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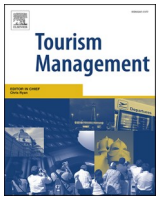

Wellness tourism and spatial stigma: A case study of Bama, China

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ABSTRACT

This study focused on the stigmatisation of an emerging wellness tourism destination due to patient travel for tourism. The concept of spatial stigma was adopted to explore how local residents perceive, experience and manage the particular negative effects of wellness tourism. The study investigated Bama Yao Autonomous County, colloquially known as 'Bama', in China, to which many tourists with cancer and other chronic diseases travel. The results showed that the influx of wellness tourists brought significant challenges in this area. The residents reported ambivalent experiences of and feelings about wellness tourism in local communities, and disagreed with the vilification of wellness tourists. However, they were concerned about the potential consequences of wellness tourism. To manage and resist spatial stigma, the residents deliberately separated themselves from the places occupied by wellness tourists. The theoretical contributions and managerial implications of the study are discussed.

1. Introduction

Wellness tourism has developed rapidly in recent decades (Voigt & Pforr, 2013). The term refers to the phenomenon of people travelling to tourist destinations that offer good natural environments and/or particular cultures to preserve or improve their health (Devereux & Carnegie, 2006; Mueller & Kaufmann, 2001). In contrast with 'medical tourism', which typically refers to travelling abroad to a destination to seek medical intervention to cure an illness (Carrera & Bridges, 2006; Yu & Ko, 2012), 'wellness tourism' refers to achieving health and wellness through a holistic (body and mind) approach without medical intervention during the holidays (Jolliffe & Cave, 2012). Many studies have focused on the characteristics of the demand for wellness tourism and the formulation of strategies for developing wellness tourism (Chen, Prebensen, & Huan, 2008; Heung and Kucukusta, 2013; Hudson, Thal, Cárdenas, & Meng, 2017; Kucukusta and Heung, 2012; Sayili, Akca, Duman, & Esengun, 2007). However, few researchers have investigated local residents' perceptions of the effects of wellness tourism, even though residents' perceptions of tourism effects have traditionally been the main topic of research in tourism studies (Sharpley, 2014). The effects of wellness tourism on destinations may be different and should be better understood (Suess, Baloglu, & Busser, 2018).

One of the key issues related to the effects of wellness tourism is that tourists suffer from certain types of illness. These include life-threatening illnesses, terminal illnesses or infectious diseases. Their effects on destinations may be just as 'dark', and have yet to be investigated in health and wellness tourism studies (Willson, McIntosh, Morgan, & Sanders, 2018). This study attempts to fill this gap by adopting and developing the concept of 'spatial stigma' to understand the effects of wellness tourism, as it explains how people's identities, feelings and other aspects of everyday life can be distorted by their place of residence (Pearce, 2012). This concept has been discussed in research in sociology and urban geography (Bourdieu, 1999; Kearns, Kearns, & Lawson, 2013; Kelaher, Warr, Feldman, & Tacticos, 2010; Klocker, 2015; Tabuchi, Fukuhara, & Iso, 2012; Wacquant, 2007). People considered to have certain degrading attributes and their relationships with others in specific places are frequently discussed in these studies (Kelaher et al., 2010; Makki & van Vuuren, 2017; Rhodes, 2012).

In recent decades, China's Bama Yao Autonomous County, colloquially known as 'Bama', has attracted many tourists with travel motivations related to health and well-being because of the quality of its natural environment and its reputation for longevity (Huang & Xu, 2014). Bama's emerging market as a wellness tourism destination has caught the attention of newspapers (e.g., Legal Evening News, 2014; Yanzhao Metropolis Daily, 2014) and online news media (e.g., People.cn, 2014; Sohu.com, 2014; Tencent News, 2017). According to their reports, many wellness tourists in Bama are elderly people with chronic diseases, and many suffer from terminal illnesses such as cancer.

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Although Bama is considered a last resort for these people, there are many negative public opinions about its transformation into a place for sick people (Luo, 2016). Many media sources have commented that Bama has become a 'cancer village' and have suggested that healthy tourists should not travel there (Luo, 2016). The 'dark' side of wellness tourism in this case has publicly stigmatised Bama and put pressure on local residents (Luo, 2017). In examining the case of Bama, this study aims to better understand the complex effects of wellness tourism on destinations.

2. Literature review

2.1. Wellness tourism

Wellness tourism is considered a holistic mode of travel that integrates the need for physical health, beauty, longevity, consciousness raising, spiritual sensibility and connections with the community, the environment or religion (Bushell & Sheldon, 2009; Steiner & Reisinger, 2006). Wellness tourists are active health seekers determined to play a role in their own health (Smith & Kelly, 2006). They are usually attracted by good natural environments, particular cultures, traditional communities or alternative wellness services and activities (Gonzales, Brenzel, & Sancho, 2001; Sayili et al., 2007; Smith, 2007). Therefore, rural areas (Hjalager, Tervo-Kankare, & Tuohino, 2016), forests (Ohe, Ikei, Song, & Miyazaki, 2017), mountains (Pechlaner & Fischer, 2006), hot spring resorts (Joppe, 2010), sacred sites providing spiritual restoration (Devereux & Carnegie, 2006) and spaces or places offering alternative wellness activities (e.g., yoga, meditation and spiritual retreats; Lehto, Brown, Chen, & Morrison, 2006; Kelly, 2010; Voigt, Brown, & Howat, 2011) are the main wellness tourism destinations.

With its rapid development, wellness tourism has caught the attention of researchers in recent years. On the supply side, researchers have focused on the characteristics and potential of, barriers to and development strategies for the wellness tourism industry (e.g., Goodarzi, Haghtalab, & Shamshiry, 2016; Heung & Kucukusta, 2013; Kucukusta & Heung, 2012; Lee & King, 2008; Supapol, Barrows, & Barrows, 2007). In contrast, on the demand side, attention has been paid to the socio-demographic and behavioural characteristics (Hallab, 2006; Sayili et al., 2007; Williams, Andestad, Pollock, & Dossa, 1996), motivations (Kelly, 2010; Kim, Chiang, & Tang, 2017; Lim, Kim, & Lee, 2016) and experiences (Luo, Lanlung, Kim, Tang, & Song, 2018) of wellness tourists, along with the factors that enhance their well-being (Thal & Hudson, 2017; Voigt, Howat, & Brown, 2010) and influence their travel decision-making (Hudson et al., 2017; Lehto et al., 2006). However, the literature has paid limited attention to the issue of illness in wellness tourism or its effects on destinations (Willson et al., 2018).

Studies have pointed out that the effects of tourism on destinations are strongly influenced by the characteristics of both the travellers and the destinations (But & Ap, 2017; Chen, 2011; Jackson, 2008; Johnston, Crooks, Snyder, & Kingsbury, 2010; Kim & Petrick, 2005). However, the effects of tourists' personal attributes on destinations remain underexplored. As wellness tourists are usually in poor health, suffering from illnesses and even fatal illnesses, their effects on destinations must be explored.

