Disability and Rehabilitation

ISSN: 0963-8288 (Print) 1464-5165 (Online) Journal homepage: https://www.tandfonline.com/loi/idre20

Cumulative stigma among injured immigrant workers: a qualitative exploratory study in Montreal (Quebec, Canada)

Daniel Côté, Jessica Dubé, Sylvie Gravel, Danielle Gratton & Bob W. White

To cite this article: Daniel Côté, Jessica Dubé, Sylvie Gravel, Danielle Gratton & Bob W. White (2019): Cumulative stigma among injured immigrant workers: a qualitative exploratory study in Montreal (Quebec, Canada), Disability and Rehabilitation, DOI: 10.1080/09638288.2018.1517281

To link to this article: https://doi.org/10.1080/09638288.2018.1517281

DISABILITY AND REHABILITATION
https://doi.org/10.1080/09638288.2018.1517281

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

Cumulative stigma among injured immigrant workers: a qualitative exploratory study in Montreal (Quebec, Canada)

Daniel Côté[a,b], Jessica Dubé[a,c], Sylvie Gravel[b], Danielle Gratton[d] and Bob W. White[b]

[a]Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST), Montreal, Canada; [b]Département d'anthropologie, Universite de Montreal, Montreal, Canada; [c]École des sciences de la gestion, Université du Québec à Montréal (UQAM), Montreal, Canada; [d]Centre intégré de santé et de services sociaux de Laval, Laval, Canada

ABSTRACT

Purpose: This paper presents the phenomenon of stigmatisation among injured immigrant and ethnocultural minority workers experiencing a long-standing disability. Stigmatisation was one of the main findings of our study, the aim of which was to gain insight into the work rehabilitation process in the context of intercultural relations in Quebec. Various categories of stakeholders took part in the study, which sought to describe their experiences and perspectives and to identify the constraints, barriers, facilitators, and specific needs they encounter in terms of intercultural competencies.

Methods: A purposive sample of 40 individuals was selected and divided into four groups: workers ($N = 9$), clinicians ($N = 15$), workers' compensation board rehabilitation experts ($N = 14$), and workplace representatives ($N = 2$). Semi-structured interviews were conducted using the critical incident technique, combined with an "explicitation" interviewing technique. Data collection and analysis procedures were based on grounded theory.

Results: This study shows that immigrant and ethnocultural minority workers may experience stigmatisation as a cumulative process involving different concomitant parts of their "identity": age, gender, social class, ethnicity, mental health, and occupational injuries. Cumulative stigma may aggravate personal distress and feelings of shame, rejection, and disqualification from full social acceptance. Negative anticipatory judgements made by practitioners may undermine the therapeutic relationship and breach mutual trust and confidence.

Conclusions: The phenomenon of stigmatisation is well documented in the sociological and health literature, but studies tend to focus on only one type of stigma at a time. Future research should focus on the cumulative process of stigmatisation specifically affecting immigrant and ethnocultural minority workers and its potentially damaging impact on self-concept, healthcare delivery, rehabilitation interventions, and the return to work.

ARTICLE HISTORY
Received 7 March 2018
Revised 22 August 2018
Accepted 25 August 2018

KEYWORDS
Stigmatisation; cross-cultural care; occupational health services; immigrants; minority health; return-to-work

➤ IMPLICATIONS FOR REHABILITATION

- The repetition of certain clinical situations with people from certain groups should not lead practitioners to undue generalizations, even if they may sometimes be accurate; these generalizations must always be verified on a case by case basis.
- Ethnicity and culture, along with other social attributions, should serve as working hypotheses or support tools in health communication, not as hindrances to clinical reasoning.
- Practitioners should deepen their understanding of the patient's treatment expectations and the support available for rehabilitation in his family and community.
- Stigma in the context of care is linked to the idea of conforming to the proposed institutional models of care (including expected beliefs, attitudes, and behaviours). Therefore, practitioners should be aware that alleged differences, misunderstanding or disagreements can highlight an asymmetry in practitioner–patient power relationships.
- Organisations should also promote exchange and reflection on how to adapt their institutional models to avoid asymmetrical power relations.
- Intercultural training should be promoted at the various organisational levels so that managers, decision-makers, and practitioners share a common knowledge of the challenges of intervention in multiethnic settings.

Introduction

Every year, a large number of workers experience disability at work due to an occupational injury. For 2015 alone, approximately 233,000 workers were compensated for an occupational injury [1] in Canada. In that same year, 65,859 workplace injuries were reported in the province of Quebec, where our study took place.

CONTACT Daniel Côté cote.daniel@irsst.qc.ca Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST), 505 De Maisonneuve Blvd. W., Montreal, Quebec H3A 3C2, Canada

Supplemental data for this article can be accessed here.

Work disability may have considerable impacts on workers' personal life (e.g., self-concept, feeling of loss, fear of not returning to work, fear of having to live with a permanent impairment, and financial burdens). The frequency and severity of workplace injuries varies, depending on the industry and type of occupation. For example, the manufacturing industry in Quebec signals the highest number of injuries, followed by the health and social services sector, the retail trade, construction, transportation, and warehousing [1]. Gender variation and age may also influence the statistical distribution of occupational injuries [2]. Provincial workers' compensation boards (WCBs) do not take the situation of immigrant and ethnocultural minority workers into consideration in their demographic data. Despite this lack of statistical monitoring, Quebec's WCB (known as the CNESST: Commission des normes, de l'équité, de la santé et de la sécurité du travail) estimates that nearly half of the injured workers receiving compensation in the city of Montreal (the largest metropolitan area in Quebec) were born abroad [3], while they represent roughly one-third of the city's population [4]. This estimate was corroborated in our own inquiry among CNESST rehabilitation experts, who estimated that immigrant and ethnocultural minority workers could represent between 50% and 80% of their caseload in terms of workers at high risk of developing a chronic condition or long-term disability [5]. Numerous authors have reported that this segment of the labour force is more likely to have sub-standard working conditions or in industrial sectors or occupations that pose a higher risk of injury or accident and of exposure to pesticide, chemical, or environmental contaminants [6–12]. In Quebec, for the period 2010–2012, most compensated injured workers did not require rehabilitation treatment or programmes and were able to resume work within an average of 50 days [13]. However, some did require an individualised rehabilitation programme and were off work for an average of approximately 619 days. The financial and human costs are therefore considerable at various levels: societal, organisational, and personal [14,15].

Diversity issues

Canada recognises the contribution of immigration to cultural and social diversity. Every year it admits around 260,000 new immigrants, most of them on the basis of a series of well-documented selection criteria [16]. In addition, more than 60,000 workers are admitted annually through the Temporary Foreign Workers programme. In Quebec, where our study was conducted, approximately 50,000 immigrants are admitted every year with permanent status, and most of them reside in Montreal. While immigration is officially seen as an asset in terms of meeting the labour needs of the market, counterbalancing the effect of an aging labour force, and contributing to cross-cultural dynamics, dialogue, and exchange, it can also pose major challenges in terms of inclusion, employability, and communication. Although diversity is generally valued in Canada [17], especially in official legislation and policies [18], demographic changes caused by increased and new forms of immigration can also give rise to asymmetric power relations and inequality [19–21], especially with regard to access to healthcare and social services. Ethnic diversity means that different standards, values, and ways of thinking, saying, and doing can exist side by side in any given society. In the context of healthcare and social services delivery, such differences may hinder interpersonal interactions and communication [22]. In addition, complex employment trajectories may characterise immigrant and ethnocultural minority workers, who are faced with multiple forms of precariousness [23], unequal access to healthcare and services [24,25], and various forms of stigma [26].

Stigmatisation

According to Goffman, the concept of stigma refers to a stereotypical view of an individual or a group of persons whose attributes are considered "deviant" from dominant societal norms [27]. In his view, stigmatisation plays a role in interpersonal interactions and can lead to disqualification, exclusion, social isolation, and poverty when, for example, an injured worker no longer meets the expected requirements and is unable to perform his or her occupational duties, or when a specific social attribution or identity prevents him or her from accessing employment [28–34]. The application of stigma greatly reduces a person's chances in life and compromises his or her right to equality. There are three main types of stigma according to Goffman: (1) physical stigma, (2) stigma related to personal character traits (perceived, e.g., as a weak will, misguided beliefs, dishonesty, or a moral flaw, and sometimes related to health or social status or to lifestyle habits), and (3) "tribal" stigma, which include race, nation, and religion. Stigma related to sex, gender, age, or language could be added as new categories as they too may interfere with social roles and status [35]. Stigma affect social relationships; they are at play when people with a socially constructed negative attribute choose to conform to dominant social norms, values, and expectations [36]. People with such attributes may develop strategies for managing their social identity and relations with others in a positive way, strategies coined by anthropology in the phrase "negotiation of a social space" [37]. For this reason, these attributes can be seen as a "threshold" [36], with their personal and social impacts depending on the extent to which a society, group, business, or people give space to things that commonly deviate from what they consider to be normal. This is particularly true in the context of intercultural interactions where differences in communication patterns, expression of emotions, and collective representations might readily be subjected to misunderstanding, misconception, prejudice, and moral judgement [38]. Clearly, this situation can be counterproductive for the therapeutic alliance and for clinical outcomes [5,39,40]. The same stigmatisation process is reported when the clinicians are perceived as being part of "diverse" communities [41].

