

STIGMA AND ITS CONSEQUENCES DURING THE COVID-19 PANDEMIC

Evelyn L. Bush, Ph.D.

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“[The unvaccinated] are extremists who don’t believe in science, they’re often misogynists, they’re also often racists. It’s a small group that muscles in. And we have to make a choice...Do we tolerate these people?”

- Justin Trudeau, Prime Minister of Canada, September 16, 2021

“If you are walking among us unvaccinated, you are an enemy.”

- Gene Simmons, co-lead singer of the rock band KISS, November 10, 2021

“In a world of threats and tyrants and terror, you know what our biggest enemy is in America? Our fellow Americans... Far too many are still in the anti-vax camp.”

- Chris Cuomo, former CNN news personality, October 6, 2021

“Because frankly we know that we can’t trust the unvaccinated.”

- Leanna Wen, healthcare executive and op-ed columnist for the Washington Post, July 29, 2021

“In my America, all hospitals would be closed to you. You’re going to go home and die.”

- Howard Stern, “shock jock” media personality, January 19, 2022



Group Think. Scapegoating. Authoritarian personality.

Enroll in any introductory sociology course and you will be introduced to these concepts. You will read about the famous Milgram experiments, in which research subjects were easily swayed by scientific authority to administer electrical shock to strangers; Solomon Asch's perception study, which showed how individuals will readily defer to others' judgment rather than believe their own eyes; and the Stanford prison experiment, which demonstrated how easily authority figures and institutions can compel ordinary people to become submissive or abusive based on little more than random assignment into the roles of prisoner or guard.

These concepts and studies are important because they help us to understand periods and places where ordinary people suspend their own judgment and in doing so turn against their friends, family, neighbors and co-workers. Whether actively or passively, they participate in violations of their basic rights. These classic studies also illustrate the roles that authorities

and institutions play in shaping such socially malignant behavior. In extreme cases, such as during war or genocide, government and media manipulation of opinion and perception encourage tribalism and permit cruelty, thereby threatening the very right to life. But we do not need to refer to extraordinary events to observe these social tendencies. The attitudes, beliefs and dispositions that underpin such moments, and efforts of powerful actors to exacerbate and manipulate them through messaging, law, and policy, are always present, supporting day-to-day forms of prejudice and discrimination along lines of race, class, political affiliation, and ability, to name a few.

But there was something different about the events following the declaration of a COVID-19 pandemic by the World Health Organization (WHO) in March 2020. The major divisions that marked (and continue to mark) our society prior to then had been with us for a long time, deeply rooted in historical legacies whose origins are often hidden from view. Such long-standing

social antagonisms between groups can seem taken for granted, since we were all born into worlds where the boundaries have already been drawn.

In contrast, the institutional responses to COVID-19 showed us in real time how governments and their corporate media allies could create new forms of division, seemingly out of thin air. Day after day, throughout 2021 and 2022, news and entertainment media exposed us to a monotonous and coordinated repetition of accusations and insults, describing those who questioned pandemic protocols as ignorant, selfish, untrustworthy and dangerous; in short, enemies of the people. We were able to see how, practically overnight, a new social status – unvaccinated – that that had previously been a source of little more than occasional concern or curiosity, became a basis for the full-blown creation of a pariah class, in many places barred from employment, education, public transportation and community life. As with the creation of marginalized groups in other periods in history, the key to this social transformation was the manufacture and weaponization of stigma.

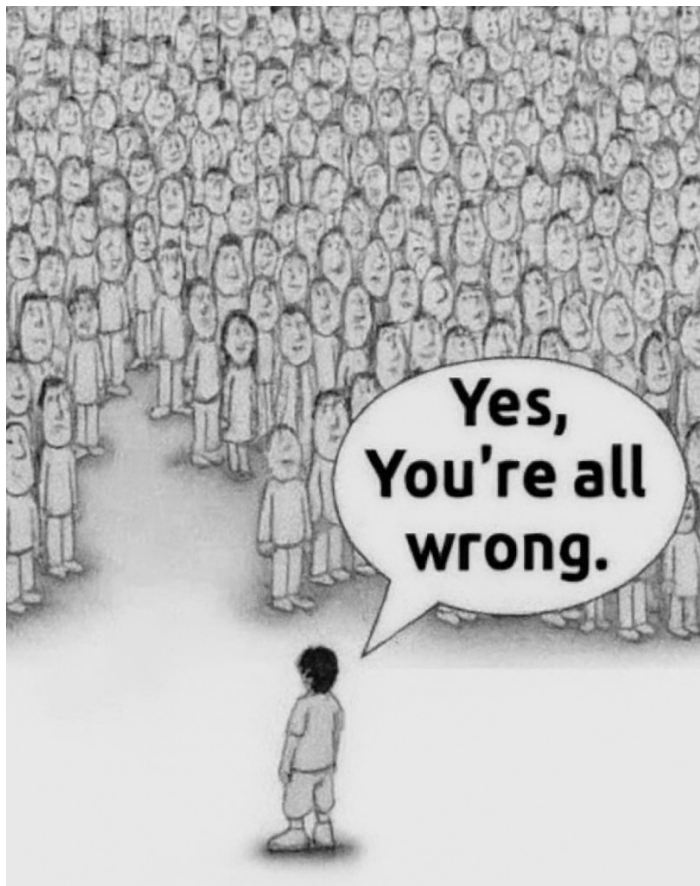
Stigma has also long been a feature of societies' reactions to illness and disease,¹ and health researchers have held a variety of positions on the role that stigma should play in efforts to influence health behaviors. On the one hand, some public health messaging campaigns have intentionally stigmatized, guided by the belief that stigma can discourage negative health behaviors such as smoking, drinking, or unhealthy eating habits;^{2,3} but on the other, stigma is widely recognized as counterproductive to public health responses.^{4,5,6,7} Stigma is known to be particularly counterproductive in the context of infectious disease outbreaks, and for several reasons.

First, as described by the CDC in reference to the 2003 SARS epidemic, “persons who are feared and stigmatized may delay seeking care and remain in the community undetected.”⁸ Second, the isolation and stress provoked by stigma can lead to depression⁹ or

anxiety,¹⁰ which are, themselves, associated with poor health outcomes.^{11,12} And third, the social isolation that is associated with stigma¹³ shields individuals from the health-protective benefits of relationships.¹⁴ Health researchers have also established that health stigma exacerbates existing health inequalities,¹⁵ such as those based on race, gender or sexuality, and further stigmatizes groups who are already marginalized.^{16,17} And yet, despite health researchers' widespread awareness of stigma's detrimental health effects, those who set the tone for the COVID-19 pandemic response either tacitly condoned it or actively encouraged it.

