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**“(De-)Stigmatisation? Disability, Disorders, and Illness in
Austrian AHS ELT Coursebooks, 1980-2020”**

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Abbreviations

AHS: allgemeinbildende höhere Schule (=non-vocational secondary school)

LS: lower secondary

US: upper secondary

HL: health literacy

FHL: functional health literacy

IHL: interactive health literacy

CHL: critical health literacy

S-CHL: stigma-sensitive critical health literacy

HLS-EU: European Health Literacy Survey

ÖPGK: Österreichische Plattform Gesundheitskompetenz (=Austrian Health Literacy Alliance)

SDOH: social determinants of health

JHA: JustHealthAction (=NGO)

ELT: English language teaching

CLIL: content-and language-integrated learning

WHO: World Health Organisation

TESPW: The English-Speaking World

ETWO: English the World Over

GB: Getting Better

MIW: Meanings into Words

MYWWE: Make Your Way with English

MYWA: Make Your Way Ahead

PT: Prime Time

IE: Into English

EiC: English in Context

W2G: Way2Go

comp.: Companion booklet/ Part 2

1. Introduction

(Health-)Stigma has accompanied humanity for a long time. It generally entails a “mark [...] to differentiate and separate marked individuals (“them”) from unmarked individuals (“us”)” (Fudge Schormans 2014: 6336), producing stereotypes, prejudice, and discrimination (cf. Sheehan et al. 2016: 10), which are bound to evolve together with notions of stigma attributes (cf. Earnshaw et al. 2022: 238). Yet critical reflections on this process, its negative implications for individuals and marginalised groups in the light of societal power relations were only established fairly recently since the mid-20th century (cf. Goffman 1963; Durkheim 1895). An essential factor in such considerations is representation, which can considerably influence processes of such (de-)stigmatisation and (in- or) exclusion (cf. Fleras 2011: 3). This applies to different audio-visual mass media, such as the television, and social media, but also printed formats, such as the news, and literary texts, all of which frequently carry dominant stigmatising and essentialising textual and visual narratives of devalued groups. Educational materials, such as ELT coursebooks, are also not out of the equation. They not only draw heavily on these previously mentioned authentic sources, but also themselves are complex, not neutral “cultural artifacts” (Gray 2000: 274) as well as sites of power struggle, which also mirror dominant ideologies and societal trends (cf. Gray 2010: 24). Previous coursebook research on racism and ethno-centrism (cf. Liu 1998; Neil 2004), sexism and gender bias (cf. Tajeddin, Janebi Enayat 2010; Levine, O’Sullivan 2010; Lopriore, Vettorel 2013; Aydınoğlu 2014; Alter, Köffler 2021) and disability representation (cf. Kow Yip Cheng, Biglar Beigi 2011) in international ELT coursebooks has emphasised this. Though progress has been made especially since the post WW period with regards to discrimination-awareness of these groups, problematic content is still to be found in many ELT materials.

Similar implications also apply to my own personal observations regarding the (stigma-sensitive) representation of people with various disabilities, disorders, and illnesses (especially terminal ones) in Austrian AHS ELT coursebooks over the past few years. (Austrian) ELT is commonly enhanced through the discussion of several social justice issues, such as gender equality, as well as feminist and humanitarian concerns. Yet health equity and stigmatisation appear to not be of great importance, though these topics would fit well into ELT’s increasing focus on health education and health literacy ever since the 1970s. Furthermore, significant policy changes took place in the educational sector then, not only enabling greater access to secondary education for people across the socioeconomic spectrum, but also providing students with free-of cost coursebooks (“Schulbuchaktion”), adapted to the thoroughly revised and modernized curricula, and produced by the state (cf. Pham Xuan 2019). This time was characterised not only by considerable societal changes and movements (such as 1968 counterculture movements, alongside civil and disability rights movements), but also by the advent of the ‘health literacy’ (HL) concept (cf. Simonds 1974), which gradually impacted (public) health education (Okan et al. 2019: xxii). It first considered primarily the functional dimension of health-

information processing skills and was later expanded to include ‘critical health literacy’ (CHL) (cf. Nutbeam 2000: 259). This third and newest HL subtype has generally directed the focus towards community and society health, deeper reflections on health-related information itself as well as social determinants of health in the larger context of health equity (cf. Nutbeam 2000: 259). Though it **came** into being in the 2000s, some predecessors of CHL in the context of critical reflection on health action can be observed in some 1980s coursebooks with a social justice focus, according to my initial analysis of coursebooks, which was initially propelled by the use of more recent coursebooks (from the 2010s and 2020s) during my teaching practicums.

In one of these coursebooks, namely from the 2020s (W2G 8), I have noted a striking shift towards discussing mental health issues and related stigma in terms of functional and critical health literacy. However, contrary to my assumptions that stigma-sensitive CHL would by then be enhanced, the discussion did not involve specificities on the variety of predominantly stigmatised mental disorders, such as personality disorders (cf. Sheehan et al. 2016) or tasks to foster social advocacy skills, one of CHL’s based curriculums (cf. Mogford et al. 2010: 7). Additionally, I have also briefly found textual and visual representations of other commonly stigmatised disabilities and terminal illnesses to differ only little since the 1980s. These groups, according to studies, are still commonly stigmatised in society, with substance use and mental disorders (cf. Barry et al. 2014: 1270) being more stigmatised than many disabilities, such as intellectual disabilities (cf. Pelleboer-Gunnink et al. 2019: 2), or terminal illnesses and death itself (cf. Kang 2021: 317). Simultaneously, other innovative research in the field has indicated promising stigma(tisation)-reducing effects of activities fostering critical health literacy within a social justice curriculum in primary, secondary (cf. Mogford et al. 2010: 6) and tertiary education (cf. Okan et al. 2019: 22-28). Additionally, the general necessity of stigma-sensitive education has been recently pointed out by Earnshaw et al. (2022), who particularly emphasize the vulnerability of children and adolescents with regards to being stigmatised by friends, family, teachers, and healthcare providers (cf. 239). This is due to their still insufficiently developed “coping skills, self efficacy and social power” (239), which sets this “sensitive period” (239) apart from other life phases generally characterised by increasing stigmatisation resilience and coping mechanisms (240).

Considering all of these factors, as well as the power of language to influence stigma (cf. Gernsbacher 2017; Botha et al. 2020) and the generally fairly recently reported surprisingly low-levels of health literacy (HL) within the Austrian adult population (as found in the first European Health Literacy (HLS-EU) survey in 2011/ 2012) (cf. Nowak et al. 2019: 453), despite the implementation of a greater HL (“Gesundheitskompetenz”) focus in Austrian primary and secondary school curricula since the mid-1990s (cf. AHS curriculum 1995: 7625), an investigation into ELT coursebooks of the past 40 years needs to be conducted to seek to understand developments and their implications for future teaching. Put more concretely, this process will revolve around two main research questions, which

concern both the stigmatising attitudes of ELT coursebooks themselves as well as evolving stigma-sensitive CHL (S-CHL) task design:

1. In which ways has the representation of stigmatised people with disabilities, disorders and terminal illnesses changed in Austrian AHS upper-secondary ELT coursebooks over the past 40 years?

1.1 How do coursebooks themselves encourage or discourage health-stigmatisation in their units?

2. How is students' S-CHL fostered in corresponding tasks in these coursebooks?

2.1 How are students made aware of processes of de-stigmatisation and their personal roles in them?

To answer these questions a certain approach was used, outlined in the next section.

As this thesis is concerned about the broad overall topic of health-stigmatisation of people with disabilities, disorders, and terminal illnesses in Austrian upper secondary ELT coursebooks over 40 years, the analysis process included several phases: After initial investigations into various ELT coursebooks, which presented interesting material for analysis, as well as into previous research on the topic, literary considerations with regards to the concepts of health-stigmatisation, (teenage) health literacy, disabilities, health disorders, terminal illnesses as well as the production and implementation of ELT materials and Austrian curricular developments ensued as a theoretical basis. Secondly, coursebooks were researched and selected in the online catalogues of both the Austrian National Library (search.onb) and the library of the University of Vienna (usearch), using 'Englisch', 'Lehrbuch', 'AHS', 'Unterricht', 'Sekundarstufe I & II' and the years ranging from 1980 to 2020 as filters for both lower- (LS) and upper-secondary (US) coursebooks. Thirdly, after collecting physical copies of complete coursebook series for the LS¹ and the US², a total of 106 (LS: 50, US: 56) coursebooks, including companions and workbooks, were scanned for the key concepts of 'health', 'illness', 'discrimination', 'disability', 'disorder', 'marginalization' and 'stigma'. They were then compiled into a list resembling a corpus and quantitatively and qualitatively analysed with regards to word frequency, stigma awareness in the topic context, definitional variations and coursebook positioning in order to understand general tendencies over the past decades and facilitate hypothesis and research question development. (Here, the brief investigation into the LS coursebooks was added to facilitate greater understanding of stigma-related developments for US materials, as they are interlinked within the language learning process.) After that, further selection of US coursebooks ensued with regards to concrete findings of (non-)stigmatisation and S-CHL fostering tasks, which formed the basis of the main material analysis following critical discourse analysis.

¹ LS: *Hallo Girls, Hallo Boys, Ticket to Britain, Your Ticket to English, More, Red Line, The New You & Me*

² US: *The English-Speaking World, English the World Over, Getting Better, Meanings into Words, Make Your Way with English, Make Your Way Ahead, Prime Time, Into English, English in Context, Way2Go*

Critical discourse analysis (CDA) lends itself as a methodological basis for the diachronic analysis, due to the complexity and longstanding entrenchment of health-stigma as a social issue. This is because CDA is a “form of critical social science geared to a better understanding of the nature and sources of social wrongs, the obstacles to addressing them and possible ways of overcoming those obstacles” (Fairclough 2010: 235). Furthermore, it is also interested in power relations between society and discourse, which is also of great value to the ELT context (cf. Kazemi et al. 2017: 227). Thus, Fairclough’s (2010) four-stage approach was used to guide the work process, consisting of identifying a “social wrong in its semiotic aspect” (stage 1), “[i]dentify[ing] obstacles to addressing the social wrong” (stage 2), “[c]onsider[ing] whether the social order ‘needs’ the social wrong” (stage 3) with regards to power struggles, and finally, “identify[ing] possible ways past the obstacles” (stage 4) (235-239).

After critical considerations of analysis findings, general recommendations for future S-CHL sensitive ELT material development were formulated. These were paired with a personally created exemplary S-CHL fostering US ELT materials revolving around Down Syndrome, of one of the health-stigmatised groups found to be underrepresented in the analysed coursebooks. *Just Health Action’s* (2004) CHL framework (outlined in p. 30-31) focusing on the social determinants of health and social advocacy skills alongside critical pedagogy were used as approaches for material development. Though developed materials arguably have a rather subjective, narrow focus on only one group, they provide tentative ideas for innovative S-CHL teaching in the Austrian ELT context, a realm that needs further exploration. Furthermore, these developed materials would need to through additional phases of coursebook development work in the areas of task order, layout, as well as authentic input from people in the Down Syndrome community and piloting in the US AHS context. Despite such limitations, these initial attempts of tackling this complex HL as well as de-stigmatisation and social advocacy skill development in the secondary school context, may propel future advancements in this field.

Next, important terms and definitions will be briefly discussed to clarify basic conceptual understandings. As this thesis will draw on several concepts, it is important to briefly define them here. ‘Stigma’ is generally understood as “social rejection resulting from negatively perceived characteristics” (Sheehan et al. 2016: 10) and leading to “spoiled identity”, according to Erving Goffman’s (1963) conceptualisation. (This also applies to the term ‘health stigma’ in relation to disorders and illnesses.) Stigma manifests itself in three ways, namely stereotypes, prejudice, and discrimination and on various levels within society (cf. Kosyluk et al. 2016: 325). ‘Processes of de-stigmatisation’ are intent on reversing stigmatising individual or societal attitudes towards marginalised groups, achieving greater awareness for misconceptions and myths surrounding them as well as working towards stopping tendencies of social exclusion. This is closely linked to a subtype of ‘health literacy’, namely ‘critical health literacy’, which, for this thesis, takes on a specific stigma-

sensitive focus in addition to its social justice concept. For a more concise text, I have abbreviated it as S-CHL. (Other abbreviations, such as coursebook titles, which are listed on after the table of contents, also occur throughout the text.)

Since there is significant conceptual overlap between the three investigated groups, their individual understandings for this thesis must also be briefly outlined. ‘Disability’ is arguably a very broad, scholarly contested (e.g., Barnes 2016; Linton 1998) and complex construct, which from a purely medical point of view (one of many other perspectives on the topic) frequently encompasses ‘disorder’ and ‘terminal illness’ (Altman 2001: 100). Due to organisational constraints and research purposes of the thesis these terms are separated. ‘Disability’ is used here to refer to people with (non-)congenital constraints with regards to communication (e.g., muteness, deafness), visual (e.g., blindness) or mobility (e.g., cerebral palsy) or people with chromosomal conditions, such as Down Syndrome (Chong-Ming 2018: 978). But also, autism spectrum disorder is included here (for organisational purposes), though there have been inconsistencies in its not-uncontroversial definition as a developmental disability (cf. O’Reilly et al. 2015: 253). ‘Disorder’ is applied with regards to mental disorders: The first is concerned with addictive substances, such as drugs. Due to stigma-sensitive language purposes (cf. Kelly et al. 2016; Volkow et al. 2021) they are now frequently termed ‘substance use disorders’ (e.g., drug use, nicotine use and alcohol use disorder). Additionally, mental disorders, (e.g., eating or body dysmorphic disorders), as well as mental health problems (e.g., depression and anxiety) are also assigned to the overall disorder concept. People from these stigmatised groups will be addressed through alternations of person- and identity-first language, following current recommendations for respectful, stigma-sensitive language use (cf. Dunn, Andrews 2015: 261).

To have greater insight into the implications of the findings of the upper-secondary, tendencies of the lower-secondary from the 1980s until the 2020s need to be considered briefly. Naturally, levels of content complexity are not comparable between the two, as they are in an interrelated, chronological relationship with regards to the ELT curriculum. Some interesting similarities and differences can be found with regards to general visual and textual representational trends of the three groups (see figures 7 and 8, in appendix p. 3-4) disabilities, disorders, and terminal illnesses.

It appears that a greater variety total of disabilities is included in the lower-secondary, already in the 1980s and 1990s, decreasing in the following two decades. This contrasts with the upper-secondary, which barely discusses them before the 2010s. With regards to chronic illnesses, such as liver and heart disease, diabetes, AIDS, US books show more frequent mentions in the 2010s, but otherwise they are comparable in their lack of prior representation. Such tendencies also apply to terminal illnesses, which apart from seldom cancer mentions, are virtually non-existent in both levels. Further differences are also observable in the realm of substance use disorders, such as alcohol and drugs, which are only mentioned in LS books of the 2000s, coinciding with the teenage ecstasy crisis, which

was dealt with more extensively in US books, concerned about the general teenage drug epidemic since the 1980s. Representation of body dysmorphic, and some other mental health disorders, such as depression and anxiety, appears to be reserved only for US coursebooks since the late 2000s and early 2010s. The only exception is created by the few mentions of eating disorders in the 2000s and 2010s in LS materials. This initial comparison shows that certain societal trends with regards to the visual and textual representation of disability, disorder and terminal illness can be seen in both levels over time. It also applies to lacking representation, which may reflect related processes of exclusion and health-stigmatisation of particular group members, such people with Down Syndrome or personality disorders in society.

As these preliminary findings discussed above do not yet address potentially occurring issues of (de-)stigmatisation of the three groups over time, an analysis of selected US coursebooks was conducted (to be discussed in chapters 3, 4 and 5). Focal points of analysis were potential perpetuation of stigma(-awareness) through language, narratives, content positioning as well as to the presence of activities designed to foster stigma-sensitive critical health literacy, which ultimately aims at detection of and activism against health-stigmatisation. (Due to the scope of this thesis, an analysis of visual elements of representation was omitted, which would present an interesting field of inquiry for future research due to the stigma-perpetuating potential of images (cf. Johnstone, Grant 2018: 37).) In the next chapter the most important theories behind stigmatisation and health literacy, which form the basis for the research, will be outlined.

2. (Health-) Stigmatisation & Health Literacy

This chapter is concerned with defining, outlining Goffman's (1963) concept of stigma in order to not only arrive at an understanding of the complexity of stigmatisation and its implications for media and coursebooks, but also consider forms of (educational) processes of de-stigmatisation in stigma-sensitive language teaching. In the latter sections of the chapter will concern themselves with health literacy as well as its critical type and relate these concepts to health (de-) stigmatisation, media, teenagers and the educational sector.