2.2. Illness-related public stigma

'Stigma', as posited by the sociologist Goffman, is defined as 'an attribute that is deeply discrediting' (1963, p. 12). Goffman (1963, p. 3) argued that this attribute diminishes the perception of an individual by other people 'from a whole and usual person to a tainted, discounted one'. Public stigma has been separated from self-stigma in recent research (Boyle, Dioguardi, & Pate, 2016; Corrigan, Rafacz, & Rüsch, 2011). Public stigma represents the beliefs, attitudes and reactions of the public to a stigmatised group (Boyle, 2018). Three components of public stigma, stereotypes, prejudices and discrimination, lead to an avoidance reaction or even the hostile behaviour of a 'normal' group towards a stigmatised group (Rusch, Angermeyer, & Corrigan, 2005). In reality, public stigma is socially and culturally constructed. Those who do not fit in with the 'normal' image constructed by the mainstream discourse system in society, such as people with disabilities, are vulnerable to stigmatisation and thus othered (Maritz, 2011). Othering is 'a process that identifies those that are thought to be different from oneself or the mainstream', emphasising unequal relationships in society (Johnson et al., 2004, p. 253). By othering stigmatised individuals or groups, one magnifies their difference from oneself and sometimes unintentionally reinforces positions of domination and subordination (Johnson et al., 2004). Therefore, people with attributes perceived as shameful often experience marginalisation and exclusion (Rusch et al., 2005), simultaneously affecting their self-identity and self-representation (Maritz, 2011).

Many serious diseases and chronic illnesses are usually perceived by members of society as stigma, including but not limited to HIV/AIDS, psychiatric disorders, mental illness, various forms of cancer, diabetes mellitus, sickle cell disease, infertility, systemic lupus erythematosus and hepatitis (Fu et al., 2015; Golden, Conroy, O'Dwyer, Golden, & Hardouin, 2006; Leger, Wagner, & Odesina, 2018; Sehlo & Bahlas, 2013; Wilson & Luker, 2006; Kim & Yi, 2014; Wang, Bai, Lu, & Zhang, 2017; Rusch et al., 2005; Kearns, Joseph, & Moon, 2012; Parker & Aggleton, 2003). Despite differences in beliefs about health and disease in different cultural contexts, illness-related stigma is a common phenomenon in many countries, such as Iran (Hassanpour Dehkordi, Mohammadi, & Nikbakhat Nasrabadi, 2016), the United States (Stites, Rubright, & Karlawish, 2018; Whittle et al., 2017), Germany (Angermeyer & Matschinger, 2003), Russia (Angermeyer, Buyantugs, Kenzine, & Matschinger, 2004), Ireland (Golden et al., 2006), Nigeria (Leger et al., 2018), New Zealand (Kearns et al., 2012) and China (Fu et al., 2015). This illness-related public stigma not only creates tremendous psychological pressure and negative emotions for patients, but also results in the rejection of social interactions and social relations, unemployment and low income, a poor quality of life and poor psychological well-being (Cheng et al., 2013; Corrigan, Tsang, Shi, Lam, & Larson, 2010; Vyavaharkar et al., 2010).

As a serious chronic disease, cancer is usually perceived more negatively than any other disease (Asami, Ishida, & Sakamoto, 2012; Bonanno & Esmaeli, 2012; Chan, Hon, Chien, & Lopez, 2004; Cho et al., 2013; Lebel & Devins, 2008; Phelan et al., 2013; Wang et al., 2017). Cancer is considered a stigma by non-patients for the following main reasons. First, the fear of illness and death influences people's perceptions of cancer (Wang et al., 2017), as cancer is often associated with death because of its high mortality rate (Chambers et al., 2012). The second reason is people's beliefs about their own risk of developing cancer (Balmer, Griffiths, & Dunn, 2014; Fujisawa & Hagiwara, 2015). In some communities, a large proportion of the population still mistakenly considers cancer a contagious disease, triggering feelings of insecurity, anxiety and fear when cancer patients are nearby (Salant & Gehlert, 2008; Wongkim, Sun, & Demattos, 2003). Third, cancer and its treatment damage patients' body image and can make them visually 'ugly', causing people to distance themselves from patients (Fujisawa & Hagiwara, 2015). For example, chemotherapy-induced alopecia seriously affects the social acceptance of cancer patients (Rosman, 2004). Finally, cancer patients are frequently believed to be responsible for their conditions (e.g., smoking, unhealthy living habits; Balmer et al., 2014; Chapple, Ziebland, & McPherson, 2004; Marlow & Wardle, 2014; Marlow, Waller, & Wardle, 2015).

Although illness-related stigma is common in many countries, there are some differences on how stigma emerges and its effects in different cultural contexts. Asian people have different attitudes towards and reactions to cancer patients (Kagawa-Singer, Wellisch, & Durvasula, 1997). In many Asian countries, 'cancer is generally viewed as a disease brought on by bad luck, weakness of character, and/or the consequence of one's lifestyle or moral wrong' (Cheng et al., 2013, p. 793). Some

Asian populations have a fatalistic view of cancer, believing that the illness is 'God's punishment or bad karma' (Wongkim et al., 2003, p. 23). This is also true for Chinese people (Chen, 2001; Ding, Zhang, & Zhu, 2008; Yeo et al., 2005). Chinese people are afraid of cancer and rarely mention it in normal conversation (Wongkim et al., 2003). In addition, they are unwilling to spend time with cancer patients because they fear that the ill luck (晦气) will rub off on them (Cheng et al., 2013). Ill luck (晦气) is perceived as a kind of energy suspended in the air and attached to certain people, which can be transmitted from one person to another. Staying away from ill luck (晦气) is a practice that has been perpetuated in China since ancient times. In Chinese festivals, cancer is even defined as a taboo, and cancer patients are not welcomed by their relatives due to the associated ill luck (Cheng et al., 2013). Although great changes have occurred in Chinese society, the belief in ill luck is still widely accepted by Chinese people and influences their daily practices. Although ordinary people generally show empathy for these sick people, the fear of facing ill luck scares them away. In addition, studies examining cancer knowledge among Chinese people and Chinese Americans have shown that a large number of people lack scientific knowledge about cancer and some of them believe that cancer is a contagious disease (Mo, 1992; Xu & Chen, 2015; Yu et al., 2001).

These factors have led to stereotypes, prejudices and negative reactions to cancer patients. Ordinary people (e.g., strangers or acquaintances) often feel uncomfortable when they meet someone with cancer, usually because they do not know what to say and find it easiest to resort to feelings of sympathy, sadness, anxiety or fear (Tang, Mayer, Chou, & Hsiao, 2016; Walter & Emery, 2006). It has been shown that when cancer is diagnosed, social interactions with the patient significantly diminish or even disappear (Marlow et al., 2015; Tang et al., 2016; Wilson & Luker, 2006), resulting in smaller networks among cancer patients (Cheng et al., 2013). Some may not even receive social support from close friends and relatives (Cheng et al., 2013). Howard, Balneaves, and Bottorff (2007, p. E31) showed that female patients with breast cancer not only perceived that they were treated as 'others' by the hospital's medical staff, but also 'fe[lt] abandoned, isolated, and neglected by their families'.