Throughout the months after the pandemic was declared, governments and their allies in corporate media around the globe forged aggressive messaging campaigns that stigmatized individuals who refused or simply questioned coercive aspects of the public health response, particularly vaccine mandates. Often at the behest of governments, employers fired or withheld income from life-long employees, universities refused educational access to tuition-paying students, while professors were fired or placed on unpaid leaves of absence. Professional associations barred their colleagues from conferences and networking events, business owners and entertainers banished customers and fans from their establishments and performances, and private citizens disinvited family and friends from holiday gatherings and weddings, all because they declined an investigational drug.

So, what were the outcomes of these measures? Were they worth it? Did the vaccine mandates *work* as intended? And with what consequences for those who chose not to be vaccinated? This eBook examines published research on health stigma during the COVID-19 pandemic in order to address these and related questions.



What Is Stigma?

Social-psychologist Erving Goffman defined stigma in terms of “spoiled identity” (Goffman 1963).¹⁸ He writes, “The Greeks...originated the term *stigma* to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier. The signs were cut or burned into the body and advertised that the bearer was a slave, criminal or traitor – a blemished person, ritually polluted, to be avoided, especially in public places.”¹⁹ Today, the term “stigma” refers more to shame and disgrace attributed to a characteristic than to any visible mark.²⁰ But now as then, stigmatized individuals are perceived by what Goffman calls “normals” (those without stigma) to be less than human. This dehumanization is not harmless or fleeting in its consequences. To

the contrary, it pushes people to the margins of society and serves as the basis for concrete forms of discrimination that reduce stigmatized individuals’ life chances in terms of, for example, employment, housing, or treatment by healthcare providers.^{21,22,23}

Illness and disease can be both catalysts and consequences of stigma. In terms of stigma’s consequences, stigma is not only a “central driver of morbidity and mortality,” but a fundamental cause of health inequality.²⁴ In terms of stigma in response to disease, historically, Hensen’s disease (leprosy), typhoid, and the bubonic plague were legendary for the fear they’ve provoked. And while fear of disease transmission continues to be an important factor in the perpetuation of stigma today,²⁵ stigma is not always or only rooted in fear. Health stigma is also driven by beliefs about underlying behaviors or character traits (e.g. sexual promiscuity, malingering, lack of self-control, untrustworthiness, lack of intelligence) that people attribute to those who have non-contagious conditions, such as mental illness, obesity, disability or addiction. People with controversial diagnoses such chronic fatigue syndrome, fibromyalgia, Gulf War syndrome and vaccine injury are also stigmatized, as healthcare professionals and laypersons alike often believe that they are imagining their symptoms or inaccurately attributing their causes.

Where Does Stigma Come From?

At first glance, since ordinary people engage in stigma, we might assume that it occurs entirely naturally, through day-to-day social interaction. Emile Durkheim, for example, described stigma as sometimes serving a group survival function. By socially isolating deviants and drawing exclusionary

boundaries (creating outsiders), those who conform to group norms create social cohesion among themselves.²⁶ The European witch hunts would be an extreme historical example, with some writers entertaining the hypothesis that they restored social order during periods of pronounced upheaval brought on, for example, by plague and war.^{27,28}

Of course, another way of looking at the social functions of witch hunts was that they did not benefit society as a whole. To the contrary, in the context of witch hunts, slavery, genocide, or war, the stigma that creates social cohesion for some comes at the cost of thousands, even millions, of lives of others. Rather than benefitting “society,” stigma works in the interests of society’s more powerful groups.²⁹ And much of the stigma that seems to be organic – or produced from below – is actually manufactured from above by those who control society’s institutions – government, media, entertainment, religion – which have tremendous reach and authority to shape everyday beliefs and behaviors.

In this regard, stigma is closely related to scapegoating, which is a tool wielded by powerful actors to place blame for their own failures and destructive actions on less powerful groups, in the process maintaining or strengthening their own grip on resources such as money, prestige, political office, or other positions of authority.^{30,31} As stated by Link and Phelan, “for stigma to occur, power must be exercised” and it is done in ways that “...achieve the aims of stigmatizers with respect to the exploitation, management, control or exclusion of others.”^{32,33}

Health stigma is a form of scapegoating that public health authorities have used to shield themselves from responsibility for their own policy failures, inefficiencies, or abuses. They accomplish this through health messaging that simplistically reduces the complex causes of public health problems to individual, voluntary choices.³⁴ The phrase “pandemic of the unvaccinated” is one such simplifying message

that rhetorically reduced the complex factors driving COVID-19 to a simplistic mantra blaming one particular group – the unvaccinated. As described in an [article](#) that appeared in the journal *Frontiers in Public Health*, the unvaccinated were “often publicly blamed as ... the major cause of infective surges, thereby becoming the new, transnational political scapegoat for cumulative public health inefficiencies and related socio-economic shock-waves.”³⁵ Similarly, a [2021 article](#) in the *Journal of the American Medical Association’s* Health Forum argued that the media’s focus on “vaccine hesitancy” among minority communities placed the blame for race-based health inequalities on individuals’ decisions not to vaccinate. In reality, the poor health outcomes among minority communities were rooted in a long history of neglect and unequal access to healthcare resources that became more visible in the context of COVID-19.³⁶

But messaging is only part of the story. Authorities create stigma not only through writing and speech, but through *structural stigma*, a term which refers



to [laws, policies and practices](#) that systematically treat some people unfairly.³⁷ Structural stigma takes a variety of forms, some of which we can recognize from the COVID-19 response, such as physical and social isolation (restrictions on visitors to healthcare facilities), segregation (requirements that the unvaccinated dine outdoors), and barriers to employment, education, and public accommodations (vaccine mandates and vaccine passports). Examples of other forms of structural stigma include restrictions on the right to vote, to sit on a jury, or to maintain custody of one's children.³⁸ And, as with structural stigma more generally, stigma against the unvaccinated was not simply a natural response from everyday people who were frightened by the possibility of infection; to the contrary, it was orchestrated from above.

Stigma and Social Engineering During the Pre-Vaccine Covid-19 Panic

Stigma against the unvaccinated did not emerge overnight with the introduction of the COVID-19 vaccines; rather, government and media created the conditions for it during the period prior to the vaccine rollout, when government officials tore asunder societies' networks of social support and ordered all but those who they deemed essential workers to stay home. Already by the early months of COVID-19, some health researchers were sounding the alarm about governments' actions and drawing attention to the

dangers of health stigma. They raised concerns about stigma against two groups in particular: first, those who were perceived to be at higher risk of COVID-19 infection and, second, racial and ethnic minorities.