Stigmatisation (of any kind) is intricately linked to societal labelling processes from an early point onwards: 'Stigma', meaning, 'tattoo' or 'mark' in ancient Greek, indicates a certain process of showcasing unique, religious people or degrading the value of certain people, deemed 'morally bad', namely slaves, traitors or criminals, (cf. Coleman-Brown 2016: 133), by ways of tattooing them with a 'stig', a sharp stick (cf. Stuart et al 2012: 3). Such measures were taken by the Greeks to publicly convey the message that this person, "blemished" or "ritually polluted", was "to be avoided" (Goffman 1963: 9 in Coleman-Brown 2016: 133). In comparison, the Christian tradition later on added "two layers of metaphor" to this: "[T]he first referred to the bodily signs of holy grace that took the form of eruptive blossoms on the skin; the second, a medical allusion to this religious allusion, referred to bodily signs of physical disorder" (Coleman-Brown 2016: 133).

The socially degrading and shameful meaning of ‘stigma’, which is widely known today, started to develop around the time of the late 16th and early 17th century, in the context of mental illness (cf. Stuart et al. 2012:3): Prior to this, during the time of the inquisition, “mental illnesses became linked with sin” and also with alleged witches, as already presented in 1486, in the *Malleus Maleficarum*, also known as the *Witches’ Hammer*. This important text written by an inquisitor, provided instructions on identifying witches and according to Anderson (1970: 69), also delineates a number of mental illnesses from a clinical point of view, which today are diagnosed as schizophrenia and depression. Moving on to the 19th century, physicians commonly believed that “lunacy” was linked to dysfunction in the brain” (cf. Stuart et al. 2012: 4). Over the century, other notions of mental illness, which involved the idea of “hereditary predisposition” as the sole cause of “madness”, as well as the Darwinian understanding of “regression to an earlier, primitive state of mental development” (Stuart et al. 2012: 4), ensued. Additionally, the practice of identifying “morally defective” people via “morphological stigmata, such as pointed ears, stunted growth, and cranial abnormalities” (Stuart et al. 2012: 4) together with ‘degeneracy theory’ were widespread up until WWI, especially among criminologists and within the eugenics movement (cf. 4). These developments not only stopped the early search for treatment, but also encouraged the installation of insane asylums: Since “mental illnesses were the result of a hereditary taint, their control was not a medical problem” and such thinking lead to the belief that they “were inextricably linked to other forms of degeneration, which conferred a broader stigma of moral incapacity on all of its victims” (Shortt 1986: 4 in Stuart et al. 2012: 4). Today, the common understanding of stigma is more based on the sense, initially proposed by the Greeks, “but it is applied more to the disgrace itself than to the bodily evidence of it” (Coleman-Brown 2016: 133-4).

Within the complex field of stigmatisation, it is necessary to consider societal dynamics involved. In the 19th century, Émile Durkheim (1895), a founding figure of the social sciences, initiated a scholarly focus on social marking, deviance, and branding of certain groups within society. This concept was later termed ‘stigma’ by Erving Goffman (1963), a sociologist doing foundational work in the field, mainly analysing texts about people “with physical disabilities or ‘deformities’, mental illness, blindness, deafness” (Carnevale 2007:9-10) and arguing that they (and all other) people are organised normatively by society. This creates difference between ‘normals’, “who engage in discriminatory activities to act on their beliefs”, “which enable[e] them to rationalize that the stigmatized are dangerous” (Joachim, Acorn 2001: 244) and ‘deviants’, which are “tainted and discredited” (Goffman 1963:3) due attributes leading to stigmatisation, such as “character ‘deformities’, or membership in a ‘marginal’ social group” (Carnevale 2007: 10). The former, ‘normals’ tend to not distinguish between the varieties of disabilities or conditions (Strauss et al. 1984: 4) in their practices of stigmatisation.

There are two groups present in any type of stigmatisation setting, the ‘discreditable’ and the ‘discredited’: ‘Discreditable’ are those people who have a potential to be stigmatised, who “possess a

stigmatizing characteristic but have not yet been discredited, mainly because this quality has not yet been fully revealed” (Carnevale 2007: 10). The latter are the ‘discredited’, “those who have been socially judged and marginalised by their surrounding social world” (Carnevale 2007: 10). They switch from possibly regarding themselves as ‘normals’, to experiencing the reality of being different from them, being disrespected, which leads to “feelings of self-hate, self-isolation, depression and/or hostility” (Carnevale 2007: 10). In such a situation, means of social support can still exist in the form of fellow stigmatised peers or a “social sphere within which to feel ‘normal’” (10). Undoubtedly both of these roles can cause much distress within these individuals and their social relationships, thus necessitating coping mechanisms to overcome their challenges. (Joachim and Acorn (2001: 246) visualize these processes, defined by Goffman (1963), concisely (see figure 1.), with regards to the stigma of (in-)visible chronic health conditions.)

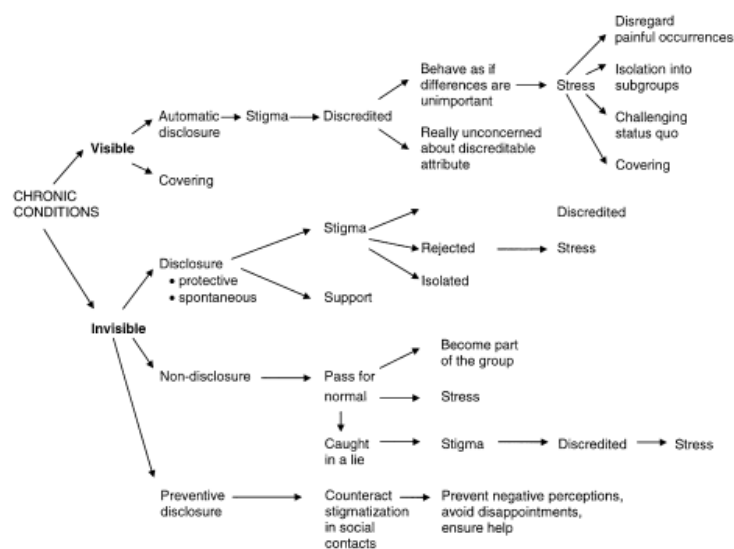


Figure 1. “Stigma and factors that influence disclosure or non-disclosure in chronic illness” (cf. Joachim, Acorn 2001: 246)

In the context of health, Jones et al (1984) also argue that these stigmas can be experienced in six dimensions, expanding the notion of Goffman’s four proposed criteria for different stigmata, namely ‘visibility’, ‘publicity’, ‘obtrusiveness’, and ‘relevance’ (1963: 25): Firstly, ‘concealability’, “the degree to which the condition is hidden or visible”, which is essential since produces “negative social reactions” (Joachim, Acorn 2001: 244). Secondly, the ‘course’ of the condition, “the extent to which the condition changes over time” (244). Thirdly, the ‘strain’ that is placed on relationships through stigmatisation (244). Fourthly, ‘aesthetic qualities’, which determine “the extent to which a condition affects the appearance of a person” (244). Fifthly, ‘cause’ of the stigma, namely whether the condition is congenital or acquired (244). And finally, ‘peril’, “the dangers associated with stigmatized persons” (244). These determinants can lead to various types of stigma experienced on different levels, outlined in the next section.

2.1 Levels and Types of (Health-) Stigmata

Stigmatisation itself can take place on various levels in society. Generally, Goffman (1963) proposes three types of social stigma, found most frequently: First “abominations of the body”, namely “physical deformities” (Ogden, Nyblade 2005: 7), then “blemishes of individual character”, “such as people who are considered to be weak-willed, to have unnatural passions or to be dishonest” (Ogden, Nyblade 2005: 7), and finally, “tribal stigma”, “or stigma relating to race, nation or religion, or membership of a despised social group” (Ogden, Nyblade 2005: 7). Within the context of health (care) and education about marginalised groups, stigmata can occur on various levels, ranging hierarchically from the structural level to the interpersonal and finally individual level, and many layers in between (Link, Phelan 2001: 363). In order to tackle and stop perpetuating these stigmata effectively in the educational system and within society, all of them need to be identified.

Firstly, stigma can take place on a ‘structural’ level. This is a relatively recent concept coined by Link and Phelan (2001), who related the concept of ‘institutional racism’ to this form of stigmatisation (Hatzenbuehler 2016: 2). As previous research has mostly focused on the ‘micro’-level of interpersonal and individual stigma (742), Link and Phelan argue that this new focus on the grander scale of things “sensitizes us to the fact that all manner of disadvantage can result outside of a modal in which one person does something bad to another” (2001: 382). ‘Structural’ stigma “occurs when stigmatic assumptions become embedded in social policies and practices. Through the language of risk, particular groups are identified as “dangerous” (to health, to moral order, to security etc.), which in turn legitimizes myriad forms of surveillance and intervention” (Hannem, Bruckert 2012: 4). In this setting usually not much opposition to this unjust practice happens, due to a “lack of access to resources”, “invisibility”, “a lack of collective will” (Hannem, Bruckert 2012: 5) by those affected and others aware of it. Even from within “intra- group stigmatisation engaged in as a form of identity management by stigmatized individuals is counterproductive to collectively challenging structural form of stigma” (Hannem, Bruckert 2012: 5).

Within the health care context, this type of stigma can “impact availability of services, quality of services, and research”, causing a lack of tools needed for diagnosis and screening (10). Some stigmata-aware doctors even consciously withhold their diagnosis of a specific condition, in order to protect their patients from being labelled with a stigma-evoking condition, as in the case of personality disorders, which appear to be especially stigmatised among all mental disorders (cf. Cathoor et al. 2015; Magallon-Neri et al. 2013), not only publicly, but also among medical staff diagnosed by psychiatrists (cf. Sheehan et al. 2016: 10-11). Such stigma, which is experienced primarily through staff in health care is called ‘provider’ (Sheehan et al. 2016) or ‘professional’ (Subu et al. 2021) stigma and is especially common in persons with mental illness (cf. 9). For example, people with personality disorders may experience differential treatment and ‘perceived discrimination’ (10). In such contexts, “[s]tigma may [...] discourage people from seeking and continuing treatment” (Sheehan et al 2016:

10). Lastly, ‘structural’ stigma is intricately linked with ‘institutional’ stigma, which also can be spread throughout various institutions, such as health care facilities and schools. In both realms, these stigmata can be “reinforced by legal frameworks, public policy, and professional practices, thereby becoming deeply embedded in society” (Subu et al. 2021: 2). Similarly, in the educational context, health-related stigmata can (unintentionally) be perpetuated by educational policies, materials, and teachers themselves, which is why awareness needs to continuously be raised on the issue, requiring close monitoring by all participants and changes through leadership. Such implications are also intricately linked with the factors of ‘public’ and ‘social’ stigma.

A second type of stigma is that on the ‘public’ or ‘social’ level, which impedes or entirely blocks a stigmatised individual’s personal goals, regarding housing, occupation, social participation (Subu et al. 2021:8) among other activities in public life. Even non-stigmatised people, who have close relationships with them, may experience ‘courtesy’ or ‘transferred’ stigma, as a “collateral punishment of association with a [...] marginalized person” (Hannem, Bruckert 2012: 4).

Thirdly, there is stigma at the ‘interpersonal’ level, which has been deemed “[o]ne of the most interesting and least understood or researched areas related to social stigma” (Crocker et al. 1998: 538 in Hebl, Dovidio 2005: 156). It “refers to interactions that occur between the stigmatized and the non-stigmatized” (Hatzenbuehler 2016: 2) and “direct or enacted forms of stigma, such as verbal harassment and/or physical assault based on one’s social identity” (Link, Phelan 2001: 378). As these two parties interact, “the stage for the expression of bias” is set (Richeson, Shelton 2010: 279), which also incorporates psychological and socio-cultural components (cf. 279).

In the context of such ‘intergroup contact’, most theorists (e.g., Fazio 1990; Dovidio, Gaertner 2004) agree that for the non-stigmatised person a direct expression of implicit biases is rare (cf. Richeson, Shelton 2010: 281). Instead, a subtle expression combined with a certain personal attitude, influenced by prejudice, as well as emotions, such as anxiety (281), corresponding with the underlying social setting (cf. 279) is more likely to occur. However, even if this person is intent on responding without prejudice, this can “result in paradoxical behavioral outcomes” due to high cognitive involvement and “contribute further to inconsistencies between non-stigmatized group members’ verbal and non-verbal behaviors” (282). This ultimately may end up in a biased expression after all, causing confusion for the stigmatised person as spontaneous utterances shine light onto various implicit biases (279).

The stigmatised person, on the other hand, may also adapt to the given levels of prejudice he/she expects from the other interlocutor, leading to a focused “detection of their partners’ biased behaviors” while also heightening “the extent to which their partners’ ambiguous behaviors will be attributed to prejudice” and minimizing “the extent to which they can behave in positive, affiliative ways during the interaction” (285). (Conversely, the stigmatised person can specifically utilize strategies for compensation, such as smiling, or contributing to the conversation more actively, which at times “can create smooth intergroup interactions” successfully (286).) Thus, the detection of implicit biases is

essential in order to work towards more effective intergroup contact and avoid ‘interpersonal’ stigma. (Harvard’s *Project Implicit* is currently doing promising research on biases, using tools designed to measure and educate participants on their implicit biases towards societal groups, such as ‘race’, ‘sexuality’, ‘disability’ (cf. implicit.harvard.edu). However, stigmatised individuals may also internalize perceived stigma, resulting in ‘self-stigma’.

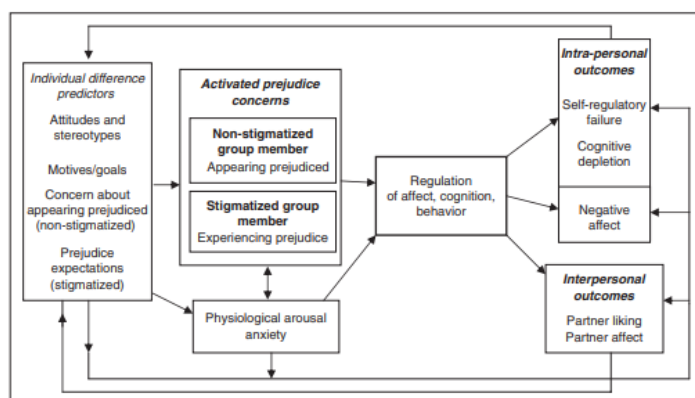


Figure 2. “A relational model of intra-personal versus interpersonal interaction outcomes” (cf. Richeson, Shelton 2010: 287)

Finally, ‘self’ or ‘internalized’ (cf. Ahmedani 2011) stigma occurs in people affected by stigma, and internal change takes place: When they finally accept stereotypical notions of their respective condition as it is presented in their cultures, self-stigmatisation occurs, leading to a lowered self-esteem as well as issues with identity, disempowerment, depression and neglect or complete refusal of treatments (cf. Sheehan et al. 2016: 10). These factors need to be addressed carefully by medical staff as they can very negative effects for the individual’s health (Subu et al. 2021: 8). As people who self-stigmatize learn to adapt to various situations, “anticipated stigma” can occur, meaning that it “leads marked individuals to manage their identities through non-disclosure or selective disclosure, to withdraw from social engagement or avoid potentially embarrassing situations” (cf. Hannem, Bruckert 2012: 4). Essentially, “stigma consciousness is stigma’s “hidden” cost in that it colours individuals’ interpretations of their daily interactions and effects their way of being in the world” (cf. 4).

Looking aside the basics of stigma, stigmatising narratives and representations of discriminated groups in various media need to be critically considered, as they may be breeding grounds for stigma and/ or may perpetuate it.

2.2 Concepts & Narrative Models of (Health-) Stigmatised Groups

Over time media analysis findings (e.g., Clogston 1990) have led to the development of narrative tendencies or ‘models’ to describe portrayals of health-stigmatised groups, which are outlined in this section. Research efforts have mostly centred around rather “stereotypical framing”, of interest to producers whose own attitudes “are filled with shared beliefs... most of them are misinformed, deeply prejudicial beliefs” (Wipond 2013: 256 in Jones 2019: 335), resulting in negative depictions with all across various media forms (cf. Donaldson 1981). Closely related to models of disability (to be explained shortly), they are the ‘medical’ (or ‘consumer’), ‘social pathology’ and ‘supercrip’ model: The ‘medical’ model revolves around “persons, who are disabled [...] [and] dependent on health professionals for cures or maintenance” (Clogston 1990: 7.), essentially, they can be seen as a “marketable consumer base” (‘consumer’ model) (Jones 2019: 335). Next, the narrative model of ‘social pathology’ occurs when PWD “are depicted as disadvantaged and have to turn to the society for support” (Clogston 1990: 8). Finally, the ‘supercrip’ model is intent on presenting in people with “unexpected accomplishments or [...] a normal life just like people with no disabilities” (Clogston 1990: 9). While this model is becoming increasingly popular, it is important to note that it might offend some people, who do not wish for their disability or condition to be the sole cause of being seen as ‘courageous’ or ‘inspirational’ (cf. CDC Disability Factsheet n.d.).