2.3. Spatial stigma

The spatial clustering of people with illness can also lead to the stigmatisation of a place (Zhou, 2013). Based on Goffman's (1963) theory of stigma, the concept of spatial stigma has been developed in the fields of urban sociology and urban geography to determine how a place of residence can distort people's identities (Pearce, 2012). Spatial stigma has been conceptualised at the individual level and the social level. In the individual dimension, spatial stigma refers to the process by which people who reside in 'vilified and degraded locales' (Keene & Padilla, 2014, p. 393) are reduced from 'normal' people to degraded and discounted ones (Besbris, Faber, Rich, & Sharkey, 2018). They are marked by the stigma of place, which influences their self-identification, daily experiences, mobilities and social interactions and prevents them from being fully accepted by others (Besbris, Faber, Rich, & Sharkey, 2015; Keene & Padilla, 2010; Wacquant, 2007). At the social level, spatial stigma is conceptualised as a consequence of social inequalities (Keene & Padilla, 2014, p. 393). Therefore, the concept of spatial stigma also casts light on the broader societal structure and cultural meaning manifested in a specific stigmatised place (Wacquant, 2007, 2008).

Racial stereotypes, marginal social economies, high rates of crime or disorder and environmental issues can lead to spatial stigma (Broto, Burningham, Carter, & Elghali, 2010; Bush, Moffatt, & Dunn, 2001; King, 2015; Murphy, 2012; Rugh & Massey, 2010; Sampson, 2009; Sampson & Raudenbush, 2004; Wacquant, 2007). Residents in stigmatised areas may be subject to stereotypical ideas, prejudices and discrimination from the outside (Kelaher et al., 2010). In addition, as an ignominious label, spatial stigma affects the place identity and self-identity of local residents. Thus, the negative views and attitudes of outsiders about a stigmatised place influence residents' cognition of and affection for the place (Besbris et al., 2015). Although residents generally disagree with the negative opinions of outsiders, they imperceptibly internalise spatial stigma as part of their identity (Howarth, 2002).

People living in stigmatised areas usually manage stigma by stigmatising a smaller space and particular groups in these areas (Kelaher et al., 2010; Rhodes, 2012). To resist place-based stigma, local people usually attribute the perceived negative characteristics of a place to a smaller space and stay away from that space (Thomas, 2016). In this way, the psychological recognition and differentiation of a physical space by the residents directly lead to spatial separation and isolation, thus constructing both favourable and weak areas in one place (Thomas, 2016). To cast off stigma, the residents of the stigmatised area tend to condemn and criticise other specific groups considered responsible for this spatial stigma (Ingen, Sharpe & Lashua, 2018). As a consequence, specific groups are stigmatised and perceived as unwanted 'others' in the place, reflecting cold, strained, conflicting and even hostile social relationships (Makki & van Vuuren, 2017). These marginalised groups in stigmatised places often have certain perceived negative characteristics (such as poverty and immoral behaviour) that also make them the targets of stigmatisation in other non-stigmatised geographical contexts.

Current research has mainly focused on structural spatial stigma caused by historical and economic factors (Wacquant, 2007; Makki & van Vuuren, 2017). In contrast, this study focused on spatial stigma associated with a wellness tourism destination. By focusing on this new type of spatial stigma, this study further enriches the relevant body of work.

3. Method

3.1. Research site: Bama as a wellness tourism destination

Bama County is located in the northwest of Guangxi Autonomous Region, China. It was once one of the poorest counties in China, and perceived as a marginal place. Traditionally, local residents made a living from farming or off-farm activities. With its fresh air, clean water, abundant fruit and vegetables and beautiful natural landscapes, Bama has earned a reputation for longevity. It was awarded the title of 'Fifth Longevity Town' in the world in 1991 because of its extremely high percentage of centenarians (Huang, 1993). From 2008 to 2013, China Central Television showed several documentaries about Bama County as a place of longevity, such as *The Legend of Bama's Longevity* in 2010, *The Longevous in Bama* in 2011 and *Longevity Code* in 2013. As a result, tourism has increased significantly in the last 10 years (Fig. 1). Bama is currently one of the most famous wellness tourism destinations in China.

The majority of wellness tourists in Bama are repeat visitors who stay for at least one month each year (Huang & Xu, 2018). Most of them suffer from chronic diseases (e.g., cardio-cerebrovascular diseases, hypertension and diabetes) and some even suffer from fatal illnesses, such as cancer (Luo, 2017). Although there are no official scientific statistics, Liberation Daily (2013), managed by the CPC Shanghai Municipal Committee, stated that more than 70% of the wellness tourists in Bama are cancer patients. In Huang and Xu's (2018) study of Bama, 55 wellness tourists were interviewed, of whom 36% were healthy, 31% had a chronic disease, 26% were reluctant to share their information and 7% acknowledged that they were cancer patients. Wellness tourists come to Bama to find ways to stay healthy, cure their illnesses and live longer thanks to its good natural environment, reputation for longevity and stories about the treatment of incurable diseases. Breathing fresh air, exercising in nature, sitting in karst caves, drinking local spring water, eating local food and herbs and visiting local seniors are activities believed to help people stay healthy (Huang & Xu, 2014).

With the rise of Bama's popularity and influx of tourists, negative news reports and negative labels have emerged one after another. Bama was first described as a 'cancer village' by the media, and the label spread quickly and widely. The idea that 'the longevity town in Guangxi

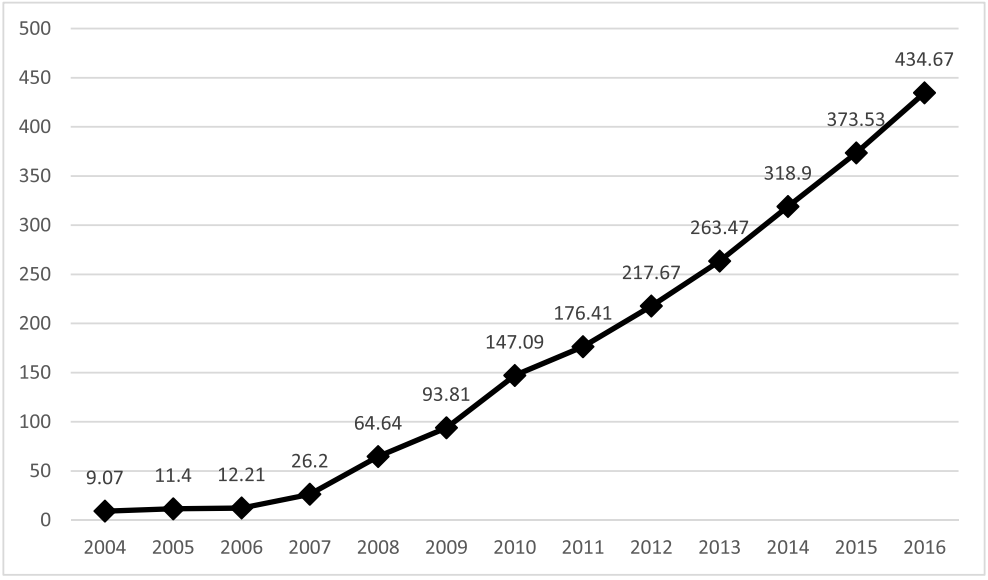

Fig. 1. Tourist arrivals between 2004 and 2016 (units: 10,000 visits), (Source: Bama Tourism Bureau).