With regard to the former, health researchers warned against blaming, socially isolating, and ostracizing groups such as front-line workers, migrants, travelers, and people who had recovered from or been close to people who had contracted COVID-19.³⁹ In fact, during a [World Health Organization press conference](#),⁴⁰ even Tedros Ghebreyesus warned, "Stigma, to be honest, is more dangerous than the virus itself. Let's really underline that. A stigma is the most dangerous enemy." This warning was indeed warranted, as in some parts of the world the stigma associated with COVID-19 was severe enough to drive some people who had COVID-19, or simply suspected they had it, to [suicide](#).^{41,42}

With regard to racial and ethnic minority groups, researchers primarily drew attention to Asian minorities, who were principally targeted, as reflected for example in a rise in anti-Asian hate crimes.^{43,44,45} But other minority groups were stigmatized as well. During the pandemic response in the U.S., pre-pandemic forms of prejudice and discrimination were exacerbated, resulting in marginalized racial and ethnic groups, particularly Hispanic and non-Hispanics Blacks, bearing the brunt of COVID-19 suspicion and blame.⁴⁶

But at the same time that researchers warned against COVID-19-related stigma, health authorities and media often worked at cross purposes, fomenting fear and social disapproval. For example, in the United Kingdom (UK), the independent Scientific Pandemic Insights Group on Behaviors ([SPI-B](#)), an offshoot of their influential Scientific Advisory Group for Emergencies (SAGE), produced a [document](#) advising on how to forge compliance with social distancing guidelines.⁴⁷ Under the subheading "coercion," SPI-B explicitly advocated for the engineering of "social disapproval" to "discourage failure to enact prosocial

behavior.”⁴⁸ This same document advocated for the inculcation of fear, stating, “A substantial number of people still do not feel sufficiently personally threatened ... The perceived level of personal threat needs to be increased among those who are complacent, using hard-hitting emotional messaging” (see also Dodsworth 2021).^{49, 50}

The social distancing that so occupied SPI-B was just one of many COVID-19 rituals that reminded populations to be fearful. Others included the arbitrary rules surrounding mask usage (wear while standing, remove while sitting), body rituals such as compulsive hand washing and sanitizing, acts of submission including degrading and, for some, painful nasal swab tests, and the reconfiguration of “permitted” and “forbidden” relationships among family, friends and colleagues. These manifestations of a “new normal” served as constant reminders that everyone was to be assumed contaminated and dangerous.

These interventions doubtless not only traumatized society but weakened social bonds. Society-wide masking and literal social and physical distancing, combined with the forced closure of indoor dining, salons, barbershops, schools, sports, playgrounds, workplaces, religious institutions, parks – in short, everything – disabled the community resources that typically nurture human relationships. In their absence, people found themselves alone and isolated in front of glowing screens, subjected to relentless and monotonous mass media messaging. The message? That a “new normal” had arrived, and that everyone must accept that collective life was being radically transformed. This new collective life was not rooted in friendship, family or the traditional ties that bind, but instead was to revolve around collective compliance with instructions from governments, who would not only be the sole source of [“truth...”](#)⁵¹ but also the sole arbiter of “the greater good.”

To demarcate the boundaries between insiders and outsiders in this new world, the compliant were treated to daily doses of ego stroking from the likes of Andrew Cuomo, Justin Trudeau, Joe Biden,

and a multitude of political opinion producers and talk show hosts, assuring those who complied with COVID-19 protocols that they were good, strong (“New York tough”), brave, caring and loving people, simply by virtue of their unwavering obedience. The subtext, of course, was that those who did not comply with government commands lacked those virtues. It was during this pre-vaccine period that the media, at the behest of health authorities, primed people to accept a reconstructed civil society based on newly established forms of segregation and exclusion, whose distinctions between good and evil would be defined strictly in terms of obedience to government mandates.

Enter the mRNA injections.



Stigmatizing the Unvaccinated: A Public Health Strategy

With the arrival of the Emergency Use Authorization (EUA) for the mRNA injections, government and corporate media replaced the central organizing principle of the “new normal” order – the belief that everyone is dangerous – with the creation of two classes – the vaccinated and the unvaccinated. This distinction rapidly became the source of pronounced polarization, as media personalities and political figures formed a unified chorus, monotonously repeating the refrain that COVID-19 was a “pandemic of the unvaccinated.”

As with the social engineering behind the pre-vaccine pandemic response, the onslaught of stigmatization of the unvaccinated was also the outcome of a coordinated plan to shape the hearts, minds and behaviors of populations that spanned the western world.

In the U.S., in early 2021, the CDC and HHS funded a comprehensive [media campaign](#),⁵² soliciting celebrities, professional sports leagues, news media and talk show hosts, clergy, and others to encourage uptake of the mRNA injections. [Documents](#)⁵³ obtained by Judicial Watch through a Freedom of Information request suggested that their explicit strategy revolved mostly around positive messaging intended to increase public confidence in the vaccines, with a strong [emphasis](#) on reaching minority communities.⁵⁴ But despite their claims to promote positive messaging, in practice, many of the celebrities and opinion producers who were presumably recruited to deliver vaccine propaganda

did so by shaming and ridiculing individuals who chose not to receive the injections. Today, there is no shortage of [compilations](#) of the aggressive, stigmatizing messages that saturated the airwaves subsequent to the rollout of the investigational injections, including [websites](#) dedicated to ridiculing unvaccinated people who died from COVID-19.

In a dramatic departure from what had at least nominally been the normative consensus in public health, the program of psychological manipulation in support of vaccination quickly developed into a torrent of scapegoating, dehumanization and threats toward those who questioned or chose not to comply with the mandates. In fact, even some health researchers stigmatized the unvaccinated, particularly in the field of mental health. This pattern marks a departure from longstanding [initiatives](#) on the part of mental health professionals to oppose stigma in their own field.⁵⁵ Rather than apply decades of accumulated knowledge about the stigmatizing effects of psychiatric labels to recommend against recklessly applying them to COVID-19-related health choices, some mental health professionals, as we will see, used mental health labels as weapons to attack those who questioned key aspects of the institutional response to COVID-19. The logical result was a double stigma, as refusal of coercive COVID measures was stigmatized not only in its own right but also as a sign of mental disorder.