Social and cultural diversity may generate stigmatisation in interpersonal relations. In the healthcare field, face-to-face encounters where cultural or racial differences are perceived as a source of friction (by both patients and clinicians) may become fertile ground for negative assumptions, intentions, and values (e.g., relating to health, illness, and the healing process) [42]. A tendency toward categorisation can emerge, influencing not only interactions but also decision-making, as observed in a Swedish study on institutional strategies in face-to-face encounters with injured immigrant workers [43]. According to that study, the presence of "cultural filters" (even when the bias is unconscious or implicit) may lead to stereotypical views, ethnocentric value judgements, and reduced empathy. It may also lead to the premature pigeonholing of immigrant workers in the category of so-called "complex cases" [43], in turn accentuating their chronicity profile and exacerbating the negative impact of stigmatisation. Use of the expression "complex cases" suggests neutrality, but often implies that patients are non-compliant, likely to avoid treatment, or simply being "difficult" [44] or "bad" patients [42]. In short, patients may be stigmatised when they do not match the expected profile regarding acceptable (institutional) health

behaviour (including pain coping, expression of suffering, and emotions) or even illness behaviour (when ill-health is also culturally and socially coded as it may be in the field of expressed emotions and negative affects) [45,46]. It has been suggested that stigma may arise when little space, if any, is given to social and cultural diversity, with newcomers and immigrants "floating in the interstices of the social structure" because they do not fit, or only partially fit, the social roles expected of local healthcare users [36]. Non-recognition by health organisations of the practical demands of clinical encounters in highly diverse settings may leave employees having to fend for themselves in this regard, with an increased sense of failure and frustration at not having enough time to understand clients' needs and trajectories (migratory process and work integration) [47]. Stereotypical views may arise out of unsatisfactory encounters and increased caseloads [26].

Stigma may result from the anticipation of negative outcomes or complicated interactions with specific individuals [28]. Stigma originating from a negative attribution can influence both the therapeutic relationship and service delivery [43,48]. The mechanics of this stigmatisation process are not easy to grasp. Stigmatisation takes place in specific organisational contexts with their own operational dynamics and logics that may not have been designed with the aim of providing services to highly diverse populations [47]. In addition, healthcare providers may be faced with their inability to adjust and overcome linguistic and cultural barriers when the institution they represent does not have (especially when its employees do not have) the flexibility needed to adapt services [49]. In Quebec, despite a law (*Act respecting health services and social services*) stipulating that health and social services must be culturally sensitive and adjust to the cultural characteristics of the individuals and populations they serve [50], gaps remain between the general legislative provisions and the implementation of programs that are sensitive to diversity.

In the context of immigration issues and intercultural communication in rehabilitation, it appears that immigrant workers experience many types of stigma that shape their different relational frame of reference [26]. Socially demeaning experiences connecting stigma and status may reflect the interweaving of various forms of power relations and inequalities that exist in society at large [35]. The social theory of intersectionality allows us to measure how social identity categories or "social locations" come into play to produce and reinforce inequalities and marginalisation [51–54].

Context

The aim of this article is to report the partial results of a qualitative exploratory study whose objective was to describe the experience of various stakeholders in the context of Quebec's system of workplace injury compensation and rehabilitation, which is administered by the provincial WCB (the CNESST). General results were published elsewhere [5,47,55]. This article focusses on one aspect of our results that describes the pattern of stigmatisation during the process of returning to work after a compensated occupational injury. This pattern operates in multiple spheres: within the healthcare system, within the family, and within the work and social environment. Health delivery in pluralistic contexts also provides evidence of the possible stigmatisation of health practitioners when they have difficulty achieving the desired clinical outcomes and meeting management expectations. This is particularly so when the practical demands of intervening in pluralistic situations are poorly understood by management, leaving practitioners with little support from colleagues and supervisors and with increased feelings of failure, dissatisfaction at work, and incompetence [47].

Methods

Sample

Our research methodology was original in that it used a qualitative approach based on a grounded-theory analytical framework. Grounded theory is recommended when very little data or evidence exists on a specific issue [56]. Although a previous literature review provided some information on the topic of cultural identity and rehabilitation [38,57], it became obvious that original empirical data on the situation in Quebec was needed to conduct a proper analysis. A purposive sample of 40 individuals was recruited on a voluntary basis through professional associations, the WCB business registry, injured workers' associations, and public or private clinics. The sample was divided into four groups: workers ($N = 9$), clinicians ($N = 15$), WCB rehabilitation experts ($N = 14$ individual interviews, $N = 2$ focus groups), and workplace representatives ($N = 2$). For the purposes of this article, clinicians and WCB rehabilitation experts are collectively referred to here as "practitioners" (unless otherwise indicated).

The clinicians were mainly occupational therapists (OT), physiotherapists (PT), or kinesiotherapists (Kin). They were recruited through invitations sent out by leading rehabilitation centres in the Montreal area and by professional bodies. Rehabilitation experts were recruited through invitations sent by the WCB to its personnel. The WCB rehabilitation experts had professional backgrounds in various fields such as social sciences and humanities, education, counselling, and health sciences, and were employed as claim adjudicators or rehabilitation counsellors. All the practitioners had to work with injured workers on long-term sick leave (sometimes called a *chronicity profile*) and with a high ratio of immigrant and ethnocultural minority workers. Injured workers were recruited through rehabilitation clinics in the Greater Montreal area. They were required to correspond to the following criteria: being foreign-born, having their occupational injury compensated by the WCB for at least 3 months and being referred to a rehabilitation program focussing on returning to work.

Table 1. Guide for interviews with practitioners.

- General intervention context in their organisation (clinic, WCB administrative unit)
- Specific role as rehabilitation professionals (in the field of occupational injuries and RTW)
- Context of work (organisational support, relations with other stakeholders, legislations, main issues)
- Views regarding key moments in the rehabilitation and RTW process (different phases in the compensation and RTW process may have specific challenges, issues)
- Their experiences with immigrant and ethnocultural minority patients/workers (how they saw differences)
- Their views of intercultural competency training (former training, content and methods of teaching, effectiveness, etc.)
- Their views regarding RTW issues specific to immigrant and ethnocultural minority patients/workers (differences and similarities in terms of needs, trajectories, life-cycle, etc.)

Table 2. Guide for interviews with injured workers.

- Representations of the problem (e.g., how they call it, symptoms, severity, anticipated duration, ability to work, expectations, what should be or should have been done, etc.)
- Social environment (e.g., social support, social network, family engagement in the therapeutic process)
- Work environment (work relations, support from colleagues/supervisors, employer's attitude regarding RTW, employment relationship)
- Perceptions of their relations with various rehabilitation professionals (clinicians, WCB) and their views of the administrative process
- Key moments or turning points in the rehabilitation process (positive and negative)

Table 3. Clinicians' profile.

Clinicians (pseudonyms)	Sex	Age	Country of birth	Profession	Years of experience
Lea	F	26	Canada	OT	5
Emma	F	27	Canada	OT	4
William	M	42	France	OT	16
Louis	M	40	Canada	PT	8
Sarah	F	34	Canada	OT	11
Camille	F	53	Canada	OT	16
Thomas	M	25	France	Kin	1
Félix	M	24	Canada	Kin	1
Olivia	F	31	Canada	Kin	3
Nathan	M	32	Canada	PT	8
Mei	F	29	China	OT	5
Susana	F	29	Italy	OT	5
Alice	F	56	Canada	OT	32
Jacob	M	29	Canada	PT	5
Eva	F	41	Lebanon	OT	17

Data collection

Interviews were held between July 2014 and November 2015. Interviews with the various stakeholders gave us access to different perspectives of the Return-to-Work process and allowed us to identify common ground and specificities. Semi-structured interviews were conducted, recorded, and transcribed. Table 1 (practitioners) and Table 2 (injured workers) list the main themes discussed during the interviews.

The interview guides for clinicians, WCB, workers, and also employers are provided in details elsewhere [58].

Stigma-related issues were not directly addressed by the researchers; they arose through the analytical process as an emergent theme, a component of counter-productive interaction processes.

Analysis procedures

Our data collection and analysis procedures drew from the principles of grounded theory (inductive, theory driven, iterative process, and interrater cross-validation check) and were processed using NVivo 10 software [59,60]. The content tree structure was constructed using the data obtained from the results analysis.