has become a cancer village' was widely disseminated by various online news media (e.g., Chinadotcom, Sohu.com, QQ.com, People.cn) and social media (e.g., microblogs and WeChat) in China (People.cn, 2014; Tencent News, 2017). The media also reported uncommon healing practices amongst cancer patients in Bama, such as drinking urine and crawling like a dog, raising general public concern (Liberation Daily, 2013). There were also some extreme comments, leading to public hostility towards Bama and even panic. For example, one cyber citizen said that 'there were cancer patients everywhere in Bama and even the air was filled with cancer cells' (Qihoo.com, 2018). In addition, Bama has been criticised for overstating its health benefits. The media reported that the years of birth on the ID cards of local seniors could have been made up and that the number of centenarians was exaggerated (BlogChina, 2017). These negative media reports have generated considerable scepticism about longevity in Bama. Finally, the negative effects of tourism on the local environment have attracted unanimous public criticism (QQ.com, 2013; Sohu.com, 2014). Overall, these negative views on Bama in recent years have put a lot of pressure on local people and governments.

3.2. Data collection and analysis

The fieldwork was carried out in Poyue Village, about 31.8 km from downtown Bama, where most of the wellness tourists live. Poyue Village

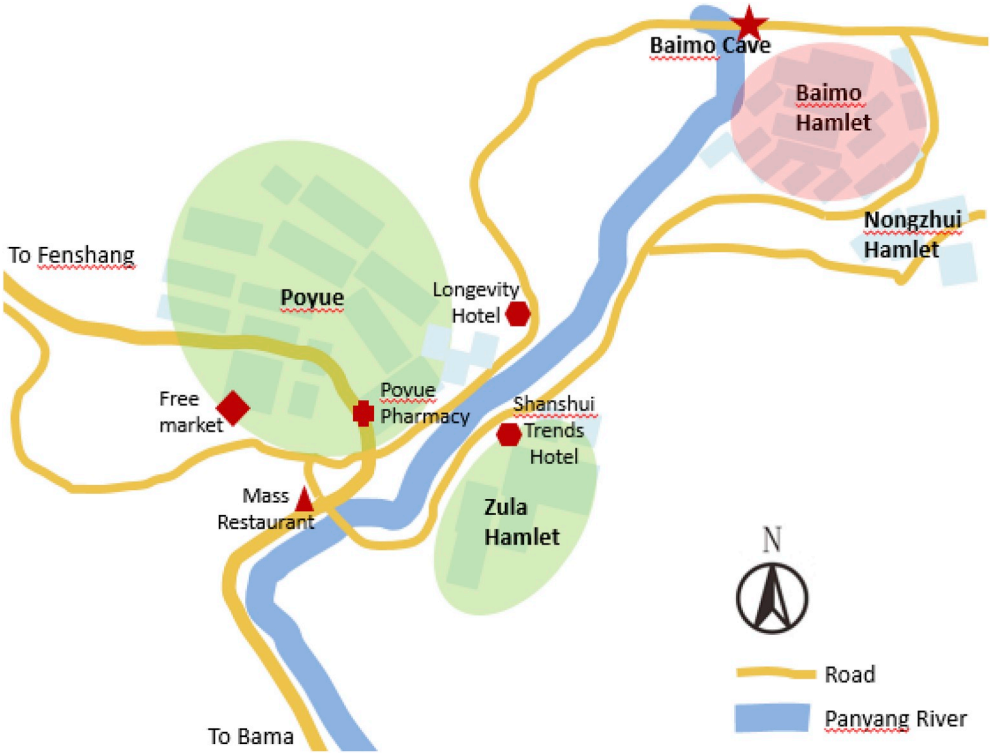

Fig. 2. Map of Poyue village.

lies at the foot of two mountain ranges, the Yun Mountains and the Min Mountains, and is near the Panyang River (Fig. 2). It has 12 hamlets, among which Baimo and Zula are where most wellness tourists live. This village is chosen by most tourists for its 'magical' cave called Baimo Cave, which is said to have a strong geomagnetic field and is therefore good for people's health and longevity.

Since the influx of wellness tourists in Poyue Village in 2008, almost all villagers have built new houses or new floors (usually five to seven floors) to rent rooms to tourists. Indeed, renting rooms is one of the main sources of income for local villagers.

The research team has been studying wellness tourism in Bama since 2012. Qualitative data focusing on the behaviour and experiences of wellness tourists in Bama were collected in July 2012 and August 2013, and 66 tourists and 17 locals (including villagers, small entrepreneurs and government officials) were interviewed. During the two fieldwork sessions, the local residents' perceptions and experiences of the negative effects of tourism on the destination drew the researchers' attention to this issue.

The third round of data collection was conducted from 26 October to November 15, 2017, focusing on how local residents experience and manage the stigmatisation of Bama caused by wellness tourism. This study used the third round of data collection conducted by the first author. A qualitative methodological approach was adopted, including participant observation, non-participant observation and in-depth interviews. To increase the accessibility of the data, the first author moved into a large guest house owned by local people and built a good relationship with the owner. By joining the daily activities of the owner, the first author got to know more local people and came to learn more about Poyue Village. By associating with the residents, participant observation was implemented. The first author informed the local residents of her role as a researcher and the purpose of this research, then asked those who were easy to approach to participate in in-depth interviews. In addition to this potential sample collection approach, the first author selected a wide range of interviewees based on their involvement in tourism and roles in the tourism industry. She went from house to house along the main roads to request interviews with the local residents. Although this sample collection method had a high refusal rate and took a long time to identify potential respondents, it was an effective way to enrich the range of respondents in this study. All of the valid semi-structured interviews were mainly conducted in residential areas or at the workplaces of the local people, and each lasted for at least 20 min. They focused on the following topics: (1) the tourism development process of Poyue Village; (2) the effects of wellness tourism on local people; (3) whether they perceived the stigmatisation of Bama as a consequence of tourism development and what they thought of it; and 4) how they managed spatial stigma. Specific questions were adjusted based on feedback from the respondents. In the end, 53 local residents living in Poyue Village for at least 10 years were interviewed during this round of data collection. In addition, the director of the Tourism Bureau of Bama County, the village head of Poyue, 8 tourists and 11 non-local small entrepreneurs were interviewed to better understand Bama and Poyue Village.