The combination of “anti-vax” stigma and psychiatric stigma is far from negligible in its implications. Psychiatric labeling exacerbates vulnerability to human rights abuses, because it moves noncompliance with “health” measures onto a legal terrain that permits involuntary civil commitment and coerced “treatment.” One only needs to examine the historical uses of political psychiatry in places like Nazi Germany, the Soviet Union, China, and the U.S., particularly during the McCarthy era, to appreciate the potential for abuse.^{56,57,58}

One of the better-known examples of this weaponization of psychiatry was the case of Swiss

cardiologist [Thomas Binder](#). In separate interviews with [The Last American Vagabond](#)⁵⁹ and [Dr. Drew](#),⁶⁰ Dr. Binder, who holds a doctorate in immunology and virology, detailed how, after speaking out against lockdown restrictions, mandates, and PCR testing, he was visited by 60 armed police officers and a Swiss anti-terrorism unit. Although law enforcement subsequently deemed Binder to be no threat to himself or others, a psychiatrist shortly after the event diagnosed him with “corona insanity” (for which there is no ICD code) and committed Binder to a psychiatric ward. In order to return to work, Dr. Binder was forced to choose between six weeks of incarceration in a psychiatric hospital or take psychiatric medication for what the psychiatrist “treating” him labeled as “mania.”

Psychiatric Labelling and Vaccination Choice

Binder’s case was consistent with a broader trend in mental health research, as practically overnight a veritable cottage industry of research accumulated attempting to link vaccine refusal and other forms of COVID-19 noncompliance with mental illness. Generally speaking, the authors of this body of research overwhelmingly framed COVID-19 vaccine refusal as a problem, and failed to question (in fact, they usually parroted) the hegemonic narratives and mantras about vaccines being “safe and effective.” Notably, they did so regardless of whether, as mental health researchers, they had the credentials to make such determinations. Authors of these

studies frequently attributed - without data or evidence - vaccine decliners’ beliefs to conspiracy theories (which authors usually failed to define or refute with evidence) and generally framed their work as motivated by a desire to “reduce vaccine hesitancy.” But some of the literature went beyond the regurgitation of media narratives and was nothing short of threatening.

Consider the [commentary](#) by Raballo, Poleti and Preti,⁶¹ who supported forced treatment of “unvaccinated COVID-19 deniers” who had positive PCR tests for COVID-19. Particularly noteworthy was their rhetorical strategy for dismissing the lack of evidence in support of psychiatric diagnoses for individuals who refused treatment: The authors admitted that “This potentially lethal, self-threatening behavior [treatment refusal] is apparently expressed *without manifest signs* of suicidal intention or documented psychopathology (emphasis added).” But instead of simply not using psychiatric labels, the authors pivoted to the claim that merely refusing treatment is nonetheless cause for coercive intervention. They then proceeded to make a sensational polemical comparison to suicide cults, stating “Such *para-suicidal behavior* in COVID-19 deniers evokes some features of faith-based (e.g., Peoples Temple in Guyana, Order of the Solar Temple in Switzerland, France and Canada, Heaven’s Gate in Santa Fe, USA)⁶² and ideologically-based suicides (e.g., *suicidal terrorism*),⁶³ since it is enacted on the background of shared, specific worldviews (emphasis added)”⁶⁴

The authors went on to attribute the “self-threatening therapeutic refusal” of these “COVID-19 deniers,” to “*para-delusional*,” “*schizotypal*,” and “*psychotic-like*” thought patterns.⁶⁵ Since the authors could not claim evidence of actual delusion or psychosis (in fact, they claimed neither to have met nor evaluated

these hypothetical patients), they fell back on claims of *para-delusion* and *psychotic-like* beliefs as justifications for forced treatment:

“compulsory treatment might be legitimately applied because the individual’s ability to make decisions about medical treatment is significantly impaired.... compulsory treatment of COVID-19 deniers would of course count as a condition of exemption from the otherwise central jurisprudential principle of freedom of choice in the bioethical matter of medical treatment⁶⁶ whose driving concept (informed consent of the patient) is challenged by illness denial.”⁶⁷ In other words, in the case of COVID-19, there should be no informed consent.

Given the threatening substance and tone taken by these health experts, could a person with COVID-19 really be blamed for having declined a trip to the emergency room?

Based on the literature review for this eBook, findings from research on a hypothetical link between vaccine refusal and mental illness were mixed but skewed heavily in favor of the null hypothesis. That is, there was little convincing evidence to show that unwillingness to vaccinate was driven by mental illness. To the contrary, in several studies, it was the vaccinated who were more likely to suffer from mental health problems. For example, with regard to vaccination in general (beyond COVID-19 vaccination), [an article in *2 Minute Medicine*](#)⁶⁸ summarized a [systematic review](#)⁶⁹ that found “no consistent relationship between mental health issues and vaccine uptake,” but “in adults aged 50-65 years, it was found that those with mental health issues had consistently higher odds of getting vaccinated compared to those without mental health issues.” Garretsen and colleagues found that reports of *lower* negative mental health effects from the pandemic were positively related to “vaccine hesitancy.”⁷⁰ [Bendau et al.](#) found that “COVID-19-related anxiety and health-related fears were associated with higher vaccine acceptance, whereas the fear of social and economic consequences showed the contrary direction [vaccine refusal].”⁷¹

[An article](#) in *Frontiers in Psychiatry* reported results of a survey of some 1,000 people prior to the rollout of the COVID-19 vaccines. The researchers found that those who expressed a willingness to be vaccinated for COVID-19 when vaccines became available scored higher on the standard General Health Questionnaire (GHQ-28), which measures a respondent’s level of psychological distress at the time of a given survey. Specifically, individuals who intended to be vaccinated were more likely than vaccine refusers to suffer from anxiety, insomnia, social dysfunction and somatic dysfunction. Interestingly, the study also found that accurate knowledge about COVID-19 was among the factors associated with *unwillingness* to vaccinate. The authors [concluded](#) that “Reluctance to vaccinate may result from greater awareness of the complexity of the disease, and thus less faith in the effectiveness of vaccines.”⁷²

Nishimi and colleagues hypothesized a link between past trauma and post-traumatic stress disorder (PTSD) on the one hand and “vaccine hesitancy” six months later on the other. They found that trauma and PTSD were not associated with a later choice whether or not to be vaccinated for COVID-19.⁷³ [A research article](#) in the *Annals of Medicine* titled “Pre-pandemic mental and physical health as predictors of COVID-19 vaccine hesitancy: evidence from a UK-wide cohort study,” likewise reported no relationship between pre-pandemic distress symptoms or diagnoses of anxiety or depression on the one hand and unwillingness to vaccinate for COVID-19 on the other.⁷⁴