These narrative models also correspond to theoretical understandings of disability, though different terminology is used here. They, too, have power to influence social conceptions of disability, as they “define disability, determine casual and responsibility attributions, influence professional practice, drive payment systems, and guide legislation” as well as “serve the structure for rehabilitation and disability research development, providing the rationale for the funding of large studies” (Smart 2009: 3). Thus, these conceptions too need to be analysed within educational material definitions of disability, as limited, singular notions of disability prevent the potential diverse models of disability have, which can be “both strengthening and enriching [...] human-made representations of reality” (Smart 2009: 3). Viewed in a broad sense there are three models, which very much also can be applied to various disorders and illnesses, as they are often regarded as undesired by society.

Firstly, the ‘biomedical’ model, which is the second oldest and prestigious model and focuses on “pathology” or “deficit orientation” (cf. Wright 1991 in Smart 2009: 4) and makes disability (or illness and disorder) appear as an “objective, standardized entity” to be “classified, quantified, measured, and standardized” (Smart 2009: 4). A long list of criticism of this model, which has been accused of birthing the inherent marginalization and discrimination of people with disabilities as well as causing “fragmentation of the [...] community into rival factions identified by their medical diagnosis” (Smart 2009: 4), also includes, “its failure to adequately respond to the changing definitions of disability”, ultimately causing fear of “acquiring a disability in spite of the fact that disability is a common, widespread experience” (5) in the general public.

Secondly, the ‘functional’ model defines disability as societal “role failure” of an individual and is “considered to be an “interactional” or “ecological” model of disability [...] defined as a three-way interaction between the individual, the disability, and the functions of the individual” (6). Criticism includes concerns that this model places too much value on its economic components, possibly causing further discrimination against disabled, similar to the ‘biomedical’ model (cf. 6). Finally, in the ‘sociopolitical’ model (cf. 3), “the disability is not seen as the identified “problem” and therefore neither individuals nor their disabilities are the focus of intervention or treatment. Rather the “problem” of disability is the lack of civil rights, and unequal opportunity that consigns an individual with a disability to a life of reduced opportunity, inferiority, and marginalization” (7). As this model is the most recent one, is based on the civil rights movement of the 1960s and sees disabilities as “politically manipulated categories”, it has the biggest strengths among the other models: Firstly, it is the most authentic presentation of disabled people (or with illnesses and/or disorders) and their daily lives, as they experience a lack of access to opportunities due to being stigmatised (cf. 8). And secondly, it can unite people with disabilities in their diverse conditions and mobilize them to take action (cf. 8). Among the more detailed models, there are the ‘moral’ or ‘religious’, the ‘social’, the ‘identity’, the ‘human rights’, the ‘cultural’, the ‘charity’, the ‘economic’ and the ‘limits’ model (Retief, Letšosa 2018: 1-7). All of these models need to generally be taken into consideration, but also in relation to analysing the potential progress of stigmata-sensitive representation of people with disorders and chronic or terminal illnesses within the last 40 years.

In contrast to these models, research on narratives about people with chronic or terminal illnesses in medical literature has opened a broad picture, which comes closer to the diverse realities of these commonly stigmatised groups. (Some of these findings also interrelate with the field of health disorders and disabilities.) With regards to language utilized in specialized literature, an increased sensitivity within medical theorists has become evident over the past 40 years, signalling a greater consideration for the diverse attributes of individuals with chronic and terminal illnesses and possibly issues of verbal stigmatisation. Such findings also have significant implications for health-discourse in other contexts, such as the media or education. In 1985, researchers (e.g., Charmaz 1983; Duval 1984; Bury 1982; Stewart & Sullivan 1982) noted predominantly negative concepts surrounding chronic illness, such as ‘suffering’, ‘loss’, ‘biographic disruption’ and ‘sick role’ (Thorne, Paterson 1998: 175). Yet over the following five to ten years (1990-1995), different vocabulary became prevalent, indicating a change of thought, moving away from a negative, victimizing view towards a more positive, hopeful and individualistic one:

“Some of the powerful images that emerge from this body of research include: being courageous [...], maintaining hope [...], restructuring [...], reframing [...], reshaping or reconstituting self [...], regaining control [...], redefining health [...], finding meaning [...], managing [...], self-transcendence [...], empowering potential [...], transformation [...], normality [...] and discovery” (175).

Though these terms convey overly positive messages, which may not be applicable to individual cases, they do represent a paradigm shift towards more diverse, non-stereotypical representations of the community in medical literature itself.

This is closely related to the view of the “Shifting Perspectives Model”, moving away from a purely medical view towards a patient’s “perspective of the illness in a larger sociocultural and psychological context” (Paterson 2001: 25). Two perspectives exist in this model with regards to the management of illness, namely the “illness in the foreground” as well as “wellness in the foreground” (23). As the terms imply, the former is dedicated to directing one’s full attention to the (newly diagnosed) chronic illness, which may have a “protective, maintenance, or utilitarian function” (Paterson 2001: 23), with regards to the patients’ (social) identity. The latter is concerned with assigning a fundamental role to the self as an identity source, rather than the body (cf. 23), “includ[ing] an appraisal of the chronic illness as an opportunity for meaningful change in relationships with the environment and others” (23). Such a perspective allows patients to be ‘empowered’, moving away from being “a victim of circumstances to creator of circumstances” (Barroso 1995: 44 in Paterson 2001: 24). Factors that can influence such perspective shifts are either various perceived medical and social “threats” (24) posed by the illness for the former, or “renewed hope and optimism” (24) for the latter. Though these views appear paradoxical from an outsider perspective (24), the model itself maintains that the value of individual patient conceptualisations of illness should be especially recognised within the health realm, as they expand predominantly negative illness narratives (24), a tendency which still applies to current times. With regards to health disorders, concepts and narratives are mostly interrelated with the observations mentioned above. However, the field of mental health disorders, such as substance use or personality disorders, frequently differs from these tendencies, since it appears to be primarily associated with violent or irrational behaviour (cf. Arboleda-Flórez, Stuart 2012: 459) throughout the past decades. All of these underlying conceptualisations influence processes of (de-)stigmatisation, not only in the media, but also in the educational setting. The interconnectedness of these factors will be discussed in the next section, which considers them in relation to the ELT context.

2.3 Stigmatisation, Representation, Media and ELT

As mentioned previously, different media can perpetuate stigmatisation of marginalised groups (cf. Lafky et al. 1996: 379), such as people whose physical and/or mental health or disability constitute attributes prone to stigmatisation. Such considerations are especially important, as ELT coursebooks and other educational materials may draw upon these sources and/ or reproduce dominant societal stigmatising narratives. In the following, modes of representation as proposed by Richard Dyer (1988), examples of (de-)stigmatisation across various media as well as relevance and implications for ELT will be considered.

In the context of disability, but also of chronic illnesses and disorders, the concept of representation needs to be considered carefully to understand its relation to the concept of stigmatisation (cf. Hartnett 2000: 26) in the media realm. Though these concepts are grounded in the media realm, they also bear significance for the construction and analysis of ELT educational materials, which draw from various forms of media to provide relevant, authentic materials for language learning. Richard Dyer, a British media theorist, defined four types and components of representation, which are “relevant in the study of the portrayals of the disabled” (Hartnett 2000: 26) within videography. (Through these types are primarily situated within videography and audio-visual media regarding disability portrayal, I argue the basic premises could also be applied to written text and visual materials that deal with the representation of other health-stigmatised groups, such as people with illnesses or disorders.) They are ‘re-presenting’, ‘being representative of something’, ‘representation as speaking for people’ and ‘representation and its meaning for the audience’ (cf. Dyer 1988 in Hartnett 2000: 27).

‘Re-presenting’, is concerned with the way television or other videographic formats ‘re-present’ reality while taking into account that “our perception is always mediated by television’s selection, emphasis and use of technical/ aesthetic means to render the world to us” (Dryer 1988: 3 in Hartnett 2000: 26). With soap operas and other TV formats, for example, there has been a tendency “towards emphasizing the disability over the complete personality of the disabled character” (Hartnett 2000: 26), a rather generalizing, objectifying view that still translates itself into other media, such as children’s books or coursebooks, limiting a more holistic, individualized view of the disabled people.

‘Being representative of something’ is intricately connected with typicality as one “cannot communicate the individuated or the unique, we must always deal with the typical” (27). Thus, stereotypical notions of marginalised groups can be perpetuated by the media, potentially have a negative impact on these groups. Especially stereotypes that focus exclusively on “pitiable, heroic, villainous” characteristics, displayed through the popular roles of the ‘evil avenger’ or the ‘supercrip’ have been widespread within the media discourse of the last few decades, “certainly not the ones that work to the advantage of the disabled” (26), for example.

‘Representation as speaking for people’, is another crucial component of representation within audio-visual media, as it is concerned with the fact that “groups outside mainstream speech” need their share of speak for themselves to be represented authentically (cf. 27). Martin F. Norden’s (1994) overview of disability representation within film over the past century emphasizes this problem arguing that filmmakers’ have continued practices of isolation between the disabled and the non-disabled, “consistent with the way that mainstream society has treated its disabled population for centuries” (Norden 1994: 1):

“[T]hey have often used the basic tools or their trade- framing, editing, sound lighting, set-design elements (e.g., fences, windows, staircase bannisters)- to suggest a physical or symbolic separation of disabled characters from the rest of society. [...] [T]his strategy has a two-fold effect: it

enhances the disabled characters' isolation and "Otherness" by reducing them to objectifications of [...] spectacle- as a means of pandering to the needs of the able-bodied majority, and it contributes to a sense of isolation and self-loathing among audience members with disabilities." (Norden 1994: 1)

To solve this matter of isolation of disabled people, which is "detrimental to the human condition" (Norden 1994: 2), the involvement of the disability community in media production, such as actors, actresses, and writers, etc. must increase together with processes of 'mainstreaming' (cf. 2). This in turn requires paradigm shifts and de-stigmatisation of people with disabilities across the spectrum of society, which will be outlined in the following section 2.4.

Finally, 'representation and its meaning for the audience', focuses on the mismatch between the images of the film (or other forms of visual imagery), which constitute "not necessarily always the same as its 'ideal' meaning, or that intended by those who produced it" (Hartnett 2000: 27), and the "experience of disabled people" (27). Thus, (audio-)visual representations of disabled people as well as of people with chronic illnesses need to be constructed carefully and realistically in order to facilitate processes of de-stigmatisation in the media, which will also have effects on the production of stigmata-sensitive educational materials, such as ELT coursebooks. Or as Berube (1997) puts it: "In the broadest possible sense, it affects our understanding of what it means to be human" (4). This is also reflected in some practical examples of representation below.

Various media have power over stigmatising representations of 'deviant' groups. Or as Heumann et al. (2019) put it: "Media reflects society and society can reflect the media. [...] [T]he media has the potential to create lasting change in the hearts and minds of the public with respect to other minority groups" (1). As educational materials, such as ELT coursebooks, draw on various media as authentic sources and potentially reproduce or dismantle dominant stigmatising narratives, closer considerations of the interconnectedness of society and media are essential in investigating the processes of stigmatisation of disability, disorders and illnesses over the last few decades. (Due to the constraints of the thesis only disability media representation will be outlined, as implications for the other two stigmatised groups are similar.)

In the last 40 years, the representations of health-stigmatised people or disabled people within print, analogue and digital media has changed only gradually, inciting a shimmer of hope about the potential societal developments regarding health-stigmata-awareness and de-stigmatisation to come. While the importance of various media has grown and waned over time, it is certain that stigmatisation has occurred in a multitude of ways through biased media representation and is gradually declining, albeit leaving much room for improvement in the diversity of representation of stigmatised health-groups as well as debunking harmful myths.

The representation of perplex with disabilities in films has remained a contested area, with the most significant number of attributes of disability portrayal happening in 2019, according to a diachronic study analysing Anglophone films from 1918 until 2022. Even then, ‘true’ representation of people in the community was (and is) very low, with approximately 95% of characters portrayed by non-disabled actors and actresses (cf. Heumann et al. 2019: 1). Related negative depictions have included the ‘supercrip’, the ‘immoral villain’ (cf. Hartnett 2000: 21), or the “evil” or “obsessive avenger” (Norden 1994: 112) in the videographic context. Media analysts have deemed such videographic representations “oversimplified and used not for their complexity as people but for their easily identifiable impairment, which is exploited by scriptwriters for dramatic effect, for emotional appeal or for blatant symbolism” (Hartnett 2000: 21), with striking similarities to female character representation criticised by feminist scholars (23).

However, simultaneously some TV shows have taken a different route. For example, BBC’s “See Hear” (1981), the first and longest running TV programme made by and for people in the dDeaf community as well as Channel 4’s extensive broadcasting of the 2012 London Paralympics corresponding with their promotional campaign on disabled athletes (“Meet the Superhumans”). The latter carefully incorporated production team members with disabilities to provide most authentic representation, a positive indicator for inclusion.³ Such examples emphasize the need for inclusive, stigma-sensitive production of content, especially in the midst of political debates, described in the following example.

Disability representation has also become politicised, as seen, for example, in Briant et al. ’s (2013) contrastive print media analysis of UK benefit claimant debates between 2004/5 and 2010/11, the latter of which especially stigmatised PWD. While very few comments attacked PWD themselves (“work-shy people”) (*The Express*, 19th October 2004), “scroungers”, “fraudsters” (*The Daily Mail*, 20th October 2004), most of the focus was dedicated to the “perceived failings of the government and professionals” (Briant et al. 2013: 6) in 2004/5. In contrast, the period between 2010/11 was marked by a drastic change in reporting, which now resumed a “relative decline in sympathetic portrayals” as well as those about “triumph in adversity”, giving way for doubts on benefit recipients as well as for increased trust in and recommendation of the government (cf. 7). This “emergence of the Folk Devil”, as Briant et al. (7) puts it, was accompanied by a decrease in the total number of articles on the marginalization of disabled people (e.g., *The Express* 22.1% to 11.6%) as well as on the needs of disabled people (13% to 9%) (cf. 7). The researchers also argue that these measures were likely to not without effects, since an “increased use of pejorative terms accompanied by misrepresentations of the levels of fraud runs the risk of increasing the already high levels of hostility towards disabled people” as well as “affecting not only perceptions about disabled people, but also the self-perceptions of

³ This also applies for the campaign, even though it followed a ‘supercrip’ narrative, which is not uncriticised by some disability advocates (cf. Silva, Howe 2012: 176).

disabled people” (15). While this example shows the problematic of widespread negative news(paper) representation, the simultaneous advent of widespread social media platforms gives hope for authentic, stigma-sensitive disability representation from people in the disability community itself.

Aside from newspapers, whose usage has started to decline over the past two decades, social media may have a similar, yet even stronger (de-)stigmatising effect while simultaneously creating platforms for stigmatised groups to not only connect with each other, but also speak out and de-mystify their conditions. They fill the gap within other forms of media and often become part of the 6.15% of influencers, who “have an engagement rate of 20% or more” (Nielsen 2022: n.p.). This is not surprising, since 52% of people with disabilities regard TV portrayals of their personal identities as widely incorrect (cf. Nielsen 2022: n.p.) and thus, move on to other platforms, such as Youtube, Facebook, Instagram, among others, to be seen and heard. For example, Alyssa Cleland, an influencer on Instagram and athlete with ectrodactyly and paraxial tibial hemimelia, has 140.000 followers on Instagram, with a 67% rate of engagement in posts. Though lacking middle fingers on both hands and an amputated shinbone, she raises awareness on her own story, lifestyle and goals, debunking stigmatizing myths on her conditions (cf.). Also, people with a variety of other stigmatised health-conditions, such as depression, cerebral palsy. These examples show gradual change for the field of disability, though perceived deficits remain the focus.

Yet in comparison, the group of mental health disorders still appears to be continuously represented negatively, particularly in videographic formats, as outlined below.

When looking at studies done on newspaper reports from both the US and the UK within the last 40 years, some problematic tendencies can be observed: From the 1980s until the 1990s US media coverage on mental illness frequently associated it with notions of violence, danger, and criminal activity (cf. Wahl 2002; Wahl 1992), falling in line with other countries, such as Canada (cf. Day, Page 1986), the UK (cf. Philo et al. 1994), New Zealand (Mental Health Commission 2015) and Spain (Aragonès et al. 2014), who had similar tendencies. Yet such representation was (and is) not accurate for the US context, as “only about 4 percent of interpersonal violence is attributable to mental illness” (McGinty et al. 2016: 1122). The authors instead argue that these stigmatizing measures were taken to strengthen various policies focusing on public safety and gun-laws (cf. 1122), “at the expense of public health-oriented policies designed to foster recovery” (1122). Such reasoning seems highly probable as it fits into the power-construct and community strengthening forces of public stigma discussed previously.