This study used the observation and interview data of the local residents collected in the third round to provide evidence of the results. Of the 53 local residents interviewed, 33 were in Poyue Village, 3 in Zula Hamlet and 17 in Baimo Hamlet (Table 1). The conspicuous difference in sample size between the three places was due to their very different sizes. Indeed, there are approximately 30 local households and 20 local households in Baimo Hamlet and Zula Hamlet, respectively, and approximately 300 local households in Poyue Village. All of the interviews were recorded with the participants' permission and key information was also written in a notebook during the interviews. For reasons of confidentiality, the interviewees were designated as 'residence (P/Z/B) + gender (M/F) + number', with P, Z and B representing Poyue Village, Zula Hamlet and Baimo Hamlet, respectively. There were 31 men and 22 women aged 20–69 years old. All respondents were members of ethnic minorities, with 52 Zhuang people and 1 Yao individual who had married someone from Poyue Village. In addition, 96% of them participated in the tourism industry, such as renting rooms, selling tourist commodities and daily necessities to tourists or catering. For instance, 77% of the respondents not only rented rooms to tourists on a monthly basis, but were also involved in the tourism industry in other ways. Table 1 provides detailed information on whether the interviewees rented rooms to tourists and their role in the tourism industry, apart from rental housing.

Table 1
Demographic information of the local residents interviewed in the third round of fieldwork.

Respondents		*N*
Gender	Male	31
	Female	22
Age	20–29	7
	30–39	23
	40–49	7
	50–59	13
	60–69	3
Ethnicity	Zhuang	52
	Yao	1
Place of residence	Poyue	33
	Zula Hamlet	3
	Baimo Hamlet	17
Rent rooms to tourists on a monthly basis	Yes	46
	No	7
Role in the tourism industry (apart from rental housing)	a. Restaurateur	6
	b. Hotel owner	4
	c. Sells daily food	13
	d. Sells featured tourist commodities	11
	e. Grocery store owner	9
	f. Member of staff in the tourism industry	2
	g. Owner of a medicine store	1
	h. None/only rents rooms	7/5

Thematic analysis, an effective method of identifying, analysing and reporting trends in qualitative data (Braun & Clarke, 2006), was used for the data analysis. The first author's reflections during the fieldwork, along with her field notes and interview transcripts, were combined for the thematic analysis to examine how the local residents perceived, experienced and managed Bama's stigma. The thematic analysis was carried out in four steps, as follows. First, a holistic impression was obtained by reading and re-reading the transcripts and field notes. Second, the researchers approached the dataset by paying equal attention to each sentence and extracted sentences with relevant keywords or concepts to produce the initial codes. If two codes had the same or a similar meaning, they were merged into one code. Third, the initial codes were systematically organised into theme piles. Different codes related to the same topic were grouped into one category and the connected categories were organised by potential theme (Zhu, Xu & Jiang, 2016). Fourth, all potential themes and logical relationships were reviewed and examined. The researchers then re-approached the dataset and discussed the validity of each theme in relation to the data (Ong & du Cros, 2012). After several rounds of review, the themes were finally refined and categorised into two aspects. One was about the residents' experiences of Bama's stigma regarding wellness tourism, which was composed of four themes: 'awareness of Bama's stigma', 'objection to spatial stigma', 'support for wellness tourism development' and 'worried about negative influences'. The second theme focused on how the residents managed spatial stigma in their tourist destination, with three themes: 'cancer patients as "others"', 'Baimo Hamlet as a place of "others"' and 'a space polluted by "others"'.

4. Findings

4.1. Residents' conflicting experiences of Bama's stigma

4.1.1. Awareness of Bama's stigma

The local people were aware that outsiders doubted Bama's healing effects and that Bama was considered by the public as a place for cancer tourists. They had obtained this information through word of mouth or the Internet and experienced prejudice and discrimination in their daily lives due to spatial stigma. Twenty-nine respondents expressed their resentment at how they were perceived by sightseers who were usually first-timers to Bama and travelled with a travel agency to stay for half a day or a day. PF7 said,

> 'Some sightseers said that our village was polluted by the cancer virus and had become a cancer village and that we traded life for tourism income. When I heard that, I was so annoyed and disgusted that I didn't want to have any interaction with tourists except for economic transactions' (PF7, female, 28).

Thirty-four respondents also frequently experienced discrimination directly related to Bama's negative stereotypes. A 29-year-old native woman said,

> '*A number of tourists thought that Bama's health benefits were exaggerated and that we would do anything to make money. Generally, they were of the opinion that the terrible change in Bama was the result of our ignorance and being blinded by gain*' (PF27, female, 29).

Illness-related stigma further deepened the horror, repulsion and mistrust of outsiders towards Bama. These feelings of insecurity and distrust were evident in everyday life, which made the local residents feel discriminated against, as shown in the following field notes:

> '*In the early morning, a female tourist in her 60s went to the market in Baimo Hamlet to buy fish. She selected a live fish and asked the shop owner to cut it. When the middle-aged man was cutting the fish, the woman noticed a slight injury to the fish's pelvic fin and immediately decided not to buy it. She said with disgust and resistance, "Why is this fish injured? Did it have cancer? I'd like to change it." At that time, the male owner was very angry and shouted at the woman, "You are sick. If the fish had cancer, all of the people here would be dead. This is the first time I hear about a fish with cancer. Don't ever come back here to buy fish"*' (field notes of 4 November 2017).

Although Bama's stigma was related to cancer patients and tourism development and not to the native villagers, they still felt psychologically abused and discriminated against because of their sense of place. One of them stated, '*It's our village and hometown. Whenever we hear tourists denigrate our village, it feels like our families are being blamed*' (PM17, male, 47).

4.1.2. Objection to spatial stigma

The local residents interviewed expressed strong objections to the negative connotations of the label 'cancer village'. Twenty-five respondents indignantly blamed the media for their 'false' reports of Bama. For instance, PF31, 47, living in Poyue Village, stated: '*There have been some changes in Bama over the years, but it is certainly not as serious as what the media report. They always like to exaggerate the facts and report negative things to get the public's attention*'.

The locals vehemently denied the label 'cancer village' and tried to refute it using different strategies. Some denied that a large number of cancer patients were living in the village and questioned the veracity of the media reports. One pointed out that '*not all patients are cancer patients, although there are many tourists with diseases in Bama*' (PF7, female, 28), indicating that the residents could accept other types of patients than cancer patients and that most attempted to distinguish between the locals and the place and cancer tourists to preserve the positive image of Bama and its people. They acknowledged the presence of cancer patients, but did not accept the label 'cancer village'. In addition, they considered that this stigmatisation had nothing to do with the place and its people, but was specific to the cancer patients in Bama. The residents of Bama made efforts to maintain their place attachment and place identity. As a 56-year-old respondent put it, '*our place is a good place for health maintenance … We have lived here healthily for generations. It is impossible that Bama has been turned into a cancer village. This stigma has nothing to do with Bama and with us. Bama will always be our hometown*' (ZM36, male, 56).

In opposing and denying this stigma, the residents felt disappointed and powerless. Forty-six respondents felt uncomfortable with Bama's stigma, but were unable to express their feelings. A typical response was, '*our village would not be called a cancer village if there weren't sick people visiting the village. I really don't like the label and I hope our village will get better and better*' (PM2, male, 27). In addition, they mentioned that they had no choice but to let the situation continue. They had neither the ability to prevent cancer patients from visiting their village nor the means to change the perceptions and stereotypes of outsiders.