In contrast, a handful of studies did find relationships between mental health issues and preference against COVID-19 vaccination. For example, [a study](#) in the journal *Health* found that survey respondents who reported that they had “ever been diagnosed with a mental disorder” were more opposed to vaccination than were people who did not self-report any history of mental health diagnosis.⁷⁵ Similarly, a study by [Kim and Kim](#) showed that self-reported symptoms of

depression were associated with being unvaccinated and with an intention to not get vaccinated.⁷⁶

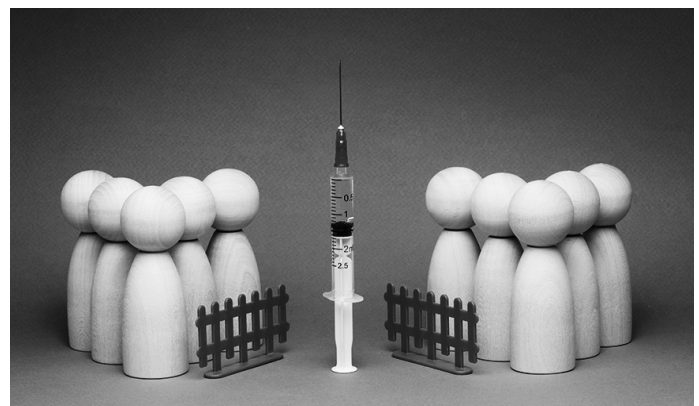
An important limitation common to many of the studies examining a hypothetical link between mental health and vaccination decisions is the use of cross-sectional data (data that are collected at only one point in time), making it difficult to infer causal relationships. Another is the lack of more in-depth qualitative data needed to interpret how or why vaccination status and mental health might be linked. For example, the study by Kim and Kim that found a link between depressive symptoms and the decision to not be vaccinated also found that “health-related reasons’ and ‘concerns about side effects or past experience of side effects’ accounted for 89% of the reasons for vaccine avoidance among individuals with depression.”⁷⁷ In other words, while the study’s mental health hypothesis implies that mental illness might drive refusal to be COVID-19 vaccinated, a more likely explanation is that poor health or previous vaccine injury are underlying factors that drive both depressive symptoms and refusal of the vaccine.

Another factor these studies fail to consider is the role of stigma against unvaccinated people. On the one hand, stigma is correlated with both depression and, as we will see, vaccine refusal. So, it could be that the fact of being unvaccinated could lead to depressive symptoms as a result of the stigma of being unvaccinated. On the other hand, the social stressors tied to being unvaccinated (e.g. job loss, ostracism, the burden of weekly COVID-19 testing, travel restrictions) might drive people toward vaccination in order ease the distress, thereby creating a positive statistical relationship between indicators of mental distress and the decision be to COVID-19 vaccinated. For example, in a study of vaccination-related conflicts among healthcare workers, several unvaccinated healthcare workers reported “mental health issues that they related to the difficult climate of interaction regarding vaccines.”⁷⁸ For some, this might result in a decision to be vaccinated in order to alleviate the psychological burden; for others, it might explain any relationship between depression/anxiety

on the one hand and vaccine rejection on the other. In the absence of more carefully designed studies that include the effects of vaccine-related stigma, statistical relationships found between vaccination status and mental health are difficult to interpret.

Given the underwhelming evidence of a link between vaccine refusal and mental disorder, perhaps mental health researchers should instead examine the legitimate concerns that refusers (now a majority) have about COVID-19 vaccines and other interventions, such as a lack of informed consent, the unreliability of PCR tests (which are, themselves, still under EUA), research evidence of adverse events, or the fact that the COVID-19 vaccines have not been proven to prevent their recipients from getting or transmitting COVID-19.

In summary, contrary to decades of public health research indicating that stigma exacerbates public health crises, in the context of COVID-19, government authorities, spokespersons, entertainers and experts proactively drew boundaries between good and evil, clean and unclean, sane and insane, solely on the basis of vaccination status, dangerously simplifying what should have been treated as a complex medical and social problem. What, then, were the outcomes of these efforts? Did shaming the unvaccinated in fact help public health organizations, pharmaceutical companies, and philanthrocapitalists achieve their goal of “a shot in every arm?” Secondly, did stigmatizing messaging, in fact, result in stigmatization of the unvaccinated by ordinary people? And if so, to what effect? The remaining sections will address these questions.



Support for Vaccine Mandates and Vaccine Uptake

Whether or not efforts to increase vaccine uptake were successful in changing public attitudes and behaviors is debatable, and varies across sectors of a given population. In the U.S., a [50-states survey](#) conducted by the COVID States Project and funded by the National Science Foundation examined changes in support for mandates “requiring everyone to get a COVID-19 vaccine” during the spring and summer of 2021.⁷⁹ Looking at all groups combined, the study showed a 2-point increase from April/May 2021 (62% support) to June/July 2021 (64% support). The study found majority support for vaccine mandates in all subgroups examined except Republicans.⁸⁰ However, the levels of increase in support for mandates varied along several dimensions. With regard to income, for example, 77% percent of individuals making \$100,000 or more favored vaccine mandates in June/July 2021, which was a 5-point increase from April/May 2021. In contrast, those earning \$25,000 or less showed the lowest support (60%), in June/July 2021, only a 2-point increase from April/May 2021. Other noteworthy gaps in support for mandates (in June/July 2021) were between Democrats (84% approval) and Republicans (45% approval); urban residents (73% approval) and rural residents (53% approval); men (69% approval) and women (60% approval); and by education (High school 58%, some college 61%, Bachelor degree 72%, graduate degree 80% approval).⁸¹

As for the effects of mandates on vaccine uptake, a [study](#) published in the *Proceedings of the National Academy of Sciences*, using state-level CDC data,

concluded that government mandates in the United States did not work as intended and, in some ways, backfired. As summarized in the abstract:

“COVID-19 vaccine adoption did not significantly change in the weeks before and after states implemented vaccine mandates, suggesting that mandates did not directly impact COVID-19 vaccination. Compared to states that banned vaccine restrictions, however, states with mandates had lower levels of COVID-19 booster adoption as well as adult and child flu vaccination, especially when residents initially were less likely to vaccinate for COVID-19. This research supports the notion that governmental restrictions in the form of vaccination mandates can have unintended negative consequences, not necessarily by reducing uptake of the mandated vaccine, but by reducing adoption of other voluntary vaccines.”⁸²

Similarly, [Sprengholz et al.](#) found that, with regard to vaccine mandates “...reactance due to a mandate was positively associated with intentions to avoid the COVID-19 vaccination and an unrelated chickenpox vaccination; it was negatively associated with intentions to show protective behaviors limiting the spread of the coronavirus.”⁸³