We performed an initial coding step using a coding tree that reflected the interview grid structure and dimensions (e.g., role and responsibilities, key issues at different steps, collaboration between stakeholders, and intercultural competency training). When a segment of the interview made reference to the "work context," we sought to identify the specific properties and attributes of that context in order to compare different participants' points of view. We also interviewed practitioners about their own expectations regarding patients' clinical or RTW outcomes, as well as injured immigrant workers about their appreciation of their rehabilitation experience. We then tried to identify possible patterns and connections between attributes in order to generate a theory or hypothesis [56,61]. The stigmatisation process was neither a part of the preliminary literature review nor a dimension of the interview grid. It appeared in the more advanced steps of our data analysis as an emergent theme which is discussed later in the Synthesis and Discussion section in the light of existing literature on the stigmatisation of injured workers. We therefore performed a literature review at a later stage in our study in accordance with grounded theory requirements specified by Glaser and Strauss [62,63]. By avoiding the existing literature in the initial steps of our data analysis, we sought to stay away from existing models or theories that could "contaminate" our views and possibly even influence the way we coded, classified, or named what we observed [62]. The following questions oriented our investigation of intercultural interactions: What types of stigma are reported or experienced (by workers and practitioners), or observed through our analytical process? In what ways do the stigma operate? What are the different dimensions of the stigma? What are their main effects on immigrant workers and the delivery of healthcare/services? Are people aware of the stigmatisation process?

Results

This section presents the different types of stigma that were reported in our interviews with the various stakeholders (fictitious names are used here to protect participants' privacy) about the rehabilitation and RTW process. Clinicians and WCB rehabilitation experts' profile is detailed in Tables 3 and 4 (sex, age, country or area of birth, profession, and years of experience) and Table 5 describes injured workers' profile (sex, age, country of birth, field of study, occupation when injured, and diagnosis).

The overall RTW process comprises various steps and key moments. Our results concerned the later stages of this process when the workers entered a chronic phase of illness and work disability. This corresponded to their admission to an individualised interdisciplinary rehabilitation program focussing on an RTW to their pre-injury job. We mainly observed stigma related to culture and ethnicity, disability or health condition, occupational injuries, socioeconomic status, language and speech, age, and gender. These stigma involved some of the attributions or types of stigma described earlier.

Ethnocultural stigma

Stigma related to ethnicity and culture are obviously more specific to workers from racial or ethnocultural minorities. This is the type of stigma that is most often reported by the participants in our study. These stigma involve anticipatory judgement of pain behaviours and adherence to rehabilitation treatment. Some practitioners in our study reported that clinical staff might, based on their prior experiences with people from a specific geographical area or cultural background, associate an individual with the entire group (and the stereotypical view of this group) to which he or she belongs, prior to face-to-face validation. Such an association influences the way clinical staff plan their work schedules and case management, as described below by a clinical director.

> It has become obvious: as soon as I get a patient coming from [Region A], we all know what to expect, we already know, and we haven't even evaluated them [...] I'll sort them out in a way that won't overload my staff [...] If they were the only clients I had to deal with, I couldn't

Table 4. WCB rehabilitation experts' profile.

WCB rehabilitation experts (pseudonyms)	Sex	Age	Country of birth	Field of study	Years of experience
Florence	F	29	Canada	Social work	7
Chloé	F	32	Canada	Correctional intervention	4
Charles	M	62	Canada	Anthropology	9
Rosalie	F	29	Canada	Criminology	1
Béatrice	F	55	Canada	Psychology	15
Zoé	F	27	Canada	Industrial relations	2
Alexis	M	25	Canada	Social work	3
Laurence	F	30	South America	Education	1
Charlie	M	34	Canada	Psychoeducation	2
Clara	F	59	Canada	Human resources	26
Charlotte	F	30	Canada	Human resources	3
Victoria	F	34	South America	Social work	7
Juliette	F	45	Canada	Psychoeducation	3
Olivier	M	30	Canada	Communication	3

Table 5. Injured workers' profile.

Injured workers (pseudonyms)	Sex	Age	Country of birth	Field of study	Occupation when injured	Diagnosis
Amine	M	36	Morocco	Law	Factory worker	Chronic regional pain syndrome
Carmen	F	–	Colombia	Speech therapy	Maintenance worker	Low back pain
Umberto	M	50	Italy	Mechanics	Mechanics	Hand pain
Belkacem	M	–	Tunisia	Specialist nurse	Patient attendant	Low back pain
Valencia	F	49	Haiti	Auxiliary nurse	Auxiliary nurse	Shoulder pain
Harica	F	50	Turkey	Administration	Cook	Arm pain
Leticia	F	55	Argentina	Institutional cooking	Cook	Shoulder pain
Rocio	M	61	Salvador	Leather work	Maintenance worker	Shoulder pain
Dario	M	47	Salvador	Industrial design	Upholsterer	Low back pain

> take it any longer. (Nathan, 32, PT, clinical manager, 8 years of experience)

While this practice may involve good intentions in that practitioners or clinical managers try to prevent a work overload, at the same time, the immediate consequence is that they anticipate attitudes, behaviours, or health-related beliefs that may not necessarily be held by the worker/patient. Such stigma appear to have impacts on the quality of the therapeutic relationship and the emotional bond or alliance that is so essential during the rehabilitation and return-to-work process:

> [Regarding patients from region B], I have noticed that my employees do not want to spend time with them […]. I find that they're even neglected. I make a point of telling my employees to give them closer attention. (Nathan, 32, PT, clinical manager, 8 years of experience)

This clinical director thus seemed sorry about the lack of care provided to some patients, but at the same time, found it difficult to re-organise his team working in a pluralistic context. Participating injured workers reported some discriminatory practices in the workplace, a kind of division of labour based on ethnicity, when they tried to reintegrate into their jobs with new duties after an injury:

> There's a lot of racism in this industry. Some people think we're just overrunning them, stealing their jobs. I've already been told that "administrative duties are for Quebecers. Your job is down there, in the shipping department". (Dario, 47, upholsterer, family-owned coffee estate in his native country in Central America)

Our study revealed that, compared to other types of stigma, ethnic or cultural stigma can be assigned in different ways, for example, by division of labour, anticipatory judgements about workers' beliefs, attitudes, and coping behaviours (including adherence to treatment). The practitioners participating in our study expressed concerns about the importance of developing strategies for meeting the needs of immigrant and ethnocultural minority workers and of better understanding their clients' points of view and life-course prospects.

Our participants reported that stigma operate in complex ways in interpersonal relationships, especially when little or no space is given at the institutional level to the idea of intercultural competency (and its practical demands). Thus, the participating practitioners saw themselves at the interstices of a monocultural institutional setting. They suggested that it may even determine the quality of care in clinical encounters and its adaptation to immigrant and minority workers' needs. This view is expressed below:

> Stereotypes are there, you know, the image we have, it's there, well-engrained. We have to work with WCB rehabilitation counsellors and they say things directly: "Be careful, that worker is from [region A]," or "Watch out, that French Canadian worker is unionised," you know. We don't even have to explain anything further, we understand each other. But at the same time, I wonder whether or not we're providing these people with the appropriate treatment. Do we need training on this [intercultural] issue? I'd tend to say "yes". (Nathan, 32, PT, clinical manager, 8 years of experience)

And when failures occur:

> Have we done everything that should have been done? Aren't we crippling them even further? (Excerpt from a focus group, WCB)

Most participants, especially practitioners who were immigrants themselves saw training in intercultural competencies as necessary, as they had seen or heard things among other colleagues that they considered shocking:

> Training for practitioners would, I think, be worthwhile because when I first arrived here [at the WCB], I was shocked by some of my colleagues' attitudes or comments about immigrant workers, their way of doing things … (Laurence, 30, WCB, born in South America, training in education, 1 year of experience)

When asked whether or not she felt more equipped than her native French Canadian (or "Québécois") counterparts to intervene in pluralistic contexts, the same practitioner said the following:

> Not necessarily more equipped, but [you'd think] it would be important to understand why they [immigrant workers] have come here,

> important to understand why they're currently working in agribusinesses [precarious jobs, often overqualified].

As an immigrant herself, she was aware of the hardships faced by newcomers in finding a job and of the precariousness work trajectory many of them face. These trajectories have been documented elsewhere [55] and in relation to obstacles to the RTW [5]. This practitioner was concerned as well about the culture shock that may arise from intercultural encounters. According to her, being aware of culture shock may also help increase awareness of the tendency to "judge" or to "want to change the person" if he or she does not match the institutional expectations and dominant cultural standards.

Sharing a common cultural and linguistic background with the client may be seen as helpful, but Mei, an OT born in China, provided a more nuanced view:

> There is a good and a bad side to sharing a common cultural background. It can help for sure, but it can also be worse. When a client thinks I can understand everything, he treats me like I'm a friend or family member. It's difficult sometimes. A client may think that because we're both of the same origin I can accept any request. I have to set my own limits. I say [to my client], "[Yes,] I speak your native language, but that's it, I'm [just] your therapist!"