4.1.3. Support for wellness tourism development

Local people faced a dilemma when they established their village as a tourist destination. On the one hand, they really wanted to reject tourists with diseases to combat spatial stigma. On the other hand, they were highly dependent on the tourism economy. Although wellness tourism has brought stigma to Bama, it has generated substantial economic benefits for local communities. Indeed, after the expropriation of the residents' farmland, tourism was their main source of income. Moreover, the development of wellness tourism brought back the labour force and freed them from another spatial stigma – poverty. BM43 (male, 34) stated,

> '*Memories of my childhood, I was hungry every day but I did not have enough to eat. I am quite satisfied with my life now. There are so many job opportunities in our village that we can work close to home. In addition, our village has got rid of poverty. All of our villagers live a good life*'.

As they relied almost solely on the tourism economy and believed that the unique selling point of the place was to provide sick people with a natural environment for healing, almost all of the residents interviewed said that they had to support the development of wellness tourism despite its main negative effect – spatial stigma. Only five respondents not involved in tourism or with other sources of income than tourism did not support wellness tourism. However, most interviewees who benefitted economically from tourism revealed that they had to deal with the difficulties of interacting with sick tourists. Therefore, they adopted a series of strategies, including avoiding in-depth discussion, trying not to think about the risks and developing a fatalistic attitude. Furthermore, they rationalised their decision by considering it as pure business. BM47 (male, 36) said, '*We only earn money from wellness tourists and have no other contact with them*'.

Nevertheless, five respondents empathised with the cancer tourists. They understood that Bama had positive effects on cancer patients and enabled them to experience happiness at the end of their lives. Thus, they saw the value of Bama and supported its role as a place of healing. One typical local resident stated,

> '*Most cancer patients visiting Bama are people who have already been sentenced to death in hospitals and have abandoned medical treatment. Bama is a place of great significance and value, giving them the last joys and memories of their lives and perhaps extending them for months*' (PM16, male, 38).

4.1.4. Worried about negative influences

> '*What is a hometown? A hometown is like our mother. This means that I can talk about her problems and inadequacies, but I cannot tolerate others talking about her shortcomings in front of me*' (PF32, female, 53).

PF32's view represented the feelings towards Bama expressed by the majority of the residents interviewed. Even if they denied the stigma of Bama and supported the development of wellness tourism, they were anxious and worried about the patients, especially cancer patients, in Poyue Village. Before the widespread criticisms of Bama in the media, the local residents had not held strong perceptions of the cancer patients visiting Bama. However, as Bama's stigma spread, they became more aware of the risks of disease, especially cancer. Forty-five respondents expressed unease and discomfort around sick tourists. Although no incidents of locals being affected by tourists were discovered, they were worried about the possibility. As PF12 (female, 42) explained, '*It is reasonable that no one wants to stay with a patient and it's really hard for a healthy individual to be with a patient*'. This panic and discomfort were internalised – beyond words.

Sixteen local residents interviewed believed that there could be patients with serious infectious diseases among the wellness tourists, and were worried about contamination and the consequent risks for the whole village. For example, PM26 (male, 67) said, '*With so many patients, there may be infectious diseases, but we don't know who has them. Our people face a potential risk of contamination. Maybe one day this place will be gone*'. Nearly 20% of the residents interviewed considered cancer a fatal and contagious disease and were therefore particularly afraid of it.

One third of the respondents also feared that tourists with serious illnesses could carry viruses and germs that could contaminate their hometown. Although most of the respondents knew that certain types of diseases are not contagious, they were still afraid of biological pollution and indirect contact transmission. One resident even attributed diabetes developed by two local people in Poyue Village to the effects of wellness tourism. He felt that '*no one in our village had a chronic disease until these patients came. They brought germs and viruses to our land. As a result, local residents are also getting sick*' (PF40, female, 57).

Finally, the residents rejected cancer patients because cancer was considered a sign of death and ill luck. Forty-seven respondents expressed concern about the transmission of ill luck carried by cancer patients. Although 80% of the respondents knew that cancer is not a contagious disease in the medical sense, they believed that the ill luck of cancer patients, a mysterious intangible fate, was contagious. They feared that cancer patients would harm them and their hometown. Poyue Village has had several cases of sudden death from cancer. Therefore, the villagers repeatedly referred to real-life cases, such as the death of a cancer patient in a rented house or a cancer patient jumping from a building, to justify their fear. These deaths in the village were considered bad events that could affect the local fortune and 'feng shui' (which means luck). Therefore, they strongly urged the families of the deceased to remove the remains instead of allowing them to bury the bodies in the village. By doing so, the local residents obtained a form of psychological consolation: as long as the remains of the dead were not left in the village, all would be well.

4.2. Negotiation of spatial stigma: othering people and spaces

4.2.1. Cancer patients as 'others'

Due to Bama's association with stigmatised notions of cancer and other diseases, about 90% of the local residents interviewed tried to differentiate themselves from cancer patients, who were considered by the locals as 'others'. As explained by an old woman who had spent all her life in Baimo Hamlet,

> '*The reason our village is stigmatised as a cancer village is that many cancer patients travel to our village and stay here for a long time. They are the ones who have cancer. All of our villagers are very healthy. It's impossible for us to have cancer*' (BF38, female, 68).

Faced with spatial stigma, discrimination and the social avoidance of critically ill patients by the local residents further intensified. Wellness tourists with unethical or incomprehensible behaviours were identified as cancer patients and news of their allegedly inappropriate behaviours were spread by word of mouth, further aggravating the residents' prejudices against cancer patients. For instance, the owner of an apartment offering tourist accommodation in Poyue Village was extremely prejudiced against cancer patients. She believed that

> '*The cancer patients who come here have been dehumanised by the disease and their character is so deformed and distorted. Cancer patients often intentionally use counterfeit money when shopping. In addition, there are many racketeers who pretend to be hit by a car and claim compensation from the owner. These racketeers are cancer patients who want money to buy drugs*' (PF33, female, 26).

Moreover, the local residents socially avoided and rejected visitors who looked like cancer patients. To avoid inheriting their ill luck, the locals avoided talking to those suspected to be cancer patients and deliberately stayed away from them. In particular, all of the respondents deliberately refused and would never rent homes to these 'cancer suspects', as they believed that the death of a cancer patient in their house would be a very bad thing, bringing bad luck and misfortune to themselves and their families. People who looked pale or weak, those with obvious disabilities, and those who smelled of medicine or had thinning hair were more likely to be considered 'others'. In addition, age was used as indicator of otherness. Therefore, young tourists who stayed in Poyue Village for a long time were considered to be patients with fatal diseases. An old man explained this argument as follows:

> '*Young people who are supposed to work have no time to live in a village for so long. Even if they don't work, our village without recreational activities is too boring to attract young people to stay long. So, it is very strange to have young people living here all the time. I guess it is because they have a fatal disease*' (PM26, male, 65).

The first author, a female in her 20s, stayed in Poyue Village for about 20 days. In her initial conversations with some residents, she was misinterpreted as a potential patient with a fatal disease. Some residents looked at her with suspicion, intentionally kept their distance and inquired about her personal life to determine whether she was a cancer patient.