Another grand, diachronic study on stigmatisation of mental illness in US TV news segments and newspaper articles from 1995 to 2014, revealed similar issues regarding claims of violence and mass-shootings (cf. 1123), indicating no change in media stigmatisation, even though the media would have had the opportunity to include stigma-decreasing stories about treatment of mental illnesses (cf. 1126). Such deliberate stigma- increasing news coverage was also emphasized by a 2013 study about news

stories regarding mass shootings and mental illnesses, which indeed dramatically increased social stigma levels of individuals with mental illnesses (cf. McGinty et al. 2013). Within the UK context, the study on stigmatizing newspaper articles from 2008 to 2014, done by Rhydderch et al. (2016), revealed a glimmer of hope amidst the ongoing reports on “specific mental health diagnoses [...] persistently reported in a stigmatising manner” (45). Over time there was a

“significant decrease in the proportion of articles featuring the stigmatising elements ‘danger to others’ and ‘personal responsibility’, and an increase in ‘hopeless victim’” and a “significant proportionate increase in articles featuring the antistigmatising elements ‘injustice’ and ‘stigma’, but a decrease in ‘sympathetic portrayal of people with mental illness’” (45).

These varied examples of differently represented groups emphasize the need for further processes of de-stigmatisation to take place in the media, which also may affect ELT materials, since they frequently draw on various media in order to provide authentic content.

2.4 Establishing Processes of De-Stigmatisation in Language Education: Person- and Identity-First Language & (Imagined) Intergroup Contact

De-stigmatisation needs to not only occur within media and society itself, but also in the educational sector. Especially in the context of language education processes of de-stigmatisation can take root, critically dissecting stigmatising narratives from a sociolinguistic point of view. In the ensuing section several approaches will be outlined in relation to upper secondary ELT, starting with a discussion of stigma-sensitive language use in ‘person-‘ and/or ‘identity-first’ language use and followed by (imagined) ‘intergroup contact’ methods.

Language is a powerful tool, which can influence people’s thinking and mental concepts (cf. Sapir 1949/ 1985; Whorf 1956). Consequently, it can promote or inhibit stigmatisation in various contexts, notwithstanding educational materials. Especially within the public domain, (de-) stigmatizing language is utilized by those in power, seeking to control public discourse, also regarding commonly stigmatised groups, such as people with disabilities, disorders and terminal illnesses. This certainly also has implications for the production of educational materials, such as ELT coursebooks, in which stigmatising ideologies may be reproduced (cf. Gray 2010: 5), also shaping the students’ mental lexicon (cf. 7). Certainly, they can also reflect beneficial societal developments towards de-stigmatisation: One such development, which transformed awareness on stigmatizing language was the distinction between ‘identity-first’ and ‘person-first’ language use. Though scholarly debates about most befitting language to address members of various different communities apart from disability still ensue (cf. Vivanti 2020; Botha et al. 2021), these careful considerations constitute progress towards stigma-sensitive language use, which is essential for speakers (and learners) of any language.

The ‘person-first’ use of language was born out of societal changes in the 1980s and 1990s in the midst of the third disability movement, now characterised by disability self-advocacy intent on changing negative associations with disability in society (cf. Wehmayer et al. 2000: 107). Beatrice W. Wright, the “pioneer in rehabilitation psychology” (Dunn, Andrews 2015: 258), who understood disability to be a social construct and objected dehumanizing language, was influential in further promoting paradigm shifts associated with this new language use in the scholarly realm (cf. 258). For Wright persons, as well as their unique, individual characteristics, were the priority, not their respective disability, thus leading to the term “person with a disability”, instead of “disabled person” (258). This “was believed to preserve disabled people’s humanity while promoting their humanity” (258), lead to deeper reflection about the meaning of the utterance within the speaker and prevent stereotyping as well as objectification of the person (cf. 258). At its core, “[a]ny objectifying or essentializing language creates a related problem in that people with disabilities are often perceived to be victims (e.g., “stroke-victim” or “AIDS victim” rather than “someone who had a stroke” or a “person with AIDS”)” (cf. 259). Consequently, such victimization creates negative connotations about an individuals’ lack of autonomy (cf. 259), which may, in most cases, misrepresent the realities of various disabilities community members. While such language use first was desirable to some theorists in the field, concerns about the very distinction between disability and person have arisen over time, pointing out its potential for promoting a negative, shameful view of disability (cf. 259) (and other issues of disorder and illness), possibly further isolating individuals (cf. Collier 2012: 1977). Still, the influential ‘person-first’ language movement can be argued to have constituted the necessary pioneer move for emphasizing the need for careful considerations about stigma-sensitive language in relation to disability and chronic illness, paving the way for further paradigm shifts of the reconceptualised ‘identity-first’ model.

The ‘identity-first’ model, also called the ‘diversity’ model, has gained popularity in recent two decades and its development was influenced by disability studies and the ‘minority’ model (cf. Dunn, Andrews 2015: 259). ‘Identity-first’ language sees power relations within society, focusing on the “important implications for language use [...] often defined and imposed by the dominant group ignoring the cultural values of the minority group” (259). It regards disability (as well as disorder, or illness) as a “distinct cultural and sociopolitical experience and identity” (259) and as a “neutral characteristic or human attribute- not a medical problem requiring a cure, nor a representation of a moral failing” (259). This latter statement emphasizes how common understandings of this language model have shifted over the past few decades, now increasingly emphasizing its potential for actually ‘empowering’ individuals and groups previously marginalised through the identity-first language (cf. Vivanti 2020: 2), such as disabled people (though preferences vary among across and within many stigmatised communities, such as in that of autism spectrum disorder (cf. Bury et al. 2020)). Group identity is essential for disabled persons (and other (health-) marginalised groups), since it “allows for a sense of belongingness and an expression of collective beliefs and heritage” (259). Additionally, it is

“an expression of pride and is not solely based on the shared experience of oppression” (259) in the midst of a world that is largely unconcerned with disability or illness culture. Central, identity-strengthening aspects are found, for example, in the “use of disability humor; appreciation of human diversity; acceptance of human vulnerability and interdependence as a natural part of life; skill in managing multiple problems, systems, technology and assistants; and a flexible, adaptive, or nontraditional approach to tasks”, sorting out needs in the socioeconomic and political dimension (259). Certainly, other identities intersect with disability identities, which makes careful consideration of terminology necessary (cf. 260) for anyone utilizing ‘identity-first’ language.

As both models have each have drawbacks from the perspective of different communities (such as d/Deaf, blind, Down Syndrome, autism spectrum disorder, and many others) various solutions have been proposed by advocates and scholars alike. For example, the American Psychological Association (APA 2019), the American Speech-Language Hearing Association (ASHA 2020) most recently regard context dependent, respectful compromise between the two variants as an option. For example, they “recommend alternating person-first language with terms such as “disabled” or “disabled people,” but never reverting to monolithic or objectifying terms” (cf. Dunn, Andrews 2015: 261) or using “the term Disabled (with a capital “D”) to signify allegiance to disability culture instead of describing impairments” (261). Another possibility is to adapt terminology to an individual’s personal preferences (cf. 261). Sometimes the even seemingly paradox use of terminology exclusively from within the disability communities can be encouraged: Derogatory words, e.g., ‘crip’, ‘gimps’ and ‘paras’, can “promote a sense of community” and may constitute “ironic or transgressive ways to challenge the dominant (nondisabled) culture” (262), vital for “group cohesiveness” (262). Finally, some scholarly advocates even call for exclusively identity-first language use, as the person-first option arguably increase stigma due to its pointing out of difference (Gernsbacher 2017: 4).

It can be concluded that though different preferences regarding ‘person- first’ and ‘identity-first’ language use exist among various communicators, drifting more towards the latter approach in current times, the underlying emphasis should be on choosing the most respectful, stigmata-sensitive choice, depending on the context. This indeed appears to be the most inclusive option, as it requires close reflection on social issues and interpersonal competence interacting with members of individual communities. ELT materials should mirror such linguistic considerations as they also provide a sound basis for meaningful (imagined) ‘intergroup contact’, another helpful tool for propelling de-stigmatisation.

Various forms of (in)direct interaction with the stigmatised groups can also provide means of de-stigmatisation manifested in attitudinal and behavioural changes via direct or ‘imagined’ intergroup contact, which offer promising ideas also for the ELT context. This can take place in different settings, which provide carefully constructed audiovisual, visual, or verbal means of communication between the deviant and the non-deviant, namely in various media (e.g., cinematography, literature, TV,

newspapers, magazines, advertisements, social media) (cf. Sullivan et al. 2005: 297), within (health) education for different societal groups (e.g., (non-)medical professionals, politicians, teachers, students and many more), or in face-to-face interaction (cf. Pettigrew 1997: 174).

While studies have emphasized the necessity of cognitive involvement (cf. Yuker 1994: 3), namely learning theoretical knowledge ‘debunking’ stigmatising attributes of the stigmatised groups, it is only the basis for further work towards de-stigmatisation, which at some point should also address affective components to consolidate the message against stigmatisation. Within an educational context, this cognitive-affective interdependence appears to be particularly important with regards to processes towards de-stigmatisation (cf. Marquart 1983: 130). Thus, aside from providing a theoretical knowledge basis on social implications of stigma and behavioural considerations towards de-stigmatisation, it is necessary to include authentic voices from stigmatised communities themselves and consider personal experiential dimensions, via ‘imagined’ and ‘intergroup contact’.

Since different social groups commonly hold various prejudices towards each other, it is necessary to deconstruct such attitudes and beliefs carefully within interaction. Such is the basic premise of US psychologist Gordon Allport's (1954) foundational “intergroup contact hypothesis”, which considerably influenced corresponding research over the next decades: In more recent times, the complex field of intergroup communication research has come to attribute greater value to stigmatisation implications and especially the individual experiences of stigmatised group members in such interactions (cf. Richeson, Shelton 2010: 277), whose complexity was already outlined in relation with interpersonal stigma. Though this form of communication may be challenging for all participants due to differing personal attitudes, beliefs or simply the novelty of the situation itself, the thereby likely resulting increased mutual understanding can frequently influence de-stigmatisation effort outcomes positively as shown by plenty of research done in the field (e.g., McClendon 1974; Plant 2004; Brown & Hewstone 2005). Even online contact between both groups can contribute to this effect, according to a study on mutual empowerment and de-stigmatisation between athletes and audience through “social sharing of emotions” in YouTube videos done by disabled athletes (Matson-Barkat et al. 2022: 77). For the most effective path of health de-stigmatisation, it would be ideal for such intergroup interaction to take place in the educational setting itself (cf. Koslyuk et al. 2016: 325). However institutional and organizational constraints may impede its implementation alongside teaching requirements.

Thus, an indirect variant may present an equally effective option in such interventions: “By activating [...] automatic and deliberate processes that occur during *actual* contact, imagined contact should have the same positive effects on outgroup evaluations” (Cameron et al. 2011: 709). Though such “mental simulation of social interaction with a member or members of an outgroup category” (Crisp et al. 2008: 8) both adults and children alike can experience a reduction of intergroup bias according to a study done by Cameron et al. 2011 (715). Here segments of individual imagined contact based on

visual and textual input regarding imaginary disabled friends were investigated among pre-school children. Such findings may also have positive indications for older children and teenagers in a high school context, or more specifically in the ELT context. For example, extracts from authentic young adult (YA) literature written by about or by people from health stigmatised communities, such as disabilities, disorders, or illnesses, can be used as a basis for such considerations (cf. Richmond 2014).

Naturally, these endeavours also need basic health information on these three groups to enable students to interact or imagine the interaction with the stigmatised group, which is where health literacy skills also become necessary. In this a context, all three levels, functional (FHL), interactional (IHL) and critical health literacy (CHL) come in handy. Especially stigma-sensitive critical health literacy (S-CHL) is essential for de-stigmatisation purposes, since students' focus expands towards critically understanding health needs of others, social determinants of health as well as engaging in processes of stigma-sensitive social advocacy within communities. For achieving this in the educational context, the curriculum also plays an important role.

Though the Austrian upper secondary AHS curriculum does not address instruction on health-stigmatisation directly, the general educational guidelines for language subjects over the past two decades have increasingly emphasized the need to develop students' social and intercultural competences in line with tolerance, and awareness on discrimination and cultural stereotypes. Furthermore, greater comparative reflection on various languages within a holistic learning setting are the main objectives, which would lend themselves to linguistic stigmatisation considerations in ELT. Thus, there still is room for greater health-stigma-aware education in the curriculum. Such could be achieved through expanding health-stigma considerations the concept of critical health literacy (CHL) in educational settings, such as ELT. The following sections will outline key factors of the general and the critical health literacy concept and relate them to stigma-sensitivity within (Austrian) secondary school ELT.

2.5 (Critical) Health Literacy: Concepts, Teenagers, Media

Health literacy is not only a crucial factor for living healthily and making sound health-decisions, but it is also necessary for critically considering societal health-issues, such as ongoing health-stigmatisation. In the following pages, (critical) health literacy will be defined and then discussed with regards to society, teenagers and their health-information seeking habits. Furthermore, the link between CHL and (Austrian) secondary education, its curriculum, as well as implications for fostering it in a (health-) stigma-sensitive ELT context, which are relevant for the ensuing coursebook analysis and consecutive material development, will be chronologically explored.

The term of 'health literacy' was first coined in 1974 as the connection between health education and the health system was discussed (cf. Simonds 1974: 2)), starting a movement that would conduct broad research primarily in Anglophone countries (cf. Paasche-Orlow; Wolf 2007; Rootman, Gordon-

El-Bihbety 2008; Adams et al. 2009; Buchbinder et al. 2011; Sorensen, Brand 2013). Since some theorists deem this term to be a “repackaging of a number of other important concepts central to the ideological commitments, and the theory and practice of health promotion” (Tones 2002: 287 in Sykes et al. 2013: 1), discussions about its potential definitions abound: What is generally acknowledged is, that health literacy at its most basic level, is intricately connected to “general literacy” and its various related forms depicted in Rootman and Ronson’s (2005) “Framework for Health Literacy” (see figure 3.).

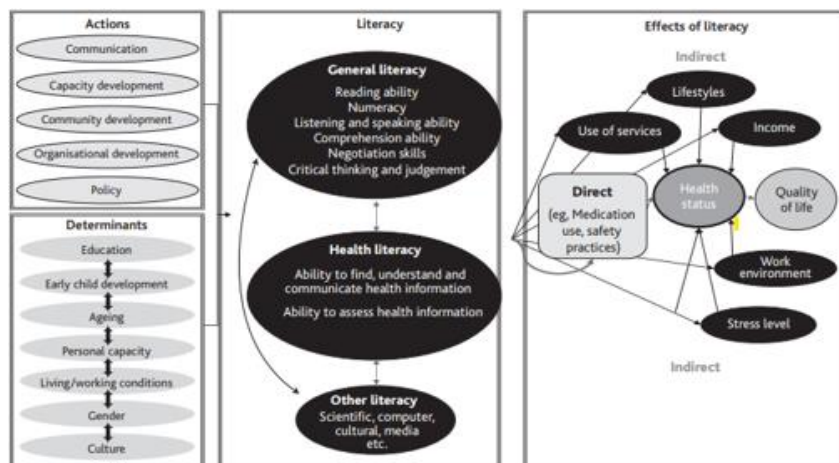


Figure 3. Rootman, Ronson’s (2005) “Conceptual Framework for Literacy and Health Research” (cf. Vamos et al. 2018: 441)

This combination of factors according to the WHO has “a “central role” in determining inequities in health in both rich and poor countries” (WHO Commission on the Social Determinants of Health 2007 in Nutbeam 2008: 2073). Essential components of HL include, comprehension and evaluation of health information, situational judgement on situation and potentially required health- assistance, risk-managing behaviour, and lifestyle decisions, the “ability to navigate the health system” and “[d]eveloping certain attitudes towards health issues” (Hagell 2015: 83).

The value of HL is most commonly viewed from two perspectives, which rely on ‘general literacy’ and the respective context of the situation (cf. Nutbeam 2008: 2078), namely as a “risk factor” and as an “asset” (cf. 2073): Firstly, HL can be seen from a “risk factor” perspective: Here HL “is a “prior status” derived from existing literacy and numeracy”, with “health education” that “is more goal-directed, intended to lead to compliance with recommended clinical care” (2077), situated in a limited clinical setting. In this rather knowledge-based approach, “the four domains of cultural and conceptual knowledge, speaking and listening skills, writing and reading skills and numeracy” (2073) all work together. Secondly, HL can be seen from an “asset” perspective: With this model, HL is “an outcome to health and patient education”, “enabling individuals to exert greater control over a broad range of factors that determine health” (2076-77). This didactic focus “can be applied to a broad range of settings” (2077), which go beyond a purely clinical focus, but instead are concerned with wider societal issues, such as “health inequities [...] rooted in structural and social determinants” (Mogford

et al. 2010: 5). It appears that in this context the “potential of health education as a tool that enables action on the social determinants of health has been somewhat neglected” (Nutbeam 2008: 2077). This points towards the future necessity to further foster HL within society and in the educational sector through health education that also includes the “empowerment of individuals and communities” with regards to “social, economic and political determinants” (Mogford et al. 2010: 5). Such matters are especially of concern with CHL (cf. Nutbeam 2008: 2075), which sees a greater need for an increased awareness of sociocultural issues of health, also intricately linked to the topic of this thesis.

