should be. I was so worked up with this in my mind that I could not fully focus on my work during the shifts.…"
- N1: "…. I was officially declared a hero in the neighborhood where I lived, I was applauded on coming home and leaving the house. Even my neighbors, who did not know me in the past, now knew me very

well, they were almost competing to meet my needs at all times, 2020 was truly the year of a nurse for me.…"

Discussions and Conclusion

The study aimed to investigate the nurses' views of stigma. In the literature, the concept of stigma from the nurses' perspective was not investigated in the course of pandemia. WHO (2020) expressed that the increase in the number of COVID-19 cases required more healthcare personnel involved with the management of the COVID-19 outbreak which introduced many challenges along with it such as stigma and discrimination to healthcare workers at the workplace and among society (World Health Organization, 2020).

Having been exposed to a discriminating attitude in society, an individual may start to feel lonely over time and withdraw into himself. The emerging thoughts such as social isolation, guilt, inadequacy, pessimism, hopelessness, and despair can trigger mental illnesses. It is said that most of the stigmatized individuals can gradually internalize social prejudices and stereotypes. Consequently, guilt, embarrassment, worries about the future, intense feelings of anger, and harming thoughts against both himself and those around may transpire and threaten psychological health eventually (TPD, 2020; Yaman & Güngör, 2013).

Other possible consequences of stigmatization are non-cooperation with treatment (Corrigan, Druss & Perlick, 2014), decreased level of social support, treatment denial by hiding sickness, (Oran, Şenuzun, 2008), and employing social isolation (Kadıoğlu & Hotun Şahin, 2015). Family and people in the social circle of the stigmatized individual are also affected negatively. These people can be stigmatized just because they are the relative of the target individual (Goffman, 2014; Kadıoğlu & Hotun Şahin, 2015). Moreover, discriminators in society deprive their targets of certain rights and benefits through stigma and prejudice (Topkaya, 2011).

As the number of cases and mortality rates increase during an outbreak, frontline healthcare workers get more prone to social isolation, stigma, and discrimination as well as higher risk of psychological problems (Xiong & Peng, 2020). These psychological problems may hinder the attention and

decision-making competences of the staff that pose troubles for the management of the ongoing crisis and staff's mental well-being. In furtherance, a study undertaken by Ramaci et al. (2020) suggested that stigma had a great deal of impact on staff collaboration. Thus, strategies creating motivation and eliminating stigma shall be embraced at the management level.

Several frontline healthcare workers serving in hospitals and laboratories have become victims of discrimination in public places which entails difficulties such as finding food and shelter (Poudel, 2020). To make matters even worse, there are recorded incidents of some healthcare workers serving in non-COVID units discriminating against their colleagues through behaviors such as refusing to talk and denying to eat in the same place. On top of all, neighbors and people in the community have been showing a kind of discontentment to allow healthcare workers to reside in their homes despite their taking all precautions and following strict disease containment procedures. Owing to circulating sketchy information and prevalent fear associated with the COVID-19 outbreak, even the healthcare professional in the field of psychiatry was found to have faced difficulty at the workplace (Tandon, 2020).

Distinctively, incidents of violence towards healthcare workers have been reported in numerous countries including India, the USA, and Australia where they have even been beaten, threatened, and evicted from their homes (Withnall, 2020; The Economist, 2020). As extreme as the cases can get, healthcare staff serving in COVID-19 units are declared untouchable based on the public stigma associated with COVID-19 which meant segregation, loss of status, and discrimination. Decline in the general population mental health naturally gets transferred to healthcare workers as well (Tandon, 2020).

Likewise, a study conducted by Guisti et al. (2020) reported high levels of burnout and psychological symptoms for the healthcare workers during the COVID-19 emergency which required tedious monitoring and treatment intervention routines. It was added that healthcare workers tackled problems such as depression, anxiety, post-traumatic stress, emotional exhaustion, depersonalization in varying levels leading to burnout whereas working hours, psychological comorbidities, fear of infection, and perceived support by friends were enumerated among the culprits.

Healthcare workers are prone to higher risks of stress and stigma during this pandemic process and require prompt countermeasures to prevent health care dysfunction thus undertaking proactive anti-stigma programs and construing resilience and wellbeing plans for the staff becomes a matter of priority considering that it is very difficult to replace specialized members of the team in case of burnout. The evaluation of nurses' views on social stigmatization during the COVID-19 pandemic process revealed that they were exposed to discriminatory attitudes both in their clinical and social environments. Passive coping methods were predominantly adopted in tackling this process which hurt nurses' psychology.

According to study results, three main themes were identified namely, the experiences of stigma, coping with stigma, and psychological-social results of stigma. It was determined that nurses, who were exposed to stigmatized attitudes in their clinical and social environments, mainly had recourse to employ passive coping methods during the process which later posed psychosocial adverse effects. In light of the data, the research results should be evaluated with its clinical, theoretical, academic, and administrative dimensions. Clinically, while healthcare workers are prone to higher risks of stress and stigma during this pandemic process and require prompt countermeasures to prevent health care dysfunction, undertaking proactive anti-stigma programs, and construing resilience and wellbeing plans for the staff becomes a matter of priority considering that it is very difficult to replace specialized members of the team in case of burnout. Theoretically, it would be critical for nursing students to have in-depth knowledge about concepts such as stigma, stress, crisis, and management methods peculiarly backed by simulation and roleplay practices, if possible. Reviewing the existing curricula in this sense is inevitable. Resilience and wellbeing plans should veridically recognize the stressors and the extent of their impact on daily health services. Relevantly, a plan should be constructed taking a proactive rather than a reactive approach. From an academic standpoint, it is noteworthy to conduct researches to develop intervention methods for identification and reduction of stigmatization effects while empowering nurses in times like this to sustain a good mental health state. Finally, from the management standpoint, managers or supervisor nurses should take measures with a multidisciplinary approach while strengthening solidarity

with non-governmental organizations and local-regional authorities aimed at mitigating social stigma and prepare action plans accordingly.

Limitations of the Study

Findings obtained from this qualitative research are limited to those who participated in this study and cannot be generalized.

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Ethical Consideration

All messages relating to human participants comply with institutional and / or national research standards and the 1964 Helsinki declaration and subsequent writing or other writing standards.

Informed Consent

Informed consent form was obtained from all individual participants participating in the study.

Conflicts of interest

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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