Despite the apparent linguistic and cultural proximity, the practitioner has his or her own worldview and professional framework that derives from an institutional logic that may or may not be shared or understood by the client [64]. Based on our observations, this can be a source of friction and discomfort on both sides that can lead to stigmatisation. In this regard, the practitioners in our study said they had some ideas about which strategy to deploy to foster a working alliance with the injured workers, but that their ideas could be disregarded or misunderstood by their colleagues and supervisors. Many of the WCB experts in our study felt that they omitted some good intercultural communication practices because they knew it would generate a work overload, especially when their managers did not acknowledge dialogue or "small talk" as a practical demand of intercultural communication, even though it is often necessary to build mutual confidence and trust. This is illustrated in the following excerpt:

> We rarely have time to spend an entire hour talking with the client and asking questions to better understand his or her culture […] Here, we don't take the time [e.g. expanding therapeutic sessions is not allowed] (Louis, 40, PT, 8 years of experience)

And in the following excerpt:

> Of course, I feel that sometimes we are overloaded too. You know, if you have 45 files, there's no way you can do what you'd like for everyone. (Victoria, 34, WCB, training in social work, 7 years of experience)

Conversely, our data suggest that organisations where managers have themselves been practitioners appear to be more flexible in this regard. However, this hypothesis requires further documentation and analysis. Teamwork, efforts to encourage diversity in the workforce, discussion groups, and communities of practice are seen by many participants in our study as efficient strategies at the organisational level.

Stigma related to work disabilities or ill-health conditions

In our study, ill-health conditions were sometimes reported to be the object of doubt or as not being taken seriously during the medical assistance process. This was particularly true when injured workers were experiencing a long-standing disability with more or less visible conditions (e.g., pain, psychological distress). One WCB expert expressed it thus:

> I realise that how their co-workers look at them is important: "What will they say? Will they talk about me behind my back, or think I'm a faker, that I'm not really sick?" They don't want it to be visible; they want to look normal because they don't want to be stigmatised. But when we plan the return to work, we have to specify that they need workplace accommodations. (Zoé, 27, WCB, training in industrial relations, 2 years of experience)

The participating practitioners reported that this type of stigma applies to any worker, regardless of immigration status or ethnic and cultural background. Mental health conditions were also reported as a source of stigma, and as particularly problematic in specific ethnic groups that sometimes have strong taboos:

> Within certain nationalities, it's taboo. It can't happen! You know, they're really excluded from their community. (Excerpt from a focus group, WCB)

One worker, after disclosing his mental illness when he returned to his country of birth, was ridiculed by his friends and relatives: "It was a joking matter for them" (Amin, 36, manual worker with a graduate degree in Law in his country and from an upper class background). "Shame" and "lack of understanding" were cited by the WCB practitioners in our study. Amin only revealed his occupational injury to his family after a year in order to avoid rejection and humiliation. WCB compensation was seen as a form of social assistance, which seemed to have a negative connotation in his social environment.

The WCB practitioners sometimes reported difficulty mobilising employers to support a gradual RTW. According to them, many employers prefer to wait for the injured worker to have fully recovered before embarking on any discussion about an RTW:

> They say "no," without even knowing what will happen. We make a phone call to explain it to them, but they stick to their positions, saying that they will only reintegrate their employee into his regular tasks when his work ability is A1. (Juliette, 45, WCB, training in psychoeducation, three years of experience)

Stigma related to occupational injuries

Different categories of stakeholders can perpetuate stereotypical views or stigma regarding occupational injury compensation patterns. Even the injured workers may share a negative view of one or more facets of the rehabilitation process and may fear or anticipate a negative reaction from people in their immediate entourage. Some workers participating in our study expressed the view that GPs may be prejudiced against the compensation system. It was not the disability as such, but rather the fact that it was work-related that was the object of the stigma, meaning (indirectly) that the GPs did not want any further involvement in a bureaucratic process:

> The first GP I saw didn't want to hear anything about the CNESST (WCB) […] The GP I consulted at that time told me, "I don't want to be tied to the CNESST, but I will help you, I will provide you with all the care you need." […] People don't want to get involved with the CNESST; [it's] too problematic, too much bureaucracy. (Dario, 47, upholsterer, family-owned coffee estate in his country in Central America)

The participants interviewed also indicated that the anticipated paperwork or litigation may discourage GPs from getting involved with the compensation system.

Stigma related to socioeconomic status

Some participating practitioners expressed points of view that reflect a general type of stigma related to socioeconomic status, regardless of any other identity attributions (e.g., gender, ethnicity, age, or disability). Class issues in the stigmatisation process are related to the assumption that lower economic status workers may seek advantages through long-term disability compensation. This is a matter of concern when it comes to immigrant and ethnocultural minority workers, since they are often disproportionally affected by unemployment and by low-income and precarious working conditions. The following remark by one of our participants illustrates a stereotypical view of the working class segment of the demographically dominant French-Canadian population in Quebec (associated with the "Québécois" identity as a whole).

> Quebecers on workers' compensation [...] they're often people from factories, blue-collar workers from the east end. They're often rude and disrespectful. [...] Do you really think that Jewish people or English-speaking Quebecers would take advantage of WCB compensation? Of course not! These people have big jobs! (Nathan, 32, PT, clinical manager, 8 years of experience)

The above citation illustrates how injured workers' occupational status may influence practitioners' perceptions of them.

Linguistic stigma

In our study, the linguistic and speech stigma reported were related to job search difficulties (prior to occupational injury), difficulties during the RTW process, and difficulties finding a suitable employment when permanent functional limitations were anticipated.

> It's hard for anybody to find a job. It's not because I'm an immigrant. But... it's more difficult when you don't speak French. (Leticia, 55, cook, from South America)

One WCB practitioner remarked as follows:

> These complex cases represent a 40% increase in the duration of the intervention because of communication problems. (Clara, 59, WCB, training in human resources, 26 years of experience)

An increase in the duration of interventions due to communication problems (linguistic as well as cultural) is reported in many studies. Our study also found evidence of language as a barrier to integration. Some of the participating practitioners cited communication problems at every stage of the rehabilitation process, but said these problems took on another dimension when the workers felt ready for a gradual RTW (or when the clinical evaluation stipulated that they were ready). Some of the practitioners also reported that, in the medical assistance and rehabilitation stage (functional restoration, capacity building), language barriers impeded communication and the building of the therapeutic relationship. At later stages of the rehabilitation process (when the progressive RTW was about to be initiated), workers' lack of proficiency in French and English was reported as a disabling condition in its own right, like the inability to make a particular movement or to perform a specific task. Our participating practitioners found this to be particularly true for workers who cannot return to work at their same employer and who have to search for another job in the same field with another employer. As reported by many of the WCB practitioners in our study, a lack of language proficiency may limit a worker's prospects of employment because he or she would not meet, in particular, the requirements of the Quebec Charter of the French Language, which makes French the "normal and everyday" language of work. This segment of the labour force that lacks the requisite linguistic proficiency can therefore be vulnerable to marginalisation and social exclusion, or to stigmatisation by their own cultural communities because of their disabilities. In our study, the WCB practitioners suggested that the lack of language proficiency should be systematically addressed much earlier in the administrative process.

Age and gender stigma

Age and gender stigma are two distinct types of stigma, but were reported in a similar way in our study and as coming into play in association with ethnic stigma. Both types of stigma were mentioned by the WCB practitioners in our study. According to their understanding of the situation, older immigrant women tend to feel less motivated about returning to work. They appear to be influenced by early retirement expectations and the ideal of devoting themselves to their self-assigned family role and to caring for their grandchildren. According to the WCB practitioners in our study, their identity as a worker in such a situation may be secondary to their identity as a family caregiver or as a grandparent.

> There are a lot of occupational injuries among workers ages 55 and older, and even more among immigrant women. From age 55 on, they expect to retire, but they can't, they're not allowed to yet. From that age on, men and women consider themselves finished and that there's nothing for them to do. This is another challenge, a very big challenge. (Zoé, 27, WCB, training in industrial relations, 2 years of experience)

Some WCB practitioners in our study also reported that female workers from ethnic minorities perceive themselves as being more disabled than their Québécois counterparts, suggesting a self-stigmatisation process among workers themselves. This phenomenon should be explored further in future research.