These findings pertaining to the backfire effects of vaccine mandates are corroborated by research suggesting that the stigma attached to non-vaccination played an important role in vaccine refusal. [Rosenfeld and Tomiyama](#) found that “greater perceived moral reproach independently predicted stronger refusal to get vaccinated against COVID-19, over and above other relevant variables.⁸⁴ Of 18 predictors tested, perceived moral reproach was the fifth strongest predictor — stronger than perceived risk of COVID-19, underlying health conditions status, and trust in scientists.”⁸⁵

Likewise, [Henkel et al.](#) did a study on how “vaccination status identification” (VSI) was related to a variety of outcomes, including attitudes toward COVID-19 regulations. They found that stronger VSI, which

was measured by a scale that included, among other items, the statement “When people are criticized for (not) being vaccinated against COVID-19, it feels like a personal insult to me,” was significantly related to unvaccinated individuals’ decisions to resist vaccination and other COVID-19 regulations.⁸⁶

It appears, then, that shaming was counterproductive to the goal of vaccinating the entire population; in fact, both structural and emotional coercion backfired. What, then, did stigma and scapegoating accomplish? The next section will describe how the stigma campaign, while failing as a vaccination strategy, nonetheless succeeded in the creation of a new source of social polarization and a new pariah class.

The Social Consequences of Stigma and Scapegoating

As a strategy for shaping public beliefs and attitudes toward the unvaccinated, “normative messaging” campaigns appear to have succeeded in the creation of a new marginalized societal class. Already by 2022, [an article](#) in *Nature*, reporting the results of three studies across 21 countries in total, revealed that the unvaccinated had become the objects of discriminatory attitudes that rivaled prejudices against other marginalized groups, and that there was significant public support for restricting the rights of the unvaccinated.⁸⁷

The first study, which surveyed 10,740 people across 21 countries, examined attitudes (how unhappy one would be) toward a family member hypothetically marrying an unvaccinated person. The study found that vaccinated respondents were significantly more

likely to be unhappy if the person their relative were to marry were unvaccinated. Furthermore, their exclusionary attitudes against unvaccinated people were not only based on fear of infection, but also on stereotypes, especially the belief that the unvaccinated were untrustworthy and incompetent.⁸⁸

The second study surveyed 3,045 individuals across six countries and found that, in all six countries, “vaccinated respondents dislike unvaccinated targets more than vaccinated targets,” while the converse was not true. The magnitude of the prejudice was illustrated by the additional finding that unvaccinated people were “disliked as much as people who struggle with drug addiction ...and significantly more so than people who have been in prison ... who are atheists or who have a mental illness.”⁸⁹

Most consequential in terms of the protection of fundamental freedoms and rights, the third study, which focused exclusively on the U.S., showed that vaccinated survey respondents were significantly more likely to approve of civil and human rights violations if the individuals in question were unvaccinated. Specifically, vaccinated respondents were more likely to say unvaccinated people should not be allowed to sit next to them on public transportation, move into their neighborhoods, be granted citizenship, speak freely without censorship, or receive welfare.⁹⁰ “Vaccinated respondents expressed significantly higher exclusionary attitudes towards unvaccinated individuals than they did against atheists on all six outcomes, against mentally ill on five outcomes, and against individuals who have been in prison or struggle with drug addiction on three outcomes.”⁹¹

Likewise, a separate [survey](#) of vaccinated German residents found support for punitive measures against the unvaccinated, including limitations of fundamental rights (46% support), exclusion from COVID relief payments (50.2% support), international travel restrictions (53.7% support), and large fines (49.5% support). The same survey found that not only pandemic-related fear, but also

negative personality stereotypes of the unvaccinated were significantly related to punitive attitudes toward them.⁹²

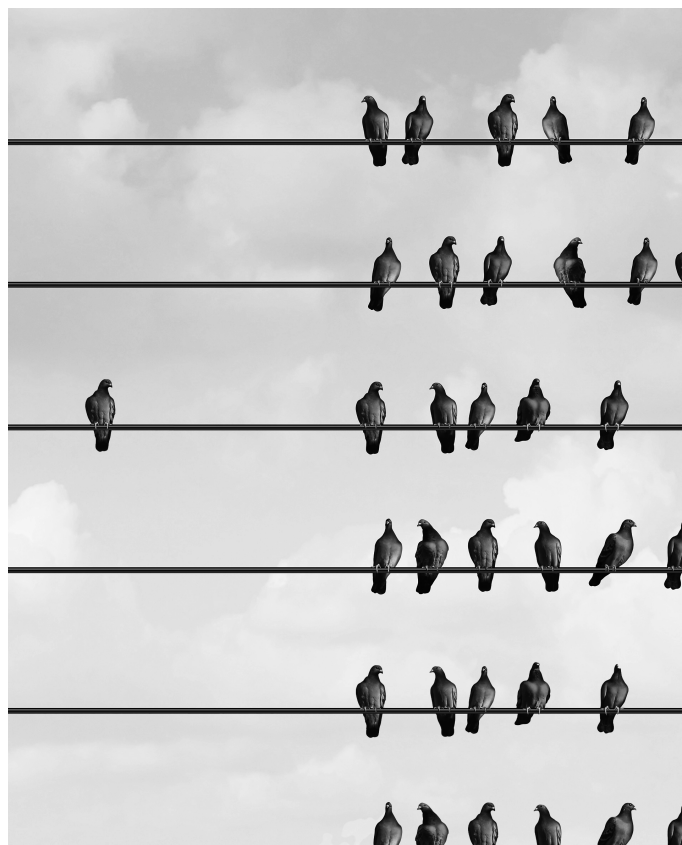
An experimental vignette study also revealed unfavorable attitudes toward the unvaccinated that would likely manifest in adverse social consequences. The [study](#) included 1,200 participants and found that research subjects were significantly less likely to report a willingness to contribute to a crowdfunding website for an unvaccinated (vs. vaccinated) person who had COVID-19. They were also significantly more likely to communicate a desire to punish, through legal liability or social condemnation, an unvaccinated (vs. vaccinated) person who unintentionally infected others with COVID-19. In both cases (refusing to help and punishing), the research participants' own vaccination status moderated the relationship, with vaccinated (vs. unvaccinated) research subjects being significantly less willing to help and more likely to desire punishment of unvaccinated individuals.⁹³

The study by Henkel et al. also found that the unvaccinated individuals were significantly more likely to report experiencing everyday forms of discrimination and social ostracism.⁹⁴ To test the veracity of these perceptions, the authors conducted a controlled experiment referred to as a “dictator game.” This type of study allows researchers to observe patterns of sharing in order to understand fairness, altruism or discrimination. In their study, vaccinated research subjects gave less money to unvaccinated individuals than unvaccinated gave to vaccinated. The authors of the [study](#) describe how these differences were exacerbated by vaccinated individuals' identification with their own vaccination status:

“Thus, the more vaccinated people identified with being vaccinated, the more they discriminated against unvaccinated players. The unvaccinated also did this but to a smaller extent. The stronger discrimination behaviour of vaccinated individuals ... suggests that reports of discrimination are not fiction but fact.”⁹⁵

Henkel et al. concluded from their findings that identification with vaccination status (VSI) had become a source of societal polarization.