HL is commonly divided into three types, namely, functional (FHL), being “able to function effectively in everyday situations” (2075), interactive (IHL), “more advanced cognitive and literacy skills” for daily life (2075), and finally, CHL which are “the most advanced cognitive skills [...] applied to critically analyse information, to exert greater control over life events and situations” (cf. 2075), the latter of which will be considered briefly in the next section.

Of all health literacies, CHL is the most complex of all, since it not only is based on the others, but also encompasses a wider societal health focus, beyond the personal health situation:

“[...] CHL acknowledges the importance of existing structural factors that indirectly influence someone’s health and wellbeing, comprising social and community networks, living and working conditions, and socioeconomic, cultural and environmental conditions. CHL encompasses the empowerment of people to challenge and take actions regarding these determinants of health and wellbeing.” (Sykes et al. 2013: 169)

These complex characteristics of CHL interrelated with and dependent on the other literacies need to be fostered through deliberate education and social experiences (Nutbeam 2008: 2075). More research needs to be done especially in the complex realm of CHL (cf. Sykes et al. 2013: 2), as it is a “unique concept” (Sykes et al. 2013: 7) in the sense that it is part of the newest “third generation of health literacy development” (De Leeuw 2012: 8), which now touches the political dimension through considerations of social determinants of health (8) through related concepts of “critical appraisal, critical consciousness and advocacy” (Sykes et al. 2013: 7).

Though more research on fostering CHL among the teenage and adult population needs to be done, the former needs to be particularly considered in curriculum planning and CHL material development, as they bear distinct information-seeking tendencies different from the latter group. The following section briefly tackles this issue and focuses on implications for educators.

Teenagers seemingly have always tended to acquire health-related information in unique ways that differed from adults: Due to their tendency to partake in steps to become independent, alternative sources of health-information, such as teenage magazines have been popular over the decades. Though these sources appear of authoritative value to teenagers, they may have perpetuated myths on taboo topics that were not addressed in school, such as STDs, drugs etc. (cf. Redcross, Grimes 2012: 17).

Additionally, the discussion of truly marginalised groups was also left out in these sources, which perpetuated stigmatisation. Since coursebooks are still the main basis for teaching and learning and still are an important resource (to consult during, but also after lessons) for students, they too need to pay close attention to the potential perpetuation of stigmatisation.

Ever since the inception of widespread access to the internet in the late 2000s and early 2010s, teenagers have increasingly flocked to various websites and forums to consult with peers (and experts) about health- and body-related issues (cf. Siegel 2002: 27). Simultaneously the number of young people seeking information from medical professionals appears to be continuously declining (cf. Jones, Biddlecom 2011; McKee et al. 2011; Wartella et al. 2015). Thus, content creators have become increasingly aware of the fact that teenagers need online resources, specifically tailored for them and not just for adults, an issue, which needs to continuous revision with regards to “the age, interests, and backgrounds of teens to better engage them with web content” (Watwood 2006: 65-73 in Greenberg, Wang 2012: 1). Health-related websites for teenagers, such as “*TeenHealthFX* (Atlantic Health System 2011), *GoAskAlice* (Health Services at Columbia University 2011), and *TeensHealth* (The Nemours Foundation 2011)” (Greenberg, Wang 2012: 1), were among the first of their kind in Anglophone settings and have proven that various health-related questions can tackled with an ‘agony aunt’ approach, which appears to be especially popular with this age range. Though they contain rather general topics pertinent to public health, such as nutrition, addictive substances, sexuality, mental and emotional health, discussions about chronic illnesses and various disabilities occur rarely, indicating a need for further discussion and de-stigmatisation in this field.

Another ever-growing source of information, which has diversified modes of information presentation (and still continues to do so), is the realm of social media (e.g., YouTube, Facebook and Instagram): For example, one such attempt at utilizing social media to promote basic HL specifically for teenagers, was *Healthflicks* a two-year project done by the National Network of Libraries of Medicine from 2010-2011. It “target[ed] health information literacy among urban teens through the creation of web videos” (Greenberg, Wang 2012: 1), a format, which corresponds to the popularity of online video sharing sites among teenagers and young adults (cf. 1). Simultaneously these platforms can be used by young people to shed light into their health-stigmatised status, debunk harmful myths and find like-minded supporters (cf. Cocq, Ljuslinder 2020; White, Forrester-Jones 2019). They can also constitute means for de-stigmatisation and sources for health information.

Overall scholars in the field (e.g., Yager, O’Keefe 2012; Park, Kwon 2018; Marent, Henwood 2021) increasingly see the potential of such developments, especially in terms of acknowledging the opportunities for health-related ‘empowerment’ and increased ‘self-efficacy’, much needed to foster the development of critical HL within them: As new opportunities for access to digital, global information arise, so do challenges to differentiate between trustworthy sources, which make valid scientific claims, and sources of false information. Though teenagers have widespread access to online

health information, studies suggest that their “strategies to appraise information are not sophisticated” (cf. Greškovíková et al. 2022: 3), with lacking media literacy skills regarding systematic online research and critical source and content consideration. Thus, teachers need to not only make students aware about these issues and the topic of media literacy, but also to utilize the coursebook material adequately. Furthermore, awareness on critical readings of various health-related content should be raised through a stigma-sensitive lens that values ‘allyship’, a term becoming increasingly widespread within contemporary society in conjunction with the fields of anti-racism and discrimination of diverse sexual orientations, but also of disability (cf. Kafer 2013; Feldner et al. 2022). Washington and Evans (1991) describe this role as

“a person who is a member of the ‘dominant’ or ‘majority’ group who works to end oppression in his or her personal and professional life through support of, and as an advocate with and for, the oppressed population” (195).

This need for social justice advocacy also very much applies to efforts of fostering stigma sensitive CHL in- and outside the classroom in conjunction with stigmatised health groups, such as disabilities, disorders, and terminal illnesses (cf. Neumann 2009: 66). The following section will consider temporal developments in this field, especially with Austrian ELT in mind.

2.6 (Critical) Health Literacy and ELT in the Austrian Educational Sector

Ever since the 80s there has been an increased focus on general HL promotion in North American and European secondary schools (cf. Hagell 2015: 84). This development was paralleled by the birth of the HL term itself and would slowly set the scene for a ‘revolution’ in the traditional health education curriculum, which until then had been primarily in favour of symptomatic descriptions and undervaluing a more skills-based focus (or in Nutbeam’s (2008) formulation ‘assets’). Such revolutionary developments were necessary due to the simultaneous onset of a widespread teenage health crisis (cf. BMJ 1992: 101), which became apparent in ever increasing rates of teenage obesity, pregnancy, and substance use (such as nicotine, drugs, alcohol), for example (cf. 101). However, the existing communication gap on health- and treatment-related information between teenagers and adults/ medical professionals (“a mutual fall out with paediatricians, [...] many teenagers don’t trust the family doctor not to pass on information to their parents”) (BMJ 1992: 101) also presented an unprecedented problem. During this time, the holistic approach taken with the ‘Health Promoting School’ concept by the WHO (cf. St. Leger 2001), encompassing all school subjects, and reflecting HL-related values as a school, became especially popular. This increasingly resulted in heightening “health and well-being outcomes through the improvement of learning and educational skills” (McDaid 2016: 11) and continues its influence today, gradually instigating more research on childhood and teenage HL (cf. Ormshaw et al. 2013), also in the context of students problematic (health) information selection behaviours predominantly across a vast media landscape (cf.

Greškovicová et al. 2022: 2), discussed in section 2.3. Such factors are also important for the educational sector, material development and teaching itself.

Though progress has been made over the last few decades, schools may often still face certain challenges in their efforts to focus on fostering individual health literacies: They include “[c]ombating the traditional structures and functions of school”, “[r]eaching the appropriate level of teaching practices and skills”, “limits to time and resources”, “finding space in the school day to support the health agenda” and finally, collaborating with school nurses (Hagell 2015: 85). Such implications also apply for teaching and learning materials, which need to be created carefully, keeping in mind the objectives of HL or in the case of this thesis, CHL in the ELT classroom, to be discussed in the following.

Despite such obstacles, the commitment to fostering HL in teenagers can have wide-reaching benefits exceeding the health realm: HL may positively influence the academic performance of young people, which seems to be especially true for “social and emotional literacy programmes, which strengthen self-awareness, self-management, social awareness and relationship skills, as well as promoting responsible decision-making” (McDaid 2016: 7). Further findings from studies in the field (such as Durlak et al. 2010; Durlak et al. 2011) also suggest that such promotion measures can and should be extended towards after-school clubs (cf. McDaid 2016: 12). All of these factors certainly not only impact their current development, but also their entire lifespan, since “good health behaviours” may have a lasting impact in terms of personal physical health (cf. 8), potentially influencing the health behaviour of people close to them, such as relatives and friends (cf. 11). But I also propose that this could also influence young people’s approach towards the three commonly stigmatised groups, one of the dimensions of CHL that need to be explored more extensively in the educational setting, as this field of CHL development has been a neglected domain in the educational sector and the ELT classroom itself. Still, some general basic guidelines for fostering CHL exist, which will be outlined below.

As CHL is still a relatively new concept, information on fostering it in the language classroom is very limited now and was non-existent for previous decades. Most considerations thus far link it with the field of critical pedagogy, which proposes an innovative, alternative perspective on current educational systems still “reproduc[ing] the relations of power and privilege [...] in spite of the efforts of many progressive educators to change to more equitable systems for all children” (Hooley 2008: 39 in Renwick 2014: 206). Instead, academic performance within high-stakes testing (cf. Renwick 2014: 205) is valued increasingly. This in turn frequently results in “alienated” students (cf. Thompson 2002: 7), who tend to view learning in relation to getting the “reward of future employment and job security” (Renwick 2014: 205). Though such developments have implications for all school subjects, health education, too, is affected negatively, since critical considerations of social determinants of health and illness are often not considered, with the predominant focus being on individual, biomedical “risk

management” (205) instead. However, classroom CHL fostering strategies expand such limited health perspectives beyond the classroom itself, engaging both students and teachers in “shared action” (207) or “educational praxis” (Kemmis 2012: 885), which can be described as “deliberate positioning and action to educate to live well while also striving to have a world that is worth living in” (Renwick 2014: 207).

Despite lacking concrete practical information on (educational) (S-)CHL interventions in the research field (cf. Sykes et al. 2013: 173) or in the health literacy movement itself (cf. 178), the US-organisation *Just Health Action* has provided suggestions for CHL development in the school setting via a CHL curriculum that focuses on “social determinants of health” and equity (SDOH) since 2004 (Mogford et al. 2010). Their framework consists of four parts, namely “knowledge” on SDOH and health as a human right and “compass”, which is “composed of activities that help students to find their own direction as a social change agent” (such as “unpacking advocacy”, “vision & goals”, “inspiration”, “find your passion”) (cf. justhealthaction.org). The other two elements are “tools”, which are “specific strategies and advocacy tools to take action on the SDOH” (such as “facilitation”, “teaching”, “dissemination”, “community projects”, “action letter”), and finally, “action”, which revolves around “develop[ing] and implement[ing] a specific action intended to increase health equity by addressing the SDOH” (justhealthaction.org).⁴ Though JHA’s developed activities mainly revolve around community health projects, health-stigmatisation and S-CHL can be also tackled following the JHA framework in the ELT setting.

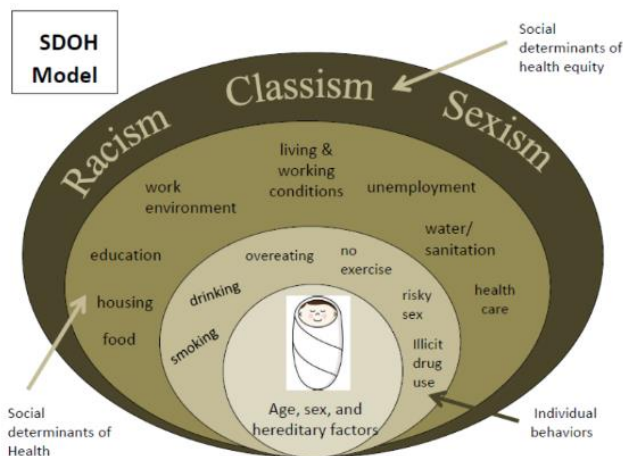


Figure 5. “The Model of Social Determinants of Health Used by Just Health Action; adapted from Dahlgren and Whitehead, 1991; Jones et al., 2009.” (cf. McHugh, Martinez 2021: 2)

At its most basic level, such an approach needs students’ reflection on reality, or according to pedagogue Paulo Freire’s (1970) “critical consciousness” concept, the process of “‘decoding’ the

⁴ It also puts recommendations by WHO’s SDOH Commission (2008) and the Ottawa Charter for Health Promotion (1986) into a more practical focus with regards to a lacking perspective on CHL (cf. Mogford et al. 2010: 5), as illustrated in figure 4. (see appendix, p.2)

social order and circumstance [...] questioning why they or others experience oppressive conditions” (Renwick 2014: 204). The resulting discussion of health-related information becomes rich as it activates both students’ and teachers’ pre-existing health-knowledge and expertise (cf. Morrell 2012: 550). In this manner, not only social justice issues (in the context of health) are tackled in the classroom through active interaction with information sources, but also awareness is raised on the “subjective[ity], malleabili[ty], and contestab[ility]” (Renwick 2014: 207) of health-related knowledge. This step constitutes the third and most complex step of Green’s (1988: 152) three-dimensional literacy model (consisting of operational, cultural, critical elements), which also lends itself to developing health literacy. I also argue that it could be linked with efforts to develop health-stigma-awareness in this context, since the conceptual approach is very much related to stigmatisation considerations. Furthermore, these ideas can also be applied to an ELT context and adapted to fit potential challenges that arise in a language teaching setting.

Students’ language-proficiency in English is most likely an important factor in determining the extent of such S-CHL considerations in the classroom itself. However, this may not constitute an insurmountable problem as students can draw upon already existing health- and stigmatisation-related knowledge from other subjects (such as biology, ethics, or religion). This is very much related to the Content and Language Integrated Learning (CLIL) approach, which has become increasingly widespread in (Austrian) ELT since the 1990s (cf. Bauer-Marschallinger 2021: 1). Though students may struggle with terminology, greater critical reflections towards transformative action itself, a major component of (S-)CHL can be enabled in their primary language laying the foundation for consequential use of JHA’s health- advocacy skills, outlined in figure 6.

Advocacy skill	Example actions by our students/workshop participants
Action letter Facilitation	Letters to policy leaders, organizations, newspapers etc. regarding a health issue 1. Teaching ORID technique using unnatural causes documentary series (www.unnaturalcauses.org)
Research, analysis and presentation	2. Lead workshop on advocacy writing 1. Research and presentations on health inequity issues 2. Presentations on global and local action projects 3. Researching comparative health system policies 4. Using human rights framework as evaluation instrument to assess current health policies 5. Interviewing local policy leaders about their knowledge of and attitudes towards health oriented public policy
Curriculum design and teaching (dissemination)	1. Health system policies in other countries compared to US 2. Teach SDOH curriculum in secondary schools 3. How racism is embodied
Art activism (dissemination)	Posters about SDOH subjects (income inequality, HIV/AIDS, gender inequality etc.)
Street theater (dissemination)	Performances at regional transit centers about teenage pregnancy and youth violence
Community project	1. Helping a low income, minority community start a farmer’s market 2. As part of an obesity campaign, raising money for a community center to buy scholarships for low income, minority youth to join sports teams 3. Graffiti cover-up and litter cleanup campaign and advice to youth about relationship between graffiti and gangs

Figure 6. “Example advocacy skills linked to specific actions taken by our students” (cf. Mogford et al. 2010: 11)

Though some of these skills may prove to be too difficult for English learners at secondary level, such as “[c]urriculum design and teaching” (Mogford et al. 2010: 11), most of these skills could be included in ELT in some form and match tasks found in some of the analysed coursebooks (to be discussed in the analysis section of this thesis). However, for widespread CHL developing efforts in Austrian coursebooks to take place, this emphasis would also need to be reflected in the respective curricula themselves (in this concrete case, the AHS version). This will be briefly touched upon in the next section.

With regards to practically implementing such suggestions in the Austrian ELT context, the most recent health reform developments are promising, though the connection between (C)HL, Austria and its educational system is still complicated. Since the discovery of Austria’s surprisingly low levels of population HL (56.4%) compared to other European countries, such as the Netherlands (29%) and Bulgaria (62%) in the first “European Health Literacy Survey” (HLS-EU) in 2012 (cf. Nowak et al. 2019: 31), efforts have been made to generally foster HL. But so far progress is only gradual with regards to the educational sector, whose main curricular objectives appear to mainly adhere to FHL and IHL, but not CHL, S-CHL or health-related discrimination issues.