Based on our observations, stigma can come into play at any moment or stage in the RTW process, from the time when the injury is reported to full or partial recovery when the workers are deemed fit to resume work by the rehabilitation experts (including GPs) who establish the diagnosis. They may hide or conceal their health issue or limitations in order to preserve their self-image (which may be shaped by socially constructed standards). One practitioner in our study put it this way:

> They'll sometimes go faster than they should; they'll try to limit the number of treatments, to resume work quickly even if it could put their health at stake and increase the risk of re-injury [...] because they're ashamed to be on sick leave. (Charlie, 34, WCB, training in psycho-education, 9 years of experience)

Synthesis and discussion

Many types of stigma were described by the practitioners in our study or observed by the researchers, including stigma related to ethnicity and culture, socioeconomic status, disability and health status, gender, age, language, and speech. Stigma assigned to injured workers have been documented in a limited number of studies. These studies suggest the possibility of unethical practices and malpractice, which clearly can have an impact on the therapeutic relationship [65–70]. Stigma may have a negative impact on the capacity for empathy and may reinforce stereotypes when practitioners have a number of unsuccessful experiences (clinical outcomes, work overload due to communication challenges, and low organisational support) [71,72]. A vast array of studies examine these same types of stigma: stigma related to gender, age, language and speech, disability or health condition,

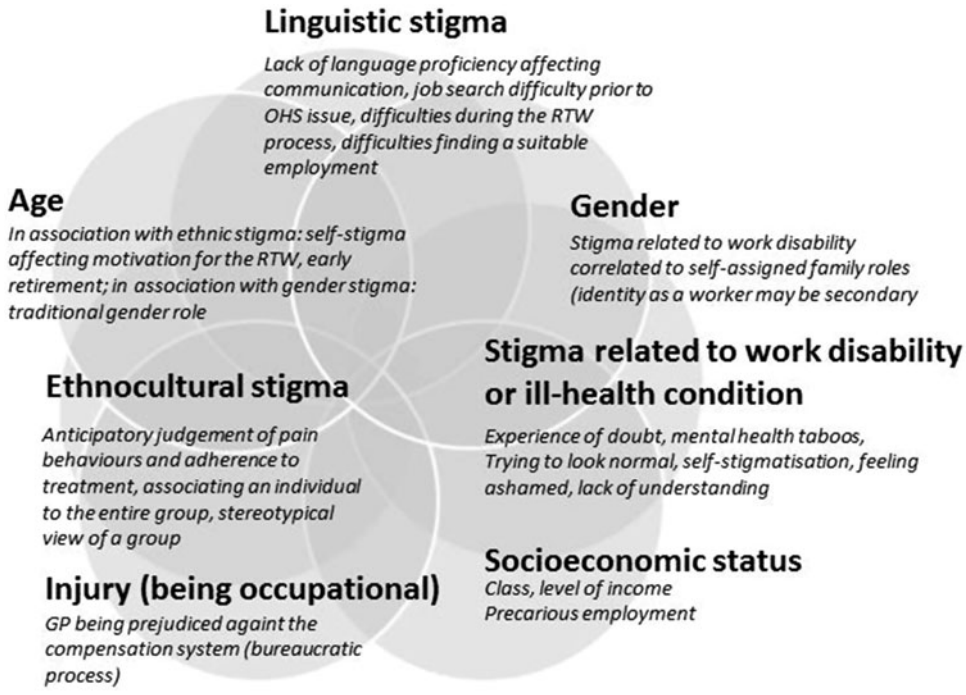

Figure 1. Cumulative stigma.

and cultural or ethnic differences. They are reported as if a single type occurred at any given time, whereas our study provided evidence of a cumulative process of stigmatisation, leading to overlapping stigmatisation of immigrant and ethnocultural minority workers, including self-stigmatisation. Self-stigmatisation is the result of the internalisation of social norms and values discrediting any kind of perception and behavioural pattern that is not seen as normal or that may negatively impact on social identity [73]. In fact, since the early days of anthropology, differential patterns have been documented with regards to the management of health and illness and its expression, the meaning of symptoms, the source of illness, and treatment expectations [74–76]. Differences in perceptions and behavioural patterns have been reported for decades. In the delivery of rehabilitation services, divergent views and behavioural patterns regarding health and illness can influence the stigmatisation process when they negatively impact the therapeutic relationship. These divergences can prelude and reinforce the construction of the perception of ethnic and cultural "otherness," generating labels such as "complex" cases, "good" and "bad" patients [42], and "difficult" patients, as well as the underlying social judgements [44]. The cultural notions of "autonomy" [77] and "decision-making" [78], among other sets of attitudes, coping strategies, and emotional responses, have been criticised for being ethnocentric, especially when divergent health beliefs and behaviours are assimilated to ideal-typical "complex cases" [43]. Autonomy is, among other things, a guiding principle in rehabilitation [77,79,80] in the context of Québec. It is a valuable concept for helping to measure the patients' treatment progression, but at the same time, appears to stem from an ethnocentric position, which may or may not be present in the rest of Canada or North America [81].

The construction or articulation of ethnic differences in intercultural clinical encounters thus becomes a "cultural filter" through which diversity is seen as a problematic issue, a risk factor defining "complex cases" [43]. At the same time, we know that cultural and linguistic differences are significant barriers that can contribute to the "complexification" of patients' trajectories, especially when there is no institutional space to provide tools and support for understanding the client's perspective [36]. How, in that case, do stereotypical views, anticipatory judgements, and attributions based on different forms of "cultural belonging" influence relationships and outcomes? How are stereotypical views of immigrants and of cultural or ethnic otherness generated, reproduced, and reinforced? Our study suggests that repeated failures on the part of practitioners can exacerbate the stigmatisation process. Cultural differences become significant when they challenge practitioners in what they take for granted [82]. In Western industrial societies where diversity is recognised through pluralistic principles and policies [83], the inability to communicate and to enter into the patients' cultural, ideological, or even political frame of reference can create misunderstandings [19]. Lack of institutional support, a work overload, and tight schedules may also be a hindrance to empathy and to the possibility of connecting with people of diverse backgrounds [47]. A cumulative stigmatisation effect is one of our main emergent hypotheses warranting further investigation. Shame, rejection, social and occupational disqualification, and racial and ethnic discrimination are, among other things, a major source of social inequities and infringements of basic civil rights. Figure 1 illustrates the types of stigma that can be assigned to injured workers.

Cumulative stigmatisation may also produce a cumulative labelling effect. We contend that the confluence of cumulative negative labelling, especially when emotionally loaded, can be seen as a source of inequity and inappropriate treatment. This is clearly an ethical issue in healthcare, and raises the issue of the need for self-criticism as well as for ways to improve empathic attitudes and compassion in therapeutic settings [84].

What does the literature say?

As explained above, the cumulative stigmatisation of injured immigrant workers is an emerging theme in our study. Field-based interviews brought this problem to our attention and led us to follow-up on our discovery by returning to the literature.

Our findings in the existing literature are utilised here as a point of comparison. While our empirical findings suggested a clear tendency towards a cumulative stigmatisation process, we wanted to know what the literature said about this issue. We tried to see how to what extent this observation was echoed in the existing literature on stigmatisation in the field of rehabilitation and RTW [62,63]. We therefore conducted a conceptual review [85] of the French and English literature by using specific keywords (see Supplementary Appendix 1) to search 16 databases in occupational health and safety, health sciences, social sciences, and humanities (e.g., CAIRN, CCHST, CINAHL, Cochrane Library, Embase, Ergonomic Abstracts, ERIC, ÉRUDIT, ISST, OSH Update, PASCAL, ProQuest Dissertations and Theses Professional, PsycInfo, Pubmed, Social SciSearch, and Sociological Abstracts).

Given the many studies on stigmatisation, we wanted to make sure they addressed workplace factors, disability, occupational injury, sick leave, and the RTW. Approximately 226 documents published between 1916 and 2016 were found. A first selection of 87 documents was made. A ranking system was developed using EndNote X7 software, and between one and five "stars" were assigned to each article, depending on the degree of proximity to the problem of occupational injuries and return to work. To meet the objectives of our study, only articles and research reports with four or five stars were selected. Five stars meant workplace injury stigmatisation; four stars meant post-sick leave RTW issues not related to workplace factors. These were excluded unless they provided an original point of view on the issue of stigma, occupational health and safety, and occupational rehabilitation. After reading the titles and abstracts, 22 articles were selected (DC, JD) for the final review. Of those articles, nine were published during the 2010–2016 period, nine during the 2000–2009 period, and the remaining one in 1998. They focussed mainly on mental health issues and physical disability. Regarding both physical and mental health issues, the selected studies in OHS showed that compensated workers are subjected to stereotyping and various forms of stigma, for example, that they are "looking for easy money," "lazy," "irresponsible," and have the moral flaw of being "dishonest" [68,70].

One study found that stigma assigned to injured workers intersected with gender, race, and ethnocultural attributions, intensifying the stigmatisation process and leading to "an extreme sense of vulnerability" [65]. To the best of our knowledge, Kirsh's study is the only one confirming the phenomenon of cumulative stigmatisation. In a systematic review of studies providing an overview of the interventions "targeting the stigma of mental illness at the workplace" [86], a negative attitude toward mental illness was observed among ethnic minority workers, and men were found to be more concerned about stigma effects than women. Concealing mental health status has been reported as a strategy for avoiding social rejection [87], lack of support, loss of credibility [86], and loss of identity [88]. The stigmatisation of workers with mental health conditions or cognitive limitations is reported as harsher than that of workers with physical disabilities and limitations [89]. Self-stigmatisation is also documented, and the underutilisation of services is reported as an effect of stigma and the fear of social judgement [69,87,90].