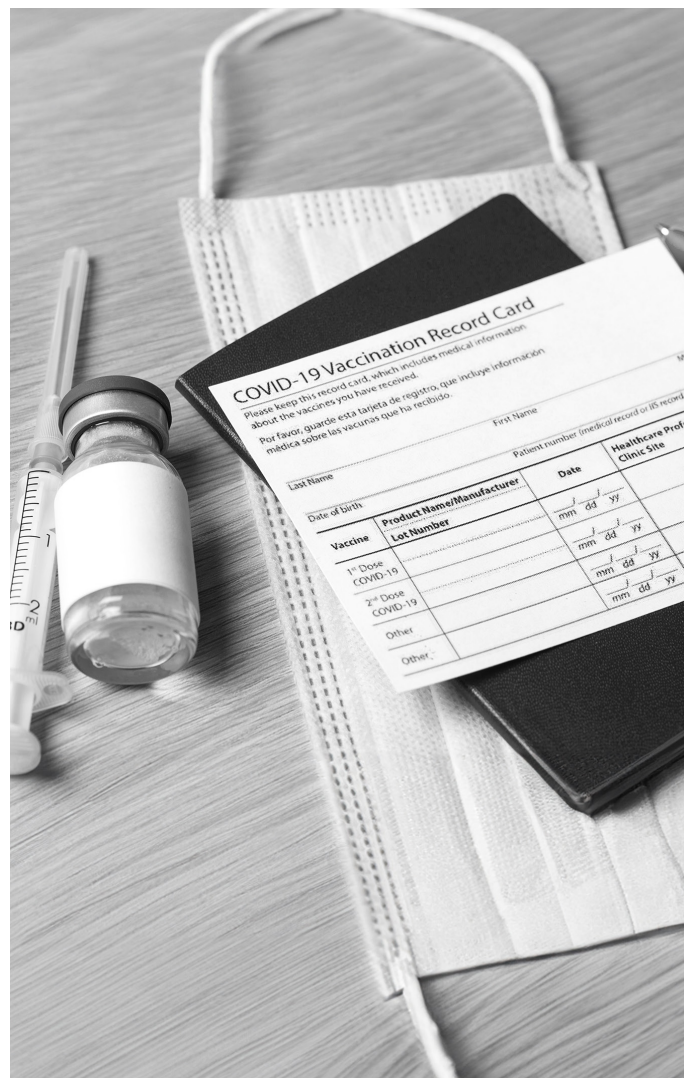
Another resource allocation [experiment](#) likewise showed how “vaccination status triggers inter-group discrimination.”⁹⁶ The study found that vaccinated participants were more likely to allocate resources to the disadvantage of non-vaccinated, as opposed to vaccinated, targets. In contrast, non-vaccinated participants were less likely to discriminate on the basis of vaccination status. Taking these observations together with other findings from the study, the author concluded that “the act of being vaccinated works as a trigger that amplifies perceived intergroup differences.”⁹⁷



Stigma in the Context of Healthcare

Stigma based on vaccination status also manifested in healthcare workers' (HCWs) relationships with their patients and with each other. [A study](#) of 74 Belgian HCWs by Heyerdahl et al., published in the journal *Vaccine*, found substantial workplace polarization around the issue of vaccination, which strained professional relationships and eroded HCW trust in the healthcare system.⁹⁸ For example, HCWs reported complaints, ridicule and denigrating comments (e.g. “deserved to die”) about unvaccinated COVID-19 patients and unvaccinated HCWs.⁹⁹ Vaccinated HCWs saw unvaccinated patients with COVID-19 as responsible for their illnesses, and “for overwhelming staff and coercing them into witnessing severe illness and death.”¹⁰⁰ HCWs described colleagues unnecessarily marking unvaccinated patients’ charts as “unvaccinated” (literally stigmatizing them) and subsequently giving them only the minimal required care.¹⁰¹

At the same time, vaccine-skeptical HCWs criticized vaccinated COVID-19 patients for reckless health behaviors that resulted from unwarranted confidence in the COVID-19 vaccines.¹⁰² An example would be vaccinated individuals catching COVID-19 after attending social gatherings, thinking that their vaccines would protect them. Unvaccinated HCWs also described fear of retaliation by patients who might learn of their vaccination status.¹⁰³ The authors reported serious schisms between vaccinated and unvaccinated HCWs, including personal attacks, threats of vandalism and severed relationships. The authors [summarized the study](#) by stating that “Loss of trust between HCW and peers or patients, along with suboptimal patient care based on vaccination status, threaten to weaken Belgium’s, and by implication, other, health systems, and to catalyze preventable disease outbreaks.”¹⁰⁴



The divisions documented by Heyerdahl and colleagues were also pervasive in the U.S. In 2022, [an article](#)¹⁰⁵ appeared in *BMC Medical Ethics* titled: “Needs to address clinicians’ moral distress in treating unvaccinated COVID-19 patients.” The author, Robert Klitzman, detailed both sides of “heated controversies” among HCWs surrounding whether or not to treat unvaccinated patients. He described “moral distress among front-line clinicians” who believed it was immoral to treat the unvaccinated who, the author stated, were the cause of overflowing hospitals. While Klitzman himself seemed in favor of providing treatment to unvaccinated patients, he detailed the arguments against it, which essentially can be summarized as endangerment to the (presumably vaccinated)¹⁰⁶ doctors, medical staff and other patients, disqualification from care due to failure

to follow health professionals' advice (which, we are told, is part of a "social contract"), and the obligation of HCWs to not get sick or die and subsequently not be available to care for future patients.