Over the past few years HL itself and strategies to foster it have received greater attention from the Austrian government especially in the field of health care (education) and public health promotion through the initiation of the “Österreichische Plattform Gesundheitskompetenz” (ÖPGK) or “Austrian Health Literacy Alliance” (457). But also “Gesundheitserziehung” has been recognized as increasingly important in the Austrian school system in the age of competence-based education. While AHS curriculum changes since the 1990s (cf. AHS Curriculum 1995: 391) emphasize the need for such health education in the general educational objectives across all subjects, the focus still appears to remain on personalized FHL in more recent times, even in health-specific subjects, such as biology (cf. AHS Curriculum 2021). This also applies to the ELT curriculum, which has vaguely included mentions of the topics “Gesundheit”, “Krankheit”, “Gesundheitswesen” and “Arzt” across the upper secondary in the late 80s (AHS Curriculum 1989: 705- 708). Though CHL is not addressed here, some social justice issues related to SDOH, such as “Ernährungs- und Bevölkerungsprobleme, mit besonderer Berücksichtigung der Dritten Welt“ (648), “Behinderte“ (648), “bildungspolitische Probleme: z.B. Chancengleichheit“ (648), are listed. Curriculum changes since 2006 have included a greater focus on diverse communicative situations about health and illness (cf. AHS Curriculum 2006: 5). Over the past decade guidelines for ELT have highlighted language competencies as derived from the GERS and the CEFR, though still not explicitly addressing critical dimensions of social determinants of health or health-related discrimination (cf. AHS ELT Curriculum 2021). As topics related to SDOH appear to be discussed more frequently in the Anglophone context, (S-)CHL will most likely be included in greater depth in Austrian ELT in the near future.

After these theoretical considerations, the main analysis part of the thesis will ensue, shedding light into how representations of commonly stigmatised groups (disability, disorder and terminal illness) have developed with regards to (de-)stigmatisation in Austrian AHS ELT coursebooks over the past 40 years.

3. Disabilities: (Un)desirable, Inspirational, Marginalised?

The disabilities community, often falsely regarded as ‘monolithic’ (cf. Chatzitheochari, Butler-Rees 2022: 5), is incredibly diverse with regards to health conditions as well as degrees of severity, socioeconomic status, ethnicity, age, religion, and many other intersectional factors. Yet affecting 16% of the global population (cf. WHO 2022), it is simultaneously one of the biggest groups experiencing marginalization and stigmatisation in many realms of (Western) society, such as the educational, job and health sector (Emerson 2015: 17). However, over the past decades, steps towards de-stigmatisation have been taken: Particularly after WWII more attention was dedicated to the disabilities community, leading up to the 1960s disability rights movement in the US, which, as a part of the civil rights movement, pushed for deinstitutionalisation, which gradually resulted in disabled persons moving from asylums to independent living (cf. Fleischer, Zames 2001: 33). Gradually, policies in favour of people with disabilities followed, such as the Rehabilitation Act in 1973, and the Americans with Disabilities Act (ADA) in the 1980s, both protecting disabled peoples’ civil rights (cf. 89), with international effects also encompassing Austria. Later, the focus was directed towards inclusive schooling, an ongoing issue, also in Austria, which has been following an inclusive education policy since the early 2000s (Debenjak et al. 2015: 5). However, progress still needs to be made in relation to public attitudes towards many individual subgroups, such as intellectual disabilities and Down Syndrome, which are often highly stigmatised in current times (cf. Scior et al. 2016: 294).

The following section will concern itself with a chronological analysis and interpretation of disability representation, education, shedding light on the research questions regarding potential de-stigmatisation instances within the coursebooks themselves and the promotion of CHL with a special focus on stigma- sensitivity.

3.1 Disabilities as “Defects”- Disability, Science and Stigmatisation

Throughout history disability was often seen as a kind of ‘defect’, a biomedical perspective. In the coursebook analyses, the disability community was found to be the largest represented commonly health-stigmatised group. Despite observable inclusion efforts since the 80s, limited ‘deficit’-oriented notions of disability are frequently represented in the sources. For example, *ETWO* 2 (1984) highlights its ‘undesirability’ and primarily regards it as a health problem. *MYWWE* 7 (1991 & 2006) continues a narrow perspective on disability, by exclusively relating Down Syndrome (and terminal illnesses) to forms of euthanasia. *PT* 7 (2011 & 2018) initiates a ‘problem-solving’ view by ethically considering

controversial treatments for mobility issues, devaluing forms of ‘incurable’ disability. Since most coursebooks, do not actively discuss the topic, the following section will chronologically elaborate on the findings of the above-mentioned books.

Among other coursebooks from the 1980s, it is only *ETWO 2* (1984) that introduces the subject of disability in conjunction with the grammatical topic of plural adjectives without nouns in Unit 6 Spending Time and Money, which is part of the first umbrella topic “School, Work and Leisure”. Yet the discussion on disabled people is lacking in (health-)informational value and instead paints a picture of disability as something ‘special’ and a ‘defect’, rather negative associations contributing to a victimising narrative of disability.

As this topic includes twelve units, the middle position of this respective unit as well as its labelling of “fairly easy” (3) may indicate its relevance for students. Within the coursebook, the primary text for this unit is about money-spending habits of different age-groups in shopping malls, it does not mention any disability. Yet in its introductory section, the companion book lists a variety of vocabulary and focuses on grammatical issues (see Extr. 1. in appendix p. 5), such as adjectives without nouns, mentioning groups of people (“the old”, “the young”, “the rich”, “the poor”) on the left with exemplary sentences on the right (*ETWO 2* companion 1984: 27). In the second category of the list, commonly known disabilities are listed, such as “the blind”, “the deaf”, “the mute”, with only two corresponding sentences (“There are special schools for the blind. The mute are usually born deaf, therefore they don’t learn to speak.”) (27). The former description focuses on non-inclusive schools, which were common during that time (cf. Kalcher 2019: 5). Though first piloting projects for inclusive education were already started in 1984 (cf. 27), a concept which still is debated today even after the Austrian “Behindertengleichstellungsgesetz” (Disability Equality Act) of 2005 (cf. 32), the majority of disabled students then attended segregated ‘special’ schools. This term, however, was already then not appreciated by disability advocates, since it was considered inappropriate, condescending, and discriminating. (Such meaning could have been unknown to the authors, since efforts to provide ‘correct’ and ‘sensitive’ language use were made by adding a note, addressing “the old” as “now often referred to as “our senior citizens”” (27).) The juxtaposition of (non-) existing, apparently finite education or communication opportunities with the second sentence (“therefore they don’t learn to speak”), as well as the following word choice (“the sick”, “the unemployed”, “the handicapped (e.g. people who can’t walk)”) represents a negative view of disability as a monolithic group as it combines it with other groups that were (and mostly still) are deemed ‘undesirable’ for society (27).

Interestingly, the use of the term “the handicapped” -although now considered inappropriate- could be argued to be an attempt at providing politically correct language, since it was then frequently used as a replacement for ‘disabled’ (cf. Posner 1984: 248). This consideration is emphasized by a second mention of ‘handicapped’ in the context of hospital personnel in Unit 19 “Hospital” in the coursebook (“Therapists who help in the rehabilitation of handicapped patients are also trained in hospitals for

their special work”) (106). Though this (then-acceptable) term is used, it is combined with another indication of the individual disabled person being at the receiving end of some ‘special’ work. It implies a certain negative ‘uniqueness’ and ‘difference’ in their situation, enabling prejudice and finally, stigmatisation. Furthermore, the term ‘handicap’ itself is frequently negatively connotated for disabled people “evok[ing] images that the whole of life is a competition, as in horse racing or golf, and implies that they will not do well” (Jaeger, Bowman 2005: 115). Such implications are paired with a list of “other illness/ defects” (ETWO 2 1984: 107) (see Extr. 2. in appendix, p. 5), negatively portraying other various forms of disability, such as “speech defects”, “deaf mute”, “they may lisp or stutter”, “hard of hearing” (107): They are assigned to the mental categories of ‘illness’ and ‘disease’, which were discussed in the beginning of the unit, another negative association. Such a mix of mostly disability- stigmatising language in this word list, except for “hard of hearing” (107), which even today is considered an appropriate alternative to the stigmatising ‘hearing impaired’ (cf. NCDJ 2021: 9), may be indicative of a lack of stigma-awareness from the authors, giving the impression that the instances of non-stigmatising language were coincidental in the creation of the book.

Another instance of such mixed language use found in the companion in Unit 6 paradoxically now focuses on re-phrasing sentences from ‘person-first’ into ‘identity-first’ language and casts further negative overtures on the ‘lack of ability’ of disabled people and their need for assistance, as they are put into passive positions: “A special sign language has been developed for people who can’t hear.” (32). Though the sentences presented here now involve person-first instead of identity-first language use, the semantic differences between the two options and their implications are not discussed, preventing the students from critically considering the issue from a linguistic perspective in conjunction with the stigma-sensitive use of this newly acquired vocabulary. (Perhaps students encountered the distinction five years later, namely in the late 80s, when ‘person-first’ advocates strengthened their position on this language use (cf. Bickford 2004: 121).

The unexplained alternation of stigmatising and non-stigmatising language use as well as the lack of critical discussion, textual and visual representation, contextualisation of the topic leads to the conclusion that *ETWO 2* is closer to stigmatisation than to de-stigmatisation of disabled people (and other previously marginalised groups), not considering the critical components of the health literacy concept. This is also emphasized by the positioning of the disability-related content, which mainly is found in the companion and not in the coursebook itself. Such marginalisation is also to be found in *MYWWE 7* (1991 & 2006), which conceptually link Down Syndrome with death, a narrow view.

MYWWE 7 (1991) tackles the rather ‘taboo’ topics of death and euthanasia, together with Down Syndrome in its Extensive Unit 6, called “Let’s talk of graves, of worms, and epitaphs...”, by dedicating a central section of the unit to an ethical discussion of the topic of euthanasia, with a magazine article taken from the *Nursing Times* and titled “Euthanasia- What do YOU think?”. Though this coursebook is the first to mention Down Syndrome, its exclusive link to euthanasia and disregard

for other opportunities presents a highly negative narrative, while also excluding the topic of stigmatisation. Furthermore, the visual illustration next to the article (see Extr. 3. in appendix, page 5), reproduces a limited narrative of euthanasia as exclusively reserved for the elderly, which, together with other informational vagueness and medical inaccuracy, renders the article as an example for medical stigmatisation of Down Syndrome, which is not critically considered with regards to medical progress of the time or S-CHL.

The article (see Extr. 3. in appendix, p. 6-7) is intent on discussing opinions about euthanasia, by presenting the survey responses towards 13 fictitious cases or rather potential ‘candidates’ for active or passive euthanasia. Four of which are discussed in the article, such as two ill, “very disabled” (80) babies with Down Syndrome, and two terminally ill women, one in great pain and the other unwilling to prolong her life, though the visual illustration implies only elderly, fragile persons are patients of euthanasia. This signals upcoming issues with the content of the text, especially with the stigmatisation of the two babies with Down Syndrome. The vocabulary section makes the stigmatising position of the coursebook clear, namely in the translation of “baby with Down’s Syndrome” as “mongoloides Baby” (83). Not only is “mongoloid” outdated as it was most frequently drawn on in the 19th century to refer to derogatively assimilate physical characteristics of Down Syndrome with those of Eastern Asians (cf. NCDJ 2021: 32), but also “Down’s Syndrome”, whose possessive -s had officially been dropped decades before the publishing of this coursebook (cf. nads.org). These linguistic inaccuracies which are taught in the vocabulary section, are highly problematic, as they continue to reinforce stigmatising notions of this form of disability, not offering students a chance to critically question the appropriacy of such formulations.

Reading the article, reveals a vague discussion of the topic, which might confirm the idea that its intended audience are people working in the medical field (as indicated by the magazine title *Nursing Times*), with prior knowledge on the ethical struggle of euthanasia. This casts doubts on the suitability of such an article in a foreign language coursebook, which would need a more specific details on the nature of such a problematic issue, which go beyond the information given in the text below. Additionally, the lack of such essential information within the text itself, as well as in pre- and post-reading tasks, may impede students’ understanding of the relevance of the presented content, which needs to be discussed critically (for students to become increasingly aware of ethical debates and to ultimately foster S-CHL).

Initially, the original Greek meaning of euthanasia (“good death”) is discussed and then briefly contrasted with its current meaning (“‘hastened’ or ‘assisted’ death”) (79). A brief pointer towards the general results is included, stating that the concept of euthanasia is mostly accepted by respondents in certain situations, yet “personal involvement in assisting in someone else’s death” (79) was generally avoided. Then, the four cases are introduced, starting with the two babies with Down Syndrome, which is where a stark contrast between non-disabled and disabled with regards to medical treatment

and stigmatisation of people with Down Syndrome can be observed, not only in terms of language use, but also ethically, pointing towards their right to life and to medical treatment.

Baby #1 is described as having “severe handicaps”, an offensive term, and experiencing “rejection from his parents” (80). Additionally, he is “discovered to have an intestinal blockage, which requires surgery. Without this the baby will die” (80). The necessity of said surgery is questioned by medical staff. Similarly, baby #2 with Down Syndrome has a “digestive tract blockage” and “[i]t is suggested that the baby should be allowed to die, although it is recognised that this is likely to be distressing for all concerned, including his parents, nurses and doctors” (80), leaving the baby’s potentially resulting pain and suffering unconsidered. Though the baby appears to not have been rejected by its parents, they are only given “the choice [...] not between life or death, but what sort of death” (80) for their baby. The article states that 80% of survey respondents chose an active approach, while 13% opted for a passive one, a result which lacks numerical accuracy, as the numbers do not add up to 100%, leaving 7% out without explanation, adding to the confusion.

After briefly touching on legal issues concerning active euthanasia, the article concludes that decision-making between both forms of euthanasia “can be terribly difficult” and that “[d]eath is personal-hospital policy and the law must respect that and, where death is inevitable, help the individual to meet it with little suffering as possible” (80). However, with the two babies discussed previously, the idea that their death is not inevitable is not considered. In contrast, the other two cases of terminally ill women, to be discussed in section 5.3, reveal a different picture in the reactions of the respondents, namely a greater hesitancy to follow through with active euthanasia.

From a stigma-sensitive perspective as well as from the perspective of modern medicine, the suggestion of denying surgery to these patients is unacceptable, outdated and highly discriminatory, yet the neither the authors of the article nor of the coursebook acknowledge that, though paradigm shifts were already taking place during that time: Already at the time of the publishing of this coursebook (1991), there was an increasing consensus among doctors, especially paediatricians and family practitioners, that infants with Down Syndrome and an intestinal blockage (“duodenal atresia”), should be able to receive surgery and that parents should be informed about this possibility, emphasizing the need for doctors to “have accurate perceptions about the capabilities of individuals born with Down syndrome” (Wolraich et al. 1991: 336). This indicates a slow paradigm shift that has been taking place in the world of medical professionals: Haslam and Milner (1992) in their comparative study confirm that doctors’ attitudes towards Down Syndrome have slowly evolved since 1975, due to “parent advocacy groups, court decisions, and studies showing that the ultimate intellectual and social skills of Down syndrome children are greater than was previously believed” (304). Especially today, scholars add such internal blockages to the list of relatively common gastrointestinal complications babies (with Down Syndrome) can experience, such as imperforate anus and tracheoesophageal fistula (cf. Midwest Fetal Care Center 2015). They argue that these conditions

are far from a death sentence and can be resolved through surgery shortly after birth. Thus, surgery would be an option for both babies in the article, putting the proposals of any form of euthanasia to shame. But also, from the view of non-medical professionals, such tendencies have problematic implications with regards to stigmatisation.

As seen from the perspective of disability rights advocates, it is frequently emphasized that stigmatisation of people with Down Syndrome and other conditions have been taking place since antiquity (cf. Reingold, Gostin 2018: 2375). This includes, for example, post-birth ‘selection’ in the form of infanticide, complete or selective abandonment of children with ‘deviant’ physical or mental characteristics (cf. Rehmann-Sutter 2022: 10). In contemporary times some advocates would also argue that such tendencies were aided by the diagnostic use of amniocentesis in 1966 as a form of pre-natal diagnosis (PND) (cf. Kelley 2010: n.p.) as well as by the development of pre-implantation diagnosis (PGD) in the 1980 (cf. Krahn 2011: 157). (The latter especially controversial issue is discussed several decades later in *EiC* 7/8 (2014), which will be discussed in section 5.2.) Other scholars from the field point out that such practices further perpetuate “the notion that disability and people with disabilities are a negative outcome, and therefore undesirable”, potentially leading to “increased exclusion of people with disabilities, increased discrimination against those already living with disability and fewer resources for the disability community as a whole” (Berne, Galpern 2008: 8).