Difficulty finding a job [91], discrimination, difficulty meeting productivity standards and measuring up to the competition [88], disqualification [73], and fearing career stagnation [87,92] are all possible effects of stigmatisation. Productivity concerns are present in both mental and physical health-related disability, but mainly mental illness, while accommodations or adjusted tasks may be perceived by workers as a sign of their being not normal [93]. In the context of intercultural relations where gaps in perceptions and representations may be an issue, the labelling of immigrant and ethnocultural minority workers as "ideal-typical complex cases" is problematic [43]. When this labelling involves an anticipatory clinical judgement or anticipated negative outcomes, "cultural filters" may impact the entire rehabilitation process (e.g., intervention strategies, teamwork, and decision-making) and may, in a way, transform the unknown into something falsely and perniciously familiar [48]. It does not mean ignoring ethnic diversity and migratory status or being "colour-blind," as they reveal real social, historical, and political issues that need to be addressed by every stakeholder [94]. Stigma, as proposed by Scambler [95], is at the "intersection between culture, power, and difference"; it is "pivotal to the constitution of social order," regardless of the form it takes and the interpersonal dynamics it determines in daily practices. We could go a step further by suggesting that a stigma is a difference that is not embedded in socially and culturally dominant frames of reference, and, for that reason, becomes an obstacle in the minds of the marginalised and stigmatised immigrant and ethnocultural minority workers who share the same values and who aspire to the same social status and rights regarding access to work [36].

The phenomenon of cumulative stigmatisation is not unrelated to social inequalities and asymmetric power relations. In our study, combined stigmas appeared to be connected to different structural factors that reinforce such beliefs as ableism, racism, classism, and patriarchy [51]. Practitioners are more or less well equipped to act in pluralistic contexts, and time or strategies (e.g., tailoring care needed to assess workers' needs and experiences may not be fully acknowledged by their organisation). Our data were produced in a specific social and historical context where workers' experience of recovery and rehabilitation is shaped by legal and bureaucratic settings [96]. In Canada, compensation systems were not typically designed to take the growing diversity of the workforce into consideration. Moreover, these systems are challenged by the changing reality of work [23,97]. These systems are likely to (re)produce social and health inequalities [98], and there are growing evidence that this situation affects immigrant and ethnic minority workers disproportionately [52,99–103]. The "system" has institutionalised in a certain way a sense of normalcy that becomes particularly relevant when examining the issue of pain behaviours and the expression of emotions which may reflect culturally dominant patterns and norms [45,104–106]. Cultural filters and stigma operate at the individual inter-personal level but they may be also regarded as class or even gender-based standards, norms, and values, that have guided the development of rehabilitation theories, practices, and assessment tools (especially those addressing psychosocial issues) [107].

It must be noted that the cumulative stigmatisation process may not be apparent if practitioners are lacking capacity for self-reflexion [19,108].

Structural factors and their cumulative effects are well documented in the theory of intersectionality [51–53,109–112]. This theory recognises multiple and intersecting inequalities and power asymmetries that may lead to discriminatory treatments [112]. While stigmatisation theory and research focusses on interpersonal interactions (practitioner and client in our study), intersectionality theory discusses the social systemic aspects of unequal treatments (the idea that there are broader forces at work). The cumulative stigma effect, combined with the idea of broader forces at work, would rather suggest a multiplicative impact on the most vulnerable sections of the population [112,113]. Indeed, the now well-established literature on

intersectionality, inspired in good part by feminist critiques, has emphasised that while cumulative factors are at play, this analysis is not sufficient to explain the impact of multiple discriminatory factors in the lives of minorities. There is an emerging sociological literature rethinking the traditional micro-sociological stigma theory in relation to the literature on intersectionality [114], opening interesting avenues for considering the interplay of various levels (social structures, construction of social identity, and symbolic representations that may affect the therapist–patient relationships) [115].

Laws and policies, among others structural factors, were underscored by many of the WCB participants in our study, particularly in cases where overqualified immigrant workers, expecting recognition of previous experience and training, had to envisage an RTW to a temporary position (as required by law), which, for them, was often perceived as devaluing or disqualifying [55]. Workers' pre-migratory, social integration, employment, and illness/disability trajectories are important biographical data to be investigated in intercultural interactions, as they allow for a more accurate identification of the person's needs, of possible obstacles, and of factors potentially having a positive leveraging effect. Understanding the personal experience of clients from other ethnic or cultural backgrounds is certainly a vital ingredient in the working or therapeutic alliance [116,117]. In the context of occupational injuries and rehabilitation, where work is at the centre of the practitioner-worker dyad, empathy should be directed at understanding the pathways of the economic integration process, especially those that are unsuccessful, failures, and sources of profound life disruption [116].

Strengths

Using a grounded theory approach, this study provides in-depth descriptions of various intervention contexts and organisational settings. It sheds light on the specific issue of stigmatisation of injured immigrant and ethnocultural minority workers, and reveals the cumulative stigmatisation process that may have major negative impacts on these workers and that may have a multiplicative impact as suggested by the literature on intersectionality. To our knowledge, it is one of few studies addressing this cumulative stigma effect through the lens of injured workers, clinicians, and WCB rehabilitation experts. It also provides greater insight into the way that the cumulative stigmatisation process can shape the therapeutic relationship and decision-making process, even when a caring attitude is present. Lastly, this study shows how a systemic approach to intercultural relations can help explain the sources of stigma and how it is reproduced within systems.

Limitations

The study also has some limitations. First, it did not investigate spouses' or siblings' perspectives, which might have provided useful clues as to the family dynamics mentioned by the participating practitioners. Moreover, as we had little access to employers, the study provided limited insight into RTW and disability management issues from the employers' perspective. The information we obtained about workplaces came indirectly from other stakeholders' representations of workplace issues, regardless of their accuracy or relevance. In addition, due to our sampling strategies, we only recruited workers in the long-term disability phase. We were therefore unable to explore stigmatisation in the early phase of the compensation process and its possible impact on the way immigrant and ethnocultural minority workers are categorised as "ethnically diverse other" and how this can influence practitioners' perception of them as "complex" cases.

Conclusions

The phenomenon of stigmatisation is well documented in the sociological and qualitative health literature, but the studies focus mainly on one type of stigma at a time. Future research should focus instead on the cumulative and multiplicative processes of stigmatisation as it affects immigrant and ethnocultural minority workers in particular, and on its potentially damaging impact on both self-image and the delivery of healthcare and services. The cumulative effect of stigmatisation can lead to a reductionist view of workers' personal experience, limited to a number of a stereotypically anticipated beliefs, attitudes, and behaviours [118]. It can influence the type of relationship that a practitioner develops with his or her client, as well as the level of empathy needed to build a therapeutic relationship [119]. Future research should also look at how service providers and healthcare professionals manage the murky waters between different forms of cultural and social diversity, and at why, in most cases, ideas about cultural or ethnic differences appear to be more tenacious or less likely to change than other types of difference. Cultural or ethnic differences could lead to an exacerbated view of the "ethnic other" and to a misunderstanding of what is actually happening in clinical and therapeutic encounters. Ethnicity and culture, along with other social attributions, should be used as working hypotheses or support tools in health communication, not as a hindrance to clinical reasoning. Practitioners should develop self-awareness and a critical view of how the stigmatisation process is triggered in face-to-face interactions in order to move beyond stereotypes and anticipatory judgements and, at the same time, improve the quality of care.

Acknowledgements

We sincerely thank the *Commission des normes, de l'équité, de la santé et de la sécurité du travail* (CNESST), *Centre intégré universitaire de santé et de services sociaux* (CIUSSS) *du Centre-Ouest-de-l'Île-de-Montréal*, *Ordre des ergothérapeutes du Québec* (OEQ), *Union des travailleurs et travailleuses accidenté-e-s de Montréal* (UTTAM), and the four clinics Physio Extra, Forcemedic, Réadaptation Universelle, and *Centre de réadaptation Constance-Lethbridge* for their support and invaluable help.

Disclosure statement

The authors declare that they have no conflicts of interest.

Ethical approval

The project protocol was approved by the Ethics Committee (#879) of the integrated university health and social services centre (Known in Quebec as the *Centre intégré universitaire de santé et de services sociaux*, or CIUSSS.) of the Centre-Ouest-de-l'Île-de-Montréal and by the Ethics Committee (#970) of the Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal.

Funding

This study was funded by the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST).

References

[1] AWCBC. National Work Injury/Disease Statistics Program (NWISP). Ottawa (ON): Association of Workers' Compensation Boards of Canada; 2017.

[2] Prud'homme P. Travailleurs immigrants et SST au Québec: État des connaissances statistiques et recension des sources de données. Montréal (QC): Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST); 2015, rapport R-890. 103.

[3] CNESST. Plan stratégique 2010-2014. Québec (QC): Commission des normes, de l'équité en emploi et de la santé et de la sécurité du travail du Québec (CNESST); 2010.

[4] Canada. 2011 National Household Survey. Canada Statistics. Compiled by the City of Montréal. Ottawa (ON): Canada Statistics; 2011.

[5] Côté D. Relations interculturelles: Comprendre le processus de réadaptation et de retour au travail. Rapport R-967, collection Études et recherches. Montréal (QC): Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST); 2017.

[6] Ahonen EQ, Benavides FG, Benach J. Immigrant populations, work and health–a systematic literature review. Scand J Work Environ Health. 2007;33:96–104.

[7] EU-OSHA. Literature study on migrant workers. Bilbao: European Agency for Safety and Health at Work (EASHW), European Risk Observatory; 2007.

[8] Kosny A, MacEachen E, Lifshen M, et al. Delicate dances: immigrant workers' experiences of injury reporting and claim filling. Ethnicity Health. 2012;17:267–290.