4.2.2. Baimo Hamlet as a place of 'others'

To avoid being affected by the bad luck associated with cancer, local people tended to spatially separate themselves from cancer tourists. Twenty-two respondents living in Poyue Village believed that cancer patients were concentrated in Baimo Hamlet and that wellness tourists in Poyue Village would be in poor health. As PF33 (female, 26), living in Poyue Village, stated, '*almost all cancer patients live in Baimo Hamlet because they want to be closer to Baimo Cave for its mystical healing effects. In contrast, there are many wellness tourists with mild chronic diseases in Poyue Village, but no people with a fatal disease*'. According to ZM36 (male, 56), a number of tourists first settled in Baimo Hamlet and then moved to Zula Hamlet a few days later because they were afraid when they heard that Baimo Hamlet was a cluster of cancer patients.

In the residents' minds, Poyue Village was divided into a 'healthy' space and a 'degraded' space. Poyue Village and Zula Hamlet were considered health-promoting spaces with 'normal' wellness tourists (green part in Fig. 2), while Baimo Hamlet was stigmatised as a 'degraded' space associated with serious illness and death (red part in Fig. 2). The people (including residents and tourists) living in Baimo Hamlet were further subjected to social discrimination and exclusion in Poyue Village.

'*There is a middle-aged local woman selling baked sweet potatoes by the roadside in Poyue Village. Every evening, many locals gather here to chat. If people who look healthy come to buy baked sweet potatoes, the locals usually chat with them. But as soon as a person says s/he lives in Baimo Hamlet, the locals become apathetic. When the person leaves, they begin to speak ill of the people living in Baimo Hamlet*' (Field notes of 12 November 2017).

In another example, a woman in her 30s turned down a job offer of RMB2,400 at a guest house in Baimo Hamlet, but accepted a job paying RMB1,800 in a homestay in Poyue Village. She explained her choice as follows: '*I felt that Baimo Hamlet had been tainted by cancer, so I wanted to stay away from everyone in that area, including local inhabitants*' (field notes of November 10, 2017).

Aware that Baimo Hamlet was associated with cancer tourists, all of the interviewees living in Baimo Hamlet denied that their homes were rented to cancer patients, and instead blamed outside businessmen for renting their apartments. BF40, a 53-year-old female resident in Baimo Hamlet, claimed, '*None of the tourists renting my rooms have cancer, all cancer patients live in apartments owned by outsiders*'.

4.2.3. A space polluted by 'others'

Most of the respondents strongly believed that wellness tourists were responsible for the deterioration of the natural landscape and the environment and should be held accountable. Thus, the residents kept a physical distance from any polluted space. Almost all of the respondents mentioned changes in air quality. Baimo Cave was considered the most typical space in which fresh air had been seriously polluted by cancer tourists. According to a local resident,

'*More than 80% of the tourists in Baimo Cave are cancer patients who spend the whole day breathing in the cave. Their germs are expelled by breathing and pollute the air. What people breathe is a toxic gas instead of oxygen*' (PM20, male, 37).

At the same time, the locals tried to stay away from Baimo Cave to avoid breathing unclean air, although they used to go to the entrance of the cave to rest and breathe fresh air.

In addition, 64% of the respondents pointed out the irreversible pollution of water. They explained that the Panyang River, nicknamed 'mother river' by the local villagers, had been severely polluted. They were aware that the direct discharge of sewage from guest houses and villagers' houses into the Panyang River had damaged the local environment, but emphasised that the unethical behaviour of tourists with illnesses had caused the pollution. Indeed, some wellness tourists believed that swimming, bathing and washing themselves in the river could have healing effects, and thus often did so. Water pollution was perceived as serious by the residents, who repeatedly expressed their outrage and concern. A female resident living near the Panyang River said:

'*We used to drink water from the Panyang River directly, but now we dare not even use it to wash our hands. Tourists like to swim in the river and some of them even wash their underwear in the river. It is disgusting. The worst is that most of them have diseases, such as cancer, skin diseases and diabetes mellitus. They carry a lot of viruses and bacteria that are dumped into the river*' (PF8, female, 39).

According to the respondents, tourists suffering from a serious disease should take responsibility for turning the Panyang River from a 'mother river' to be proud of into a 'dirty river', 'bacterial river' or 'virus river'. The local residents preferred to go deeper into the Min Mountains for drinking water than to drink from the Panyang River.

In summary, wellness tourism has had negative environmental effects due to a lack of proper management. However, there is no doubt that the public stigmatisation of diseases, viruses and germs has contributed to stronger negative perceptions of the environmental influence of wellness tourists. The residents subjectively constructed serious environmental pollution caused by diseases and related bacteria and viruses. Thus, they stayed away from the spaces they considered polluted by 'others', including not going to Baimo Cave and not using the water from the Panyang River. The locals also spatially separated themselves from 'others' blamed for the stigma of Bama.

5. Discussion

Our research examined residents' complex experiences of and reactions to spatial stigma induced by wellness tourism. The local residents were discriminated against by outsiders and denied and opposed Bama's stigma, claiming that Bama was the same as anywhere else. However, in the face of this stigma, the residents felt powerless, as they relied on wellness tourism to improve their livelihoods. In addition, Bama's illness-related stigma caused fear, panic and anxiety. Therefore, the residents adopted strategies to socially and spatially separate themselves from potential cancer tourists. They referred to cancer tourists as 'others', refusing to rent houses to those who were thought to be cancer tourists and blaming outsiders for these problems. The locals also tended to avoid associating with places believed to be frequently visited by cancer patients and thought that viruses, germs and bad luck were related to cancer tourism. Social and spatial isolation of residents and tourists may negatively impact the sustainable development of the community and the quality-of-life of both of them (Pickel-Chevalier, Bendesa, & Darma Putra, 2019; Soszyński, Sowińska-Świerkosz, Stokowski, & Tucki, 2018). Overall, our study highlighted the problem of discrimination of the outside world against local communities and discrimination of locals to wellness tourists (Fig. 3).

The victim-perpetrator cycle explored in this study is also observed in other social behaviours, such as bullying, sexual abuse, domestic violence, emotional abuse and workplace incivility (Glasser et al., 2001; Kachaeva, Dmitrieva, Rumantseva, & Drikina, 2008; Meier & Gross, 2015). The cognitive component (e.g., hostility) and the emotional component (e.g., anger, depression, anxiety) of aggression resulting from victimisation may partly explain why victims become perpetrators (Walters & Espelage, 2018). The victim is more likely to find someone more vulnerable than him/her, and the original victim may have the same experiences as the perpetrator (Chan & Wong, 2015; O'Brennan, Bradshaw, & Sawyer, 2009). In the tourism context, however, there were some differences. Wellness tourists were discriminated against because they had fatal illnesses. However, as the locals depended on wellness tourism to find business opportunities, they were still committed to hospitality services, but they tended to develop strategies to control their fear and anxiety to catch business opportunities. Therefore, they often pretended that most wellness tourists were the same as 'normal' tourists, only with a few minor health problems.