Proponents of reproductive rights take a different stance, instead emphasizing the importance of women’s reproductive autonomy, privacy, and choice in this context (cf. Berne, Galpern 2008: 8). (This has increased ever since the overturn of the controversial US Supreme Court decision on *Roe v. Wade* in 2022.) However, there also may be some overlap between the two parties, since the *Generations Ahead* report (2008) mentions that in their “Roundtable discussion” the “disability rights advocates all identified as feminists who support abortion rights”, while simultaneously “challeng[ing] unquestioned acceptance of genetic testing technologies, arguing for the inclusion of a broader, more socially contextualized perspective in an individualized pro-choice position” (8). In any case, their proposition on critically considering the societal implications of such screening practices, is essential in reflecting on practices of early-stage Down Syndrome stigmatisation in- and outside of the womb. This is due to the fact that “[e]ugenic practices are part of our largely unexamined and unspoken preconceptions about who should and who should not inhabit the world, and scientists and physicians provide the ways to put them into practice” (Hubbard 2006: 102). Women are amid this societal conflict, which often overlooks the need for supporting non-abortive decisions:

“[S]he must also feel empowered not to terminate it, confident that the society will do what it can do to enable her and her child to live fulfilling lives. To the extent that prenatal interventions implement social prejudices against people with disabilities they do not expand our reproductive rights. They constrict them.” (102)

To achieve further de-stigmatisation of disability must take place in society. Though this section of the unit focuses on the taboo topic of euthanasia, a critical discussion of the underlying issue of stigmatisation in the medical context is missing. Some of the tasks surrounding the article could have been adapted to tackle S-CHL.

One feature, that only partially aids in understanding the text's underlying issue, is the pre-reading activity on page 79 (see Extr. 3. in appendix, p. 6): Task 5 is a listening exercise revolving around a conversation of two dying people, sharing their thoughts on their impending death in relation to the experiences of loved ones as well as with regards to greater problems within institutions, such as hospitals and hospices ("Why does the man feel that dying people are treated less appropriately in a hospital than in a hospice?"). This last question is closely related to social justice issues of structural inequality, institutional stigmatisation, and unequal treatment. It reflects the importance of respecting individual dying patients' dignity, a problem which tends to occur in hospitals, and even in hospice settings, according to the US National Institute of Aging (2021: n.p.) and can be exacerbated through unequal access to medical insurance. This topic would have made a good topical basis for a S-CHL intervention, yet it is not further discussed in the unit. Instead, the focus is now suddenly put on moving towards euthanasia, which differs from the previous discussion on death.

Activities (see Extr. 4. in appendix, p. 7) following the article are concerned with preparing arguments regarding death being a taboo topic in society, justifiability of euthanasia, personal opinion on medical staff administering lethal drugs, for a "whole class discussion about death and euthanasia" (81). This task too, could have been expanded to focus on fostering S-CHL by identifying the need for alternative treatments for the two babies with Down Syndrome, their implications for others experiencing such stigmatisation and generally discussing alternative views on euthanasia, such as palliative care.

New Version: MYWA 7 (2006)

Concerning the discussion on the two babies with Down Syndrome in relation to euthanasia, nothing much has changed in, *Make Your Way Ahead* 7 (2006), with regards to the medical stigmatisation of the two babies with Down Syndrome and the lack of stigmatisation awareness in consecutive tasks.

Though the cases mentioned in the article are now considered ethically in the means of a (mental) role play, by assuming the perspective of a doctor, the inherent discrimination of denying these babies surgery is not pointed out. Furthermore, the exact conditions of the two babies with Down Syndrome are obscured in this pre-reading task (task 1, page 99), which is in stark contrast to the cases of the two women, which are provided unabridged (see Extr. 5. in appendix, p. 7): Baby #1 (case 1) is described as having "Down's syndrome", "several severe mental and physical handicaps", having been "rejected by his parents" and requiring an "urgent life-saving operation" (99). The fact that an "intestinal blockage" (100) is the cause, which, as previously mentioned is not an unusual surgery for babies

(with Down Syndrome) (cf. Wolraich et al. 1991: 336), yet it is not mentioned in the task (or text). Baby #2 “with Down’s syndrome” has an “incurable disease” and the question given revolves around “a slow and natural death” or an assisted death (MYWA 7 2006: 99), again not specifying the disease, which the text identifies as a “digestive tract blockage” (100), or whether surgery could be an option. The same medical consensus as the previous one applies to this case as well. Furthermore, the use of possessive -s in “Down’s syndrome”, continues in this version of the book, leaving the distinction of stigmatising and de-stigmatising language use unaddressed. In conclusion, MYWA 7 (2006), continues in its stigmatisation against individuals with Down Syndrome, by not updating its content since 1991, a surprising development considering that other aspects of the coursebook have been revised and updated. Such findings are uniquely related to the coursebook series itself, but the stigmatisation of people with disabilities continues in more latent ways, as for example in PT 7 (2011 & 2018). It focuses on an ethically complex discussion revolving around ways to reverse or ‘cure’ disability, perpetuating a view that is concerned with utilitarianism.

PT 7 (2011) and (2018) is characterized by a distinct lack of social advocacy skill training for ‘incurable’ disabilities (developmental disorder) in Unit 5, while their potentially ‘curable’ counterparts (paraplegia) are extensively approached through “cinemeducation” (Alexander et al. 2006: 1) in Unit 2. Additionally, they are discussed more critically in terms of finding life-improving solutions through the ethically questionable practice of stem cell research. Problems also arise with the conceptualisation of disability itself: Disabled people are occasionally addressed through the non-stigma sensitive term “people with special needs” (PT 7 2011 & 2018: 30) as well as assigned into the category of health issues, together with people having nicotine use or eating disorders in Unit 2. These issues show that the discussion of various disabilities and their realities, which were already highlighted innovatively through a young person’s peer-to-peer information on being in a wheelchair, could still be expanded to better develop students’ S-CHL.

In Unit 2 “Health issues”, the coursebook, in contrast to other previous ones, briefly critically considers the nature and definition of disability itself (see Extr. 6. in appendix, p. 8), providing specialized vocabulary that expands the previously frequent narrow focus on lack of ability, instead now also including tools for participation and inclusion (such as “hearing aid”, “assistive equipment”, “Sign Language”) (30). This is closely interlinked with an undated version of WHO’s disability definition (which is problematic, as it obscures potential questions regarding contemporary appropriateness): Here disability is seen from a functional perspective, being a “complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives” (30) as well as an “umbrella term covering impairments, activity limitations, and participation restrictions” (30). What, however, is not addressed here, are the factors of inequality, discrimination, and stigmatisation, which according to WHO’s current (2022) definition has different effects on individual disability communities, such as those with Down Syndrome or depression (cf.

World Health Organization 2022). These issues are also not discussed in the ensuing text (task 2, p.30-31) (see Extr. 7. in appendix p. 8-9) “How to live well on wheels”, an informational article exclusively intended for fellow teenage wheelchair users but adapted for use with non-disabled students, an unusual exchange contributing to inclusive, intergroup knowledge.

Tips include “acknowledge that you are a little different from other teenagers”, “focus on the fun and excitement”, “make sure you feel good and look good even if some people want to make you believe that it’s only inner beauty that counts”, “stand up for yourself” (30-31). This is contrasted with a fact file, intent on informing about disability myths from a HL perspective, such as always requiring help, being unwilling to inter-mix with others and having unique lifestyles (cf. 30) (see Extr. 7. in appendix, p. 9). But also, some critical points are raised, which direct students’ attention to preventing discriminatory behaviour by non-disabled people, such as encouraging sensitive-intergroup questions, protecting accessible parking spots, and helping to reduce (societal) barriers for disabled people (32). Though the actual issue of stigmatisation is not addressed critically enough with regards to concrete social advocacy skills, together with the reflection questions of the text, these pieces of information could provide basic steps towards S-CHL. However, further tasks reveal an ‘ableist’ view, which is intent on restoring mobility of a person with paraplegia in order to fit into the standards of non-disabled society, instead of transforming society’s underlying stigmatisation of this community.

The previously mentioned favourable discussion with regards to critically assessing potential socio medical solutions to medically ‘curable’ disability is apparent in the consecutive “cinemeducation” (Alexander et al. 2006) task 3, called “If ... cloning could cure us” (cf. 31) (see Extr. 8. in appendix, p. 9). This task design, which may offer health-educational benefits, due to its medical accuracy of most depictions and visualisation of “biopsychosocialspiritual aspects of health care” (cf. Alexander et al. 2006: 1), presents a short film on a man named Andrew Hollard. His paraplegia causes controversial stem cell research by a doctor, willing to cure him, ultimately resulting in a heated case before court. Though the topic of stem cell research is frequently addressed in upper-secondary ELT coursebooks, *PT 7* (2011) is the first to link it with disability, and discuss its ethical implications, still without paying explicit notice to the concept of stigmatisation.

The audiovisual information given builds the basis for CHL development throughout the other parts of the task. While part a is concerned with basic understanding of the issue (e.g., the protagonist’s “problem”, “ideas for a possible cure”, “controversy between supporters and opponents of stem cell research”) (31), part c is intent on students’ ability to critically form an opinion with the incentive of a quote and justify it (“The best that can be said about embryonic stem cell research is that it is scientific exploration into the potential benefits of killing human beings.”) (31). Contrary to previous ethically-difficult discussions, this task design equally presents information on various standpoints, fostering students’ CHL. Furthermore, it includes additional topic-related literary and ethically complicated ‘cinemeducational’ source suggestions, such as Kazuo Ishiguro’s *Never let me go* (2005) and *The*

Island (2005). Interestingly, the former also points towards eugenics and human biodiversity, and the issue of “eugenic world building”, which “strives to eliminate disability” (Garland-Thomson 2017: 134), which, though predominantly focusing on congenital aspects of disability, inadvertently also could provide a counterargument to the book’s ableist standards to curing paraplegia with stem cell research. However, this link is not further explored in consecutive tasks.

This emphasises the observation that the majority of coursebook discrimination-related tasks focus on actively campaigning for various socially stigmatised, potentially ‘curable’ health issues, such as smoking, eating disorders or likely treatable unspecified disabilities, albeit in ethically questionable ways, such as cloning, but do not advocate for the rights of people with various, mostly deemed ‘incurable’ forms of disability.

PT 7 (2011) and (2018) use innovative approaches to discuss disability, namely a text on in-group tips for disabled teenagers and ‘cinemeducation’ on the complex situation of a man with paraplegia, which give insight into the personal lives of some people in the disability community. CHL discussion appears to be exclusively directed towards ethically complicated treatment options requiring stem cell research, with the goal of entirely overcoming disability to fit into a ‘ableist’ norms of society. Other, deemed ‘incurable’ forms of disability are not critically considered in this context, neither are ongoing forms of social stigma many people with disabilities experience.

Combined with the other two examples show that stigmatisation of disabled people can take on different forms, which despite temporal change, mostly relate to deficit-related views, which value functionality over the inherent value of individuals.

3.2. ‘Inspirational’ Stories?- Of Overcomers, Superheroines and Superbrains -*MYWWE 5* (1998 & 2004), *IE 2* (2013), *W2G 7* (2019)

Aside from such negative views, disability is also often attributed with inspirational value derived from extraordinary or ‘superhero-’ or (-heroine-)like abilities, showcased by ‘overcoming’ the constraints of disability and participating in ‘typical’ society. This (not uncontroversial) perspective is popular in media, but also in educational materials. The following section will discuss examples from four coursebook series, starting with the teenage superheroine Aine (*MYWWE 5* (1998), *MYWA 5* (2004)), moving on to the depictions several extraordinarily, ‘superhuman-like’ talented artists with autism spectrum disorder (*IE 2* (2013)), and ending with a short description of an adventurous blind backpacker (*W2G 7* (2019)).

Paradoxically, the last coursebook to be published in the series, namely *MYWWE 5* (1998) is the book that not only is designed for the youngest age group in the upper secondary, but also finally pioneers a new, more in-depth focus on disability, namely by moving away from the focus on commonly mentioned disabilities, such as blindness, deafness, muteness etc., and instead embracing authentic stories from people in the community. This is done in the coursebook’s last unit, Compact Unit 7

“Fifteen”, which tackles teenage life, attractive personal qualities (e.g., looks and character) and friendships as well as an example of an ‘inter-abled’ friendship between Aine Rathwell, a girl with Down Syndrome and Fay Bailaye, non-disabled girl, at the very end of the book itself. Such a final, marginalised position could indicate a lack of relevance, stigmatisation, or conversely, an attempt of inclusion or tokenism (cf. Bottoms, Weintraub 2016: 157).

The discussion on Down Syndrome is limited, predominantly focusing on academic output and presenting Aine through the ‘overcomer’, ‘superheroine’ narrative in many aspects of her life, consecutive tasks barely focus on socio-critical aspects of experienced educational discrimination and societal prejudice, leaving out the explicit discussion of the health-stigmatisation concept or CHL. However, despite such shortcomings, the text (see Extr. 9. in appendix p. 10) can also be seen as a positive testimony of healthy, intergroup friendship, which transcends societal bias, ultimately a potential basis for de-stigmatisation of Down Syndrome and other disabilities.

After tasks about the selection of a potential new friend, based predominantly on looks, rather than inner qualities (such as “generous”, “intelligent”, “ambitious”, “sensitive”, “lively”, “tolerant”, “thoughtful” and “honest”) (170), the article on Aine’s and Fay’s ‘inter-abled’ friendship (“My family’s so proud of me”) (172) appears, changing the previous superficial friendship-narrative. Yet though this is a pioneer move among other coursebooks at the time, the representation has its flaws with regards to S-CHL fostering tasks as well as to the overly strong emphasis on academic performance over friendship, could also be seen as a problematic development, since it appears to attribute high value to disabled people based on their extraordinary output, not their inherent personal qualities. But also, awareness of stigma-(in-)sensitive language use, contributing to terminological incongruencies.

The title sentence in bold for the text (“Sometimes it’s a hard life being a teenager. But not many teenagers have to cope with problems like Aine Ruthwell’s.”) (172) indicates a transition from previously mentioned instances of ‘typical’ teenage lives to a ‘difficult’ one, implying that Aine’s case is rather unique, which, however, contradicts simultaneous societal developments with regards to increasing inclusive education in the UK (cf. Gov.Uk. 2014). Words, such as “hard life”, “not many teenagers” and “cope with problems” (172), paint a negative, stigmatising view from the start. The same applies for the “advice” box, which considers people with Down Syndrome to be “sufferers”, “different” yet “entitled to bully-free friendship” (172), having their condition caused by a “genetic accident at the time of conception” (172). The second paragraph of the text demystifies the exact ‘problem’ mentioned in the task instructions, by explicitly stating that it is “Down’s syndrome, which is a condition somebody is born with that stops them from developing in a normal way, both physically and mentally”. While this does provide preliminary information on the condition itself, in a way that was considered non-offensive, modern disability advocates and scholars would recommend a cautious use of “normal”, as it is only considered appropriate in a scientific, medical context (cf.

NCDJ 2021: 20). The use of “Down’s Syndrome” may be regarded an example of both correct and incorrect language use, depending on the linguistic differences between the US and the UK and the fact that the topic at hand is related to a British girl: On the one hand, the US National Institutes of Health already deemed the possessive link that is created between the discovered condition and the person who discovered it problematic in 1975 (cf. Kurzenk 2018: 451) and proposed ‘Down Syndrome’ as an alternative for the US. On the other hand, the UK reportedly considers the possessive counterpart as appropriate, though such a tendency is not uniformly represented in current language use (cf. NCDJ 2021: 20).

In terms of disability narrative, the article on Aine takes on the perspective of an overcomer, a superheroine, who suffered exclusion from society, yet has overcome barriers to finally have amazing academic achievements that earn her a place in society: Right away she is described as beating the odds (“Aine Rathwell, 16, [...] may have Down’s syndrome, but she’s proved it doesn’t have to be a handicap...” (172)). She describes herself as “different”, being “bullied sometimes” and having faced multiple challenges being accepted into dozens of different schools (“Mum had a hard time finding schools in England that would accept me. I think the schools were worried I wouldn’t do very well or that they’d have to pay for the extra help I needed.” (172)). The vital turnaround happened in Longridge Country High, which not only accepted her instantly, but also provided a teaching assistant to assist her, and thus bridging the gap of exclusion. Social interactions in intergroup contexts appear to prove occasionally difficult though, as some persons are unsure of respectful behaviour towards her, possibly due to their own personal prejudice and biases (“Sometimes people don’t know what to say when they meet me for the first time, so they act as if I don’t exist, or talk to me as if I’m a little girl rather than a teenager, which makes me feel awful” (172)). This describes common processes of social stigma which occurs in cases of a lack of social awareness of people, addressing the need for more intergroup interactions, which could contribute to de-stigmatisation processes on the grass-roots level (cf. Batson et al. 1997: 105). Aine, too, is aware of such stigmatisation and seeks to escape from falling into self-stigma by striving for academic excellence throughout secondary school, which not only improves her level of self-esteem and self-confidence, but also gives her a chance to take revenge on her critics, bullies, who took part in undermining her abilities and value as a person: “That’s why I was over the moon when I got my GCSE results. [...] [A]lthough the grades were on the low side it meant I’d won a place at college. [...] It wasn’t easy, but I was really proud that I’d proved all the people who doubted me wrong.” (MYWWE 5 1998: 172). Also, her mother sees Aine as an example for successful inclusive teaching in “mainstream education”, a subject which remains at the core of educational debates to this day (Buchner, Proyer 2020: 84) and whose discussion in this book is arguably short.