[9] McCauley LA. Immigrant workers in the United States: recent trends, vulnerable populations, and challenges for occupational health. AAOHN J. 2005;53:313–319.

[10] Salvatore MA, Baglio G, Cacciani L, et al. Work-related injuries among immigrant workers in Italy. J Immigr Minor Health. 2013;15:182–187.

[11] Edge S, Newbold B. Discrimination and the health of immigrants and refugees: exploring Canada's evidence base and directions for future research in newcomer receiving countries. J Immigr Minor Health. 2013;15: 141–148.

[12] Premji S, Smith PM. Education-to-job mismatch and the risk of work injury. Inj Prev. 2013;19:106–111.

[13] IRSST. Lésions, durées et débours selon le type de lésion et la présence ou non de réadaptatio, Québec, 2010-2012. Montréal (QC): Dépôt de données central et régional de la CNESST, IRSST; 2016.

[14] Lebeau M, Duguay P, Boucher A. The costs of occupational injuries in Québec, 2005-2007. Report R-769. Montréal (QC): IRSST; 2014.

[15] Takala J, Hämäläinen P, Saarela KL, et al. Global estimates of the burden of injury and illness at work in 2012. J Occup Environ Hyg. 2014;11:326–337.

[16] Sweetman A, Warman C. Canada's immigration selection system and labour market outcomes. Can Publ Policy. 2013;39:S141–S164.

[17] Canada. Canadian Multiculturalism: An Inclusive Citizenship. 2017 [cited March 28]. Available from: http://www.cic.gc.ca/english/multiculturalism/citizenship.asp.

[18] Canada. Canadian Multiculturalism Act (R.S.C., 1985, c. 24 (4th Supp.)). Government of Canada. 2014.

[19] Beagan BL. Approaches to culture and diversity: a critical synthesis of occupational therapy literature. Can J Occup Ther. 2015;82:272–282.

[20] Fortin S. Conflits et reconnaissance dans l'espace social de la clinique. Les pratiques cliniques en contexte pluraliste [Conflict and Recognition in the Social Space of the Clinic]. Anthropologie et Sociétés. 2013;37:179–200.

[21] Jounin N, Palomares É, Rabaud A. Ethnicisations ordinaires, voix minoritaires. Sociétés Contemporaines. 2008; 70:7–23.

[22] Beck RS, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: a systematic review. J Am Board Fam Med 2002;15:25–38.

[23] Gravel S, Dubé J. Occupational health and safety for workers in precarious job situations: combating inequalities in the workplace. E-J Int Comp Labour Stud. 2016;5: 1–30.

[24] Premji S. Barriers to return-to-work for linguistic minorities in Ontario: an analysis of narratives from appeal decisions. J Occup Rehabil. 2015;25:357–367.

[25] Premji S, Shakya Y. Pathways between under/unemployment and health among racialized immigrant women in Toronto. Ethn Health. 2016;22:17–35.

[26] Valenta M. Immigrants' identity negotiations and coping with stigma in different relational frames. Symbolic Interact. 2009;32:351–371.

[27] Goffman E. Stigma. Notes on the managment of spoiled identity. New York (NY): Simon & Schuster; 1963.

[28] Phelan JC, Lucas JW, Ridgeway CL, et al. Stigma, status, and population health. Soc Sci Med. 2014;103:15–23.

[29] Wacquant LJD. Urban outcasts: stigma and division in the black American Ghetto and the French urban periphery. Int J Urban Reg Res. 1993;17:366–383.

[30] Pescosolido BA, Martin JK, Lang A, et al. Rethinking theoretical approaches to stigma: a framework integrating normative influences on stigma (FINIS). Soc Sci Med. 2008;67: 431–440.

[31] Bayer R. Stigma and the ethics of public health: not can we but should we. Soc Sci Med. 2008;67:463–472.

[32] Massé R. Stigmatisation sociale et santé publique: les enjeux éthiques. La Santé de L'homme 2012;419: 9–11.

[33] Courtwright A. Stigmatization and public health ethics. Bioethics. 2013;27:74–80.

[34] Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Publ Health. 2013;103:813–821.

[35] Lucas JW, Phelan JC. Stigma and status: the interrelation of two theoretical perspectives. Soc Psychol Q. 2012;75: 310–333.

[36] Calvez M. Handicap a. threshold situation: elements for a sociology of liminality [article in French]. Sosan. 1994;12: 61–88.

[37] Fortin S. The pediatric clinic as negotiated social space. Anthropol Med. 2008;15:175–187.

[38] Côté D. Intercultural communication in health care: challenges and solutions in work rehabilitation practices and training: a comprehensive review. Disabil Rehabil. 2013;35: 153–163.

[39] Vasquez MJ. Cultural difference and the therapeutic alliance: an evidence-based analysis. Am Psychol. 2007;62: 878–885.

[40] Ferreira PH, Ferreira ML, Maher CG, et al. The therapeutic alliance between clinicians and patients predicts outcome in chronic low back pain. Phys Ther. 2013;93:470–478.
[41] Beagan BL, Chacala A. Culture and diversity among occupational therapists in Ireland: when the therapist is the 'diverse' one. Br J Occup Ther. 2012;75:144–151.
[42] Sointu E. 'Good' patient/'bad' patient: clinical learning and the entrenching of inequality. Sociol Health Illness. 2017; 39:63–77.
[43] Jonsson TB. Institutionalized strategies in face-to-face encounters: focus on immigrant clients. Scand J Soc Welfare. 1998;7:27–33.
[44] Macdonald M. Seeing the cage: stigma and its potential to inform the concept of the difficult patient. Clin Nurse Spec. 2003;17:305–310.
[45] Bendelow GA, Williams SJ. Transcending the dualisms: towards a sociology of pain. Sociol Health Illness. 1995;17: 139–165.
[46] Bhui K, Dinos S. Health beliefs and culture: essential considerations for outcome measurement. Dis Manage Health Outcomes. 2008;16:411–419.
[47] Côté D, et al. *Building intercultural competencies in monocultural organisations: issues and perspectives in planning rehabilitation services in Montréal (Québec, Canada)*. In: N Johnson, S Simpson, editors. Bridging differences: understanding cultural interaction in our globalized world. Oxford (UK): Inter-Disciplinary Press; 2016. p. 207–219.
[48] Meershoek A, Krumeich A, Vos R. The construction of ethnic differences in work incapacity risks: analysing ordering practices of physicians in the Netherlands. Soc Sci Med. 2011;72:15–22.
[49] Massé R. Le risque en santé publique: pistes pour un élargissement de la théorie sociale. Anthropologie et Sociétés. 2007;39:13–27.
[50] Québec. Act respecting health services and social services, S-4.2. 2017, Québec: Éditeur officiel du Québec.
[51] Bowleg L. The problem with the phrase women and minorities: intersectionality – an important theoretical framework for public health. Am J Publ Health. 2012;102:1267–1273.
[52] Hankivsky O, Christoffersen A. Intersectionality and the determinants of health: a Canadian perspective. Crit Publ Health. 2008;18:271–213.
[53] Mullings L, AJ. Schulz. Intersectionality and health; an introduction. In: AJ Schulz, L Mullings, editors. Gender, race, class, and health: intersectional approaches. San Francisco (CA): Jossey-Bass; 2006. p. 3–17.
[54] Smooth WG. Intersectionality from theoretical framework to policy intervention. In: AR Wilson, editor. Situating intersectionality. The politics of intersectionality. New York (NY): Palgrave Macmillan; 2013, p. 11–41.
[55] Gravel S, Dubé J, Côté D, et al. Le retour au travail des immigrants victimes de lésions professionnelles: les embûches de la rencontre interculturelle et la précarité du lien d'emploi. Alterstice. 2017;7:21–38.
[56] Walker D, Myrick F. Grounded theory: an exploration of process and procedure. Qual Health Res. 2006;16:547–559.
[57] Côté D. La réadaptation au travail des personnes issues de l'immigration et des minorités ethnoculturelles: défis, perspectives et pistes de recherche. Pistes. 2014;6.
[58] Côté D, et al. Intercultural relations – understanding the rehabilitation and return-to-work process [in French]. 2017, Montréal (QC): Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST).
[59] Hutchison AJ, Johnston LH, Breckon JD. Using QSR-NVivo to facilitate the development of a grounded theory project: an account of a worked example. Int J Soc Res Methodol. 2010;13:283–302.
[60] Sheridan V, Storch K. Linking the intercultural and grounded theory: methodological issues in migration research. Forum Qual Soc Res/Sozialforschung. 2009;10:Art. 36.
[61] Guillemette F, Luckerhoff J. L'induction en méthodologie de la théorisation enracinée (MTE). Approches Inductives. 2009;4:1–21.
[62] Ramalho R, et al. Literature review and constructivist grounded theory methodology. Forum: Qual Soc Res/ Sozialforschung. 2015;16:Art. 19.
[63] Dunne C. The place of the literature review in grounded theory research. Int J Soc Res Methodol. 2011;14:111–124.
[64] Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. J Counsel Psychol. 2011;58:537–554.
[65] Kirsh B, Slack T, King CA. The nature and impact of stigma towards injured workers. J Occup Rehabil. 2012;22:143–154.
[66] Knott V, Elshaug C, Mellington T. Psychological injury in the workplace: prevention and best-practice intervention. J Occup Health Saf Aust N Z. 2004;20:523–533.
[67] Links PS, Bender A, Eynan R, et al. Facilitators and barriers to doing workplace mental health research: case study of acute psychological trauma in a public transit system. Work. 2016;54:73–78.
[68] Mansfield E, Stergiou-Kita M, Cassidy JD, et al. Return-to-work challenges following a work-related mild TBI: the injured worker perspective. Brain Inj. 2015;29:1362–1369.
[69] Parry J, Barnes H, Lindsay R, et al. Farmers, farm workers and work-related Stress. Norwich (UK): Health and Safety Executive; 2005.
[70] Strunin L, Boden LI. The workers' compensation system: worker friend or foe? Am J Ind Med. 2004;45:338–345.
[71] Ray SL, Wong C, White D, et al. Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. Traumatology. 2013;19:255–267.
[72] Sabo B. Reflecting on the concept of compassion fatigue. Online J Issues Nurs. 2011;16:1. DOI:10.3912/OJIN.Vol16No01Man01
[73] Chacala A, Mccormack C, Collins B, et al. "My view that disability is okay sometimes clashes": experiences of two disabled occupational therapists. Scand J Occup Ther. 2014;21:107–115.
[74] Ember CR, M. Ember. Encyclopedia of medical anthropology. Health and illness in the world's cultures. Volume I: topics; Volume II: cultures. New York (NY): Kluwer Academic/Plenum Publishers; 2004.
[75] Scheper-Hughes N, Lock MM. The mindful body: a prolegomenon to future work in medical anthropology. Med Anthropol Q. 1987;1:6–41.
[76] Kleinman A. Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley (CA): University of California Press; 1980.
[77] Tamaru A, McColl MA, Yamasaki S. Understanding 'Independance': Perspectives of occupational therapists. Disabil Rehabil. 2007;29:1021–1033.