There are multiple deficiencies in these arguments. First, as Klitzman pointed out, HCWs do not hold patients to the "social contract" when confronted with other preventable illnesses, such as "emphysema due to smoking, diabetes from overeating, cirrhosis from alcohol abuse, and accidents from not wearing seatbelts or engaging in other risky behaviors that endanger the individual and at times others and are hence costly to the healthcare system and society."¹⁰⁷ Those HCWs who would believe that providing treatment to unvaccinated individuals is unethical also appear to have been unaware of the role that vaccinated people have played in spreading COVID-19, particularly in the context of large gatherings of vaccinated individuals; they also seem to have been unaware of, or chose to ignore, documented similarities between infected-vaccinated and infected-unvaccinated individuals in terms of viral load.¹⁰⁸

Klitzman also drew attention to how failure to treat the unvaccinated could have exacerbated race-based health inequalities, given the disproportionately low vaccination rates among African Americans,¹⁰⁹ despite the Department of Health and Human Services efforts to focus on vaccine uptake in minority communities. Sarah Ganty articulated a similar concern about vaccine mandates, warning that they "are likely particularly to affect the poor, who usually also belong to other vulnerable groups such as ethnic minorities or single parents..."¹¹⁰ In other words, if minorities were more likely than others to reject COVID-19 vaccination, not only would they disproportionately feel the effects of vaccine-related healthcare discrimination; they would also be more likely to lose employment, income, education and other rights that are taken away through vaccine mandates.

COVID-19 Related Stigma Apart from Vaccination Status

But it was not only the unvaccinated who were stigmatized. Another body of research focuses more generally on "COVID-related stigma" (CRS), which is stigma experienced by individuals who were diagnosed with, perceived as having, or perceived to be at greater risk for getting, COVID-19.¹¹¹ Although not the same as stigma based on vaccination status, it is reasonable to expect that stigmatizing noncompliance with COVID-19 mitigation measures would contribute to stigma against those who contract COVID-19, regardless of vaccination status. When HHS, the CDC, the FDA and media present COVID-19 as preventable through compliance with government advice and orders, and "allowing oneself" to contract it due to one's own disobedience is portrayed by the media as a profound moral failing worthy of contempt, it would make sense that individuals who become infected, despite compliance, might blame themselves (internalized stigma), or be blamed by others.

An abundance of research, both before and after the vaccine rollout, confirms this to be the case. For example, an article reporting research conducted in Bangladesh described stigma and discrimination against COVID-19 symptomatic persons taking forms such as abandonment by family members, denial of funeral rites and burials, forced eviction, and even the destruction of a proposed hospital for COVID-19 patients.¹¹²

In research on the U.S., CRS was strongly associated with race. [An article by Le et al.](#) examined the intersection between race and CRS across five cities in the American south in 2020, prior to the vaccine rollout.¹¹³ They found minority groups were significantly more likely than white respondents to experience both major and everyday forms of CRS, and were more likely to experience heightened vigilance due to anticipated discrimination. They also found that, for all racial groups, COVID-related discrimination was, in turn, associated positively with psychological distress and worse mental health outcomes.

A global [social media analysis](#) of “rumors, stigma and conspiracy theories” across 87 countries found healthcare workers and people of Chinese descent to be frequent targets of verbal and, in some cases, physical attacks.¹¹⁴ [Gutierrez et al. \(2022\)](#) also found that race and ethnicity (particularly Asian) were associated with the highest odds, followed by testing positive for COVID-19 and working in healthcare or as a first responder, of experiencing COVID-19-related stigma.¹¹⁵

In summary, stigma during COVID-19 did not only harm the unvaccinated; many of the vaccinated were harmed by stigma as well, especially those who were among societies’ more vulnerable.



Why Does Pandemic-Related Stigma Still Matter?

As of the time of this writing, COVID-related mandates have ended and, judging by the paucity of reflective commentary from politicians and the corporate media, those responsible for the damage would prefer that the public move on and view events through the limited reflection of a rearview mirror. In the U.S., for example, in the lead-up to the presidential election in 2024, it was hard to find a poll that asked respondents to rate candidates in terms of their response to COVID-19 or their policy intentions in the hypothetical case of a future pandemic declaration. It is quite possible that much of the public shares this lack of interest and is indeed ready to move on. So, what is the value of revisiting the societal polarization that has been manufactured around the COVID-19 vaccines?

First, there is the possibility that another pandemic will be declared in the near or distant future. If the possibility were remote, national and international agencies would not be investing massive resources into pandemic preparedness. The [World Health Organization Pandemic Treaty](#),¹¹⁶ which member states adopted in [May 2025](#),¹¹⁷ is the most obvious case in point. Meanwhile, a [Declaration of Emergency](#) for “avian flu” was issued in July 2024,¹¹⁸ and HHS [announced](#) plans to pay Moderna to develop an mRNA-based countermeasure for it.¹¹⁹ In preparation, federal health officials in the U.S. stockpiled millions of vials of a non-mRNA vaccine as a precautionary measure. For these reasons alone, it is important to keep alive public discussions about medical mandates, lockdowns, and other aspects

of the COVID-19 response that harmed individuals and societies, with the hope that engaged citizens and policy makers who support human rights and informed consent can prevent a repeat of COVID-19 abuses.

But there are also broader reasons to review the events surrounding COVID-19. While official responses stopped far short of devolving into the full-blown totalitarian nightmares of the twentieth century, we nonetheless witnessed the social dynamics that make such dystopian societies possible. The ease with which ordinary individuals fell in line and perpetuated the scapegoating and demonization that government and media personalities modeled for them serves as a stark warning that such atrocities can happen again. Tragically, the lessons of Milgrim's electric shock experiment, Asch's conformity study, and Zimbardo's prison demonstration, might have been studied and learned by those who would use them in their own exercise of authority, but not by most of the everyday men and women who do not occupy positions of power. Under the right circumstances, totalitarian rule, and the public tolerance for government brutality that often accompanies it, could indeed resurface. All that is needed is for the mass media to inculcate fear for personal safety and hatred toward a scapegoat. Fortunately, during COVID-19, despite our governments' aggressive efforts to shut down debate and dissent, there were just enough cracks in the pavement of our media environments for those who were willing to openly resist to break through. But all the same, given the continuing efforts to censor those voices, we continue to be reminded that our fundamental rights – to speech, to bodily autonomy, to privacy – cannot be taken for granted. If we are not vigilant, we could be only one declared emergency away from losing our freedoms again.

The purpose of this eBook has been to shine a spotlight on the consequences of one of the more amorphous mechanisms – stigma – through which widespread social control is established, and on the roles that it plays in enabling abuses of institutional power. In fact,

it is difficult to find a moment in history when stigma and fear were not among the more powerful weapons wielded in the service of discrimination, civil and human rights abuses, and authoritarianism. It is not an exaggeration to say that stigma is the handmaid of totalitarian control. Hopefully, by making the role stigma played in the response to COVID-19 explicit, and by examining research on its effects, we will be better able to enact strategies against stigma in post-COVID-19 struggles against threats to our human rights and dignity.

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