Our study also highlighted the issue of mobility of cancer tourists. Indeed, although cancer patients can gain significant health benefits from travelling (Hunter-Jones, 2003), they are still in a difficult situation in the tourism environment. Cancer tourists generally attempt to escape their daily communities so as to overcome the psychological stress of not being perceived as an independent and complete person in everyday life, and they hope to live with dignity and regain confidence by travelling to a new, relaxing environment where people are not aware of their illness (Hunter-Jones, 2005). Usually, a remote region away from the city with a good natural environment and a simple lifestyle is chosen as the ideal destination for healing and rehabilitation. However, in reality, cancer tourists cannot be completely free from social discrimination and social exclusion, even in such a therapeutic space, as the public stigma around cancer and the social rejection of cancer patients also occur in the tourist destination. Hunter-Jones' (2004) study also indicated that one important factor preventing cancer patients from participating in tourism is the fear of prejudice, intolerance and hostile reactions in an unfamiliar environment. Nevertheless, in our study, cancer patients came to Bama as tourists because they could hide in the crowd. Presenting themselves as 'normal' people, they made the identity

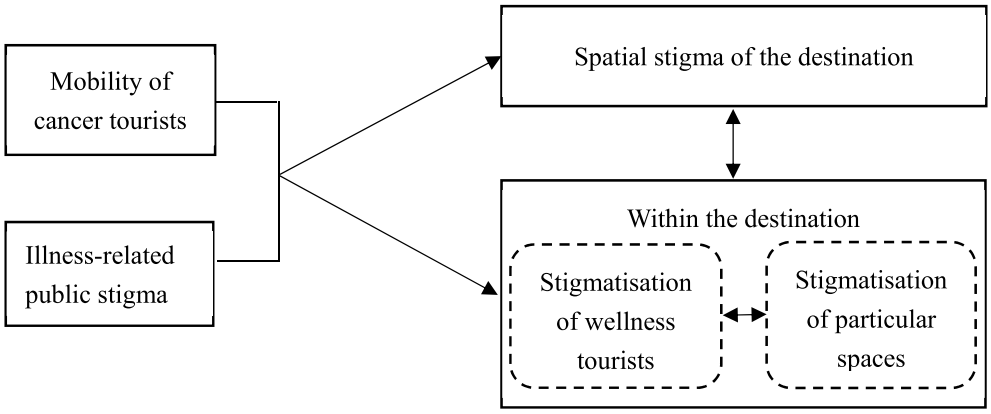

Fig. 3. The negative effects of wellness tourism on a destination.

of 'cancer patient' invisible and were therefore less likely to be accurately identified. In short, Bama acted as an open space in which cancer patients still had some freedom and could practice daily activities as 'normal' people. Appropriating strategies of invisibility was an effective tactic for cancer tourists treated as 'others'. However, it should be noted that they did not achieve real equality, as their true identity was not accepted (Maritz, 2011).

The unexpected negative effects of Bama's wellness tourism were also a consequence of demand-driven tourism development. Bama's advertising as a place of longevity by the media made this remote place well known in China, attracting many wellness tourists. However, Bama was not prepared for this situation. First, no relevant development plans and regulations for wellness tourism were formulated before the massive influx of wellness tourists. Second, as a marginalised place, Bama had little tourism infrastructure (e.g., sewage treatment works, waste treatment plants, etc.). Third, the residents lacked proper knowledge of medical requirements and care, resulting in misunderstandings between them and wellness tourists.

6. Conclusion

Using the concept of spatial stigma, this study explored the dark side of wellness tourism, particularly because of the stigmatisation of tourists with fatal illnesses. Arriving as 'dark tourists' to wellness tourism destinations, these patients brought with them stigma. Local people revealed complex experiences, emotions and attitudes to these negative consequences. They suffered from discrimination by outsiders, but they still supported wellness tourism because of their high economic dependence on tourism. While local people may verbally deny and oppose their place-based stigma, they internalised it because they were deeply concerned about the negative effect of this stigma on themselves and their hometown. Therefore, they tended to socially and physically separate themselves from potential cancer patients and the places they frequented.

This study makes the following contributions to the literature. First, as few studies have investigated the negative effects of wellness tourism, this study is a first step towards a better understanding of the negative effects of wellness tourism through the eyes of host residents. The stigmatisation of cancer tourists can be found in wellness tourism, where care is especially needed. Second, this study contributes to the body of work on the complex relationships between 'dark tourists' and local residents (Deery, Jago, & Fredline, 2012). The reason residents perceive the effects of tourism positively or negatively is related to the power-dependence relations between tourists and themselves (Ap, 1992), and the balance of power between 'dark tourists' and local residents is always relative. Although 'dark tourists' are considered a source of trouble for local people, they can stay there as tourists because of their economic power, yet local residents can also use their jurisdictional power as locals to socially and spatially discriminate against these tourists. Third, this study makes a contribution by applying the theory of spatial stigma to the tourism context. Previous studies on spatial stigma have focused on the stigmatisation of a fixed place caused by political, economic or racial reasons, gradually infiltrating the daily lives of local people (Sampson & Raudenbush, 2004; Wacquant, 2007). Our study argues that spatial stigma is also dynamic and mobile. By focusing on the stigmatisation of a tourist destination caused by the mobility of cancer patients, this research connects the idea of mobility to spatial stigma studies in the mobility context.

The study has several practical implications for wellness tourism. First, there is a need to raise public awareness that wellness tourism always includes both sick travellers and healthy travellers. Thus, wellness tourism destinations are different from other destinations in that social responsibility for care and empathy must be developed, delivered and managed. Second, the fundamental reasons for the public stigma of cancer are due to fear. Thus, local governments should take an active position in wellness tourism to change the attitude of local residents towards travellers with illness, from fear to care. Local governments should develop strategies to integrate the care component into the planning and management of wellness tourism destinations. In doing so, local governments should not only take effective measures to manage negative environmental consequences, but also bring knowledge to help local people provide services to wellness tourists. Finally, there is a need for the central government to incorporate these supportive themes into the national health system and change the public's attitude towards illness and care.

This research is not without limitations. First, the interviewees were not selected proportionally by gender and age group. As the field investigator was a young woman, female interviewees were more willing to take part in the interviews and share their attitudes towards and feelings about stigma. Thus, more women than men were interviewed. In addition, people aged 30 to 39 were the main service providers and decision makers in the local families. Most younger people were away from home for school or work and many older people had language barriers. No significant gender differences were found. However, there may be differences between age groups with respect to their attitudes towards patient travellers. Finally, Bama's stigma was mainly caused by the mobility of cancer patients, but cancer patients' perceptions and experiences of this spatial stigma were not investigated. Therefore, future research should investigate how wellness tourists and other tourists respond to spatial stigma.

Author contribution

Study design and Conceptual development: Ke Wang, Honggang Xu, Acquisition of data: Ke Wang, Analysis and interpretation of data: Ke Wang, Honggang Xu, Drafting of manuscript: Ke Wang., Critical

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