[78] Suurmond J, Seeleman C. Shared decision-making in an intercultural context. Barriers in the interaction between physicians and immigrant patients. Patient Educ Counsel. 2006;60:253–259.
[79] Gravel S, Doucet H, Laudy D, et al. L'adhésion des populations immigrantes à la valeur de l'autonomie véhiculée en santé publique. Int Migration Integr. 2009;10:31–47.
[80] Oliveira VC, Refshauge KM, Ferreira ML, et al. Communication that values patient autonomy is associated with satisfaction with care: a systematic review. J Physiother. 2012;58:215–229.
[81] Iwama MK. Toward culturally relevant epistemologies in occupational therapy. Am J Occup Ther. 2003;57:582–588.
[82] Bateson G. Form, substance, and difference, in steps to an ecology of mind. Chicago (IL): University of Chicago Press; 1972. p. 448–466.
[83] White BW. Pensée pluraliste dans la cité: L'action interculturelle à Montréal. Anthropologie et Sociétés. 2018;41:29. in press.
[84] Gibson D, Zhong M. Intercultural communication competence in the healthcare context. Int J Intercultural Relat. 2005;29:621–634.
[85] Grant MJ, Booth A. A typology of reviews: an analysis of 14 review types and associated methodologies. Health Inf Lib J. 2009;26:91–108.
[86] Dewa CS. Worker attitudes towards mental health problems and disclosure. Int J Occup Environ Med. 2014;5:175–186.
[87] Hanisch SE, Twomey CD, Szeto ACH, et al. The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. BMC Psychiatr. 2016;16:1–11.
[88] McGonagle AK, Barnes-Farrell JL. Chronic illness in the workplace: stigma, identity threat and strain. Stress Health. 2014;30:310–321.
[89] Gewurtz RE, Langan S, Shand D. Hiring people with disabilities: a scoping review. Work. 2016;54:135–148.
[90] Bettelheim B. Le Coeur conscient. Édition française. La première édition a été publiée en 1960 sous le titre The Informed Heart chez Tehr Free Press. ed. 1972, Paris: Robert Laffont. 383.
[91] Bezborodovs N, Thornicroft G. Stigmatisation of mental illness in the workplace: evidence and consequences. Die Psychiatrie: Grundlagen & Perspektiven. 2013;10:102–107.
[92] Krupa T, Kirsh B, Cockburn L, et al. Understanding the stigma of mental illness in employment. Work. 2009;33:413–425.
[93] Toldrá RC, Santos MC. People with disabilities in the labor market: facilitators and barriers. Work. 2013;45:553–563.
[94] Thornhill T. "If people stopped talking about race, it wouldn't be a problem anymore": silencing the myth of a color-blind society. In: McClure SM, Harris CA, editors. Getting real about race: hoodies, mascots, model minorities, and other conversations. Thousand Oaks (CA): Sage; 2015, p. 53–66.
[95] Scambler G. Sociology, social structure and health-related stigma. Psychol Health Med. 2006;11:288–295.
[96] MacEachen E, Kosny A, Ferrier S, et al. The "toxic dose" of system problems: why some injured workers don't return towork as expected. J Occup Rehabil. 2010;20:349–366.
[97] Barrett B, Sargeant M. The health, safety and well-being of vulnerable workers. In Sargeant M and Giovannone M, editors. Vulnerable workers; health safety and well-being. Surrey (UK): Gower Applied Research; 2011, p. 2–20.
[98] Scambler G. Social structure and the production, reproduction and durability of health inequalities. Soc Theory Health. 2007;5:297–315.
[99] Anderson B. Migration, immigration controls and the fashioning of precarious workers. Work, Employment Soc. 2010;24:300–317.
[100] Kosny A, et al. Delicate dances: immigrant workers' experiences of injury reporting and claim filing. Vol. Study Report 38. Toronto (ON): Institute for Work and Health; 2011.
[101] Saffari N. Immigration status and work disability duration in British Columbia. In: Epidemiology in occupational health conference (EPICOH). Barcelona, Spain; 2016.
[102] Frozzini JAJ. Law immigrant and migrant workers organizing in Canada and the United States: casework and campaigns in a neoliberal era. Lanham (MD): Lexington Books; 2017.
[103] Collins PH, Bilge S. Intersectionality. Cambridge (UK): Polity Press; 2016.
[104] Giordano J, Engebretson JC, Benedikter R. Culture, subjectivity, and the ethics of patient-centered pain care. Camb Q Healthcare Ethics. 2009;18:47–56.
[105] Narayan MC. Culture's effects on pain assessment and management. Am J Nurs. 2010;110:38–47.
[106] Rogers A, Allison T. What if my back breaks? Making sense of musculoskeletal pain among South Asian and African-Caribbean people in the North West of England. J Psychosomatic Res. 2004;57:79–87.
[107] Paul S. Culture and its influence on occupational therapy evaluation 39. Can J Occup Ther. 1995;62:154–161.
[108] Chang E-s, Simon M, Dong X. Integrating cultural humility into health care professional education and training. Adv Health Sci Educ. 2012;17:269–278.
[109] Hernández P, McDowell T. Intersectionality, power, and relational safety in context: key concepts in clinical supervision. Training Educ Prof Psychol. 2010;4:29–35.
[110] McCall L. The complexity of intersectionality. Signs. 2005;30:1771–1800.
[111] Meershoek A, Krumeich A. Multiculturalism and the construction of ethnic identities in labour and health practices: avoiding the culturalistic fallacy in applied research. Health Care Anal. 2009;17:173–197.
[112] Burgess-Proctor A. Intersections of race, class, gender, and crime. Future directions for feminist criminology. Feminist Criminol. 2006;1:27–47.
[113] Brah A, Phenix A. Ain't I a woman? Revisiting intersectionality. J Int Women's Stud. 2004;5:75–86.
[114] Tyler I, Slater T. Rethinking the sociology of stigma. Sociol Rev Monogr. 2018;66:721–743.
[115] Winker G, Degele N. Intersectionality as multi-level analysis: dealing with social inequality. Eur J Women's Stud. 2011;18:51–66.
[116] Comas-Diaz L. Cultural variation in the therapeutic relationship. In: Goodheart CD, Kazdin AE, Sternberg RJ, editors. Evidence-based psychotherapy: where practice and research meet. Washington (DC): American Psychological Association. 2002, p. 81–105.
[117] Leong FTL, Eggerth DE, Flynn MA. A life course perspective on immigrant occupational health and well-being. In: Leka S, Sinclair RR, editors. Contemporary occupational health psychology: global perspectives on research and

practice, volume 3. New York (NY): John Wiley & Sons; 2014, p. 97–113.

[118] Stone J, Moskowitz GB. Non-conscious bias in medical decision making: what can be done to reduce it? Med Educ. 2011;45:768–776.

[119] O'Keeffe M, Cullinane P, Hurley J, et al. What influences patient-therapist interactions in musculoskeletal physical therapy? Qualitative systematic review and meta-synthesis. Phys Ther. 2016;96:609–622.