Aine’s friend Fay Bailaye, continues to fight for Aine’s rights within society, which includes her right to be accepted, treated respectfully and have equal opportunities. Fay recounts having found “a mate in

a million” in her, as she herself learned to accept that her prejudice towards people with Down Syndrome was incorrect:

“Before I met Aine I never knew anyone with Down’s syndrome and I thought she wouldn’t be as bright as other people- but I was so wrong.” It is this friendship that has made her into a Down Syndrome ally, fighting against prejudice directed towards her friend and others within the community: “It makes me really angry when people won’t give her a chance or tease her ‘cause she’s different. Some teenagers might feel nervous about talking to a Down’s syndrome person, but I’d say, ‘Make the effort- if you ignore someone like Aine *you* ‘ll be the one who’s losing out.’” (172)

Her use of “Down’s syndrome person” (172) constitutes another unexplained use of language describing disabled persons, namely identity-first language which is preferred by some members of disability communities, such as currently the Deaf and autistic community (cf. NCDJ 2021). During the 1990s, this language use, however, was not viewed favourably by some disability advocates, leading to increased use of ‘person-first’ language (Collier 2012: 1978).

It is clear that the coursebook does not discuss such terminological issues, e.g., (de-)stigmatising language as well as the general differences between ‘person-first’ and ‘identity-first’ language use, which indicates a certain lack of (de-) stigmatisation-awareness. This also applies to the explicit task instruction, asking students to “[r]ead the article about how Aine has overcome her handicap” (172): The view of having to ‘overcome’ a handicap is criticised for being not only outdated, but also because it brings to mind the inherent competitiveness of its prior connection to sports and the struggles of “heavily weighted horses” (cf. Amundson n.d.: n.p.).

Post-reading questions reveal alternations between person- and identity-first language use, while also briefly discussing with regards to inclusive education, a very basic move towards critically reflecting corresponding discrimination of the community: Questions are concerned with schooling opportunities “people like Aine” and the ‘special’ vs. ‘normal’ school debate, potential problems in such settings, educational rights of PWD and decision makers’ influence on inclusive schooling situations. What is immediately apparent is that the coursebook draws on rather vague expressions to express Down Syndrome (and other disabilities), by utilizing “people like Aine” (170-172) instead of other possible formulations ‘disabled people’, ‘people with Down Syndrome’ or ‘people with disabilities’.

New Version: MYWA 5 (2004)

In 2004, the new version of this coursebook series, *Make Your Way Ahead* 5 (2004), also includes this unit, without changing much in 6 years: Unit 7, now titled, “Now and then”, is also part of the compact units of which there are only seven instead of eight in the previous book. It is also placed as the last unit in the book, with section 3 containing the text on Aine Rathwell, again being at the very end of the book (on page 179), preceding extra reading material. The content and the lack of a critical,

stigma-sensitive discussion have stayed the same, as well as the ‘superheroine’ narrative paired with a mix of unexplained (non-) stigmatising language. Only the layout has changed, with most of the text now printed in black instead of red and with only one picture, namely with her best friend Fay. Post-reading discussion questions have also remained the same, not tackling the issue of stigmatisation and unequal educational access or what they practically could do to resolve this issue, while keeping in mind stigmatising-practices, the ultimate goal of S-CHL.

It is a nutshell, both coursebooks pioneer in the representation of Down Syndrome in the late 90s and early 2000s, which is an important step towards awareness of S-CHL and de-stigmatisation, concepts not addressed here. In both versions the content is in an arguably marginalised position, and the underlying narrative of disability is that of an ‘overcomer’ and a ‘superheroine’, which are not uncontroversial due to their emphasis on performance and excellency to be acknowledged as a ‘typical’ member of society with regards to output and skills, overlooking a disabled person’s inherent value as a unique, individual. Other issues related to stigma-awareness, such as appropriate language use and stigma-sensitive terminology, as well as a deeper understanding of the concept of stigma are not discussed explicitly. However, despite these shortcomings, which fail to foster S-CHL, the text is a positive testimony of intergroup friendship and highlights the need for future respectful, unbiased intergroup contact in an inclusive, biodiversity appreciating society, which should also be reflected in ELT coursebooks. The following years include very little disability representation, but *IE 2* (2013) initiates a novel focus on the extraordinary abilities of people with autism spectrum disorder.

A pioneering focus on extensive disability representation continues several years later in *IE 2* (2013), following a unit-specific disability ‘superhuman’ narrative with regards to the lives of five extraordinarily talented ‘autistic savants’, while also contrasting these with a secret, undiscovered talents of a young man with cerebral palsy. Though these visual and textual depictions can be argued to provide positive insights into personal lives of the autism spectrum community, the essentialising depiction of their unanimous empowering, exceptional artistic abilities is only a narrow representation of some people along the wide spectrum of this disorder. Furthermore, discrimination and stigmatisation as well as societal prejudices against ‘typical’ people with autism spectrum disorder are not addressed, which may impede the development of S-CHL in students regarding this issue.

Unit 1 “Education- Super brains” has a prime position in the coursebook, a vital step towards sensitizing students towards people with autism spectrum disorder. This is visible in its immediate focus on several exceptional autistic artists, portrayed as ‘superhuman’ autistic savants throughout the initial pages (p. 6-9). Together with an ‘infantilization’ narrative (cf. Loftis 2018: 95), this perspective is most commonly used in stereotypical societal depictions of the disorder, yet it is “not a realistic representation of the majority of autistic people, who are not savants” (Loftis 2018: 98). “Blind Tom”, Stephen Wiltshire, both autistic artists of colour (task 1, p. 6) (see Extr. 10. in appendix p. 11), Joshua Whitehouse (task 3c, p.7) (see Extr. 11. in appendix p. 11), a teenage artist with Asperger’s Syndrome,

Gilles Trehin (task 5b, p.8) (see Extr. 12. in appendix p. 12), and Brittany Maier, a teenage, blind, autistic pianist (task 6b, p.9) (see Extr. 13. in appendix p. 12) are represented in this stereotypical manner, which only does not show the full picture of the community or correlating stigmatisation issues.

Interestingly this also applies to the depiction of their backgrounds, which appear to be surprisingly very harmonious, yet possibly unrealistic. All of them are described as having supportive parents and not having encountered any form of discrimination or stigmatisation in the educational sector, which, if correct, would be a great indication for de-stigmatisation of this disorder taking place in society. However, it cannot be ruled out that the authors of the biography or of the coursebook consciously omitted references to such injustice to avoid a taboo-conversation in this context. What students are instructed to reflect on (task 2, p. 7) though, are their own extraordinary abilities and talents, as if to compare their own abilities, a rather performance-driven, utilitarian focus, which appears to exclusively assign greater value to such features, instead of character. Such a focus on these artists' output causes their stories to become "special needs" (7) curiosities instead of critically informative pieces of information dedicated to fostering S-CHL.

The discussion of this disorder itself is rather limited in terms of scientific, stigma-sensitive language use, providing few scientifically relevant terms: Autism is classified as a "developmental disorder, causing difficulty with social relationships and learning" ("Entwicklungsstörung") (6), yet the scientifically more complex term 'autism spectrum disorder', which is also less stigmatising (cf. NCDJ 2021: 7), is not mentioned. People with this disorder are addressed predominantly through identity-first language use, without considering underlying implications of the necessity of avoiding offensive language. However, the positively connotated, though not undisputed (cf. Stenning, Bertilsdotter Rosqvist 2021: 1534), alternative terms of 'neurodiverse' and 'neurotypical', coined by sociologist Judy Singer in the late 90s (cf. Singer 1998: 7) and already in use at the time of coursebook publishing, are not addressed in the unit, in order to describe people with various disorders. Instead, to describe the diversity of autistic individuals, only "autistic savants" with "special needs" (6) are highlighted, numbering them among those with "Asperger's Syndrome", which constitutes a similar terminological problem as previously discussed with "Down's Syndrome".

The ensuing representation of Shawn (14-15) (see Extr. 14. in appendix p. 13-14), a young man with "severe cerebral palsy" (14) is very different from the previous content: Text extracts of *Stuck in Neutral* (2000) by Terry Trueman, present the protagonist's complex inner world, very much perceptive of cerebral palsy- stigmatisation in relation to a medical narrative model of disability. Yet the narrative does not indicate self-stigmatisation or a perceived victim mentality ("physically powerless, his internal life is full of unseen pleasures") (14). Though not written by a person with cerebral palsy, it aims to provide insight into the complex inner world of a young boy, by drawing on the knowledge of the author himself, a father, who wanted to represent this topic in more detail for

educational and de-stigmatisation purposes. However, the underlying issue of stigmatisation or corresponding language use is not reflected in consecutive tasks, missing an opportunity to foster S-CHL.

Positioned at the end of the unit, this text extract tackles issues integral to raising awareness on health-discrimination and stigmatisation by medical professionals corresponding with issues of stigmatising language. Shawn exemplifies the negative, hurtful effects of insensitive words, such as “special”, “retard”, “dummy” (14), addressed at him. This raises awareness on the complexity of his self-perception and the distorted version others have. Consecutive tasks only make vague assumptions about his true personality, yet considerations about the underlying issues of societal disability narratives, discrimination and means for change in the form of S-CHL are not made.

IE 2 (2013), unlike other ELT coursebooks, makes a particular effort for inclusion, albeit following monolithic disability narratives. By representing disability in relevant positions, bearing potential for S-CHL development (if content is expanded). Depictions of individual groups, such as those with autism spectrum disorder and cerebral palsy, are of different lengths, of mostly authentic origin. Yet narrative models are rather limited to a ‘supercrip’ perspective, overly intent on displaying extraordinary artistic talents, presenting a rather monolithic view of the breadth of people with autism spectrum disorder. However, the representation of Shawn’s complex inner world, includes a view that challenges stereotypical views of disabled people in relation to stigmatising language-use. Though undiscussed in tasks, such awareness could be positively beneficial in developing S-CHL in more thorough discussions. *W2G 7 (2019)* showcases a similar emphasis on authentic, personal narratives of people in the community by including a segment on a blind, brave, independent traveller.

With Unit 4 “On the move”, *W2G 7 (2019)* is the first coursebook from the selection to very briefly link the concepts of traveling and adventure with a blind and hard-of-hearing person. This is a new dimension of the ‘overcomer’ narrative of disability, which conveys a sense of geographical independence and breaking conventional, activity-limiting stereotypes of disability, which so-far have not added solo-traveling into the equation.

Though an initial text (cf. 58) (see Extr. 15. in appendix p. 15) describes him as being “mostly deaf” (*W2G 7 2019: 58*), a rather vague term to indicate ‘hard of hearing’ (cf. *NCDJ 2021: 14*), Tony Giles himself narrates his journey to becoming a world traveller over the past twenty years, using this term as most appropriate for himself in the authentic format of an FM4 interview. His stories are based around overcoming fear, while repeatedly stepping out of one’s comfort zone, and not necessarily only barriers created by blindness:

“The first time I was on my own, outside the UK or Europe, completely by myself, was in New Orleans. And at first, I did panic. [...] [B]ut then I took a few breaths, and I said *Tony, this is what you want. If you don’t want it, go back inside the hostel and go home.* I took a few more

deep breaths, walked down the street, found someone to help me to find the tram, and the rest is history.” (fm4.orf.at)

This renders the book’s short representation of disability, very authentic and non-stereotype reproducing, as it is concerned with an individual story, in the broad field of other disabilities. However, S-CHL is not tackled to point towards this de-stigmatising move of solo- travelling as a blind person, which is a significant achievement in terms of disability empowerment.

Though W2G 7 (2019) has very little disability representation, it is the first upper-secondary coursebook (of this selection) to present a positive example of a travelling, blind and hard-of-hearing person, embedded in a general discussion on life changing benefits of (solo) travel, a positive sign of inclusion. The brief task does not use the opportunity to critically discuss societal conceptualizations of disability or stigmatisation. Still, this brief section manages to present a new disability narrative related to (geographical) independence and overcoming fears, changing stereotypical views, an important step towards disability advocacy.

3.3. In- and Out-Group Disability Advocacy: Authenticity, Accessibility, and Interaction - MYWWE 8 (1991), IE 1 (2013), W2G 6 (2018)

Advocacy is crucial in tackling social justice issues and can take on many different forms (as previously discussed in section 2.6). Especially that of in-group self-advocacy, however, is particularly authentic, as personal experience and expertise are in the foreground. Combined with out-group variants, this can be very impactful. Most coursebooks in the 1980s contain very limited accounts of disabilities advocacy. However, some informative exemplars start to appear since the 1990s, giving some insights into issues of spatial and educational accessibility and communication guidelines. The following section will outline three findings in this realm, namely an instance of ‘authentic input’ on bathroom accessibility for wheelchair users (MYWWE 8 (1991)), understanding ways to communicate with d/Deaf people as well as assistive technologies (IE 1 (2013)), and finally, a brief instance of ‘imagined’ intergroup contact following the advice of a woman with cerebral palsy (W2G 6 (2018)).

Among the other books in the series, MYWWE 8 (1991), is the only one that includes a short article on disability, albeit at the very back, on the very first page in the exam preparation section. Titled “Handicaps-Spare a Thought” and taken from the *Sunday Times* it contains information about a disabled self-advocate (MYWWE 8 1991: 79). Though the rest of the book does not make any mention of disabilities, this authentic text from a person within the community, innovatively describes and consequently critically discusses the lived experiences of a 26-year-old person in the wheelchair, as they encounter accessibility problems in their non-disabled friends’ bathrooms, a rarely discussed issue. This is unique insight is a rarely discussed issue, which may sensitize students towards stigmatisation of people with disabilities through inaccessible space and tackle S-CHL.

Essentially, the article (cf. 79) (see Extr. 16. in appendix, p. 15) is a call-to-action for (non-)disabled people (“not for architects, city planners, or people like that”), following a grass-roots approach and

pointing out the positive effects of small changes in interior design, as experienced by the author: Situations of difficult access to the bathroom are described as “one of the most frustrating problems” (79) for disabled people. Thus, planning ahead is key: “It is awful waiting while people flap about moving this and that saying, ‘oh dear ... so sorry ... just a moment’ You feel guilty and embarrassed, which isn’t fair.” (79). Concrete measures to be taken by the hosts are: “Remove small rugs in advance. They are real obstacles. If you try to wheel over them, or turn on them, they ruckle up and render you immobile. If you put a stick or crutches on them they slide away” (79). Such a concise description helps to understand this different perspective, raising awareness on the specific issue of accessibility in the private home, which is rarely discussed. However, the author makes another rather innovative suggestion, which puts the disabled person and their non-disabled friend into an equal position, avoiding a wholly passive stance of people with disabilities, commonly associated with them, and instead highlighting their agency: “Let your disabled friend do things for you, too. Be on the receiving end sometimes” (79). These suggestions provide practical guidance not only for the students’ personal lives, but also inspiration for the tasks ahead, which focus on writing.

Language-wise, a mismatch between stigmatising and non-stigmatising expressions can be observed, their only common-factor being predominantly identity-first language use. The term ‘handicaps’, which is considered offensive, is utilized throughout the text and tasks. The latter almost exclusively utilizes this concept and put it in an adjectival position, as to characterise the person (e.g., “handicapped people” (79)). However, the text itself exclusively contains authorial self-referrals to being ‘disabled’, which may confuse the reader, as both terms are treated synonymously in an unexplained ‘identity-first’ manner, which differs from other textual examples in the book series. Looking aside these linguistic incongruencies, the text itself and the tasks thereafter can be seen as vehicles for CHL, even S-CHL, possibly broadening the students’ perceptions of disabled people.

The writing tasks (cf. 79) (see Extr. 17. in appendix p. 15) following the text critically reflect on other examples of PWD (task A) as well as their relation to society (task B), addressing the more critical ‘sociopolitical’ (Smart 2009: 3) and the ‘supercrip’ (Clogston 1990: n.p.) model, thus showing the most varied considerations of disability among other books. Task A proposes three writing subtasks: Firstly, a letter of the “parents of a handicapped boy/ girl [...] trying to persuade the headmaster of a school to accept their child as a pupil” (79), constitutes a focus on the functional model of disability, as it is concerned with overcoming the “medicalization of disability” (Cigman 2010: 159) through inclusive education. Secondly, an inner monologue of a “woman/man in a wheelchair [...] watching people on a beach on a beautiful summer day” (MYWWE 8 1991: 79). Thirdly, a “narrative account finishing with the following sentence: I would never have thought that a blind person would be able to do something like that” (79), a ‘supercrip’ focus, which highlights limiting societal beliefs regarding disability.

This collection of writing tasks can be argued to tackle CHL, as students are led to deeply reflect on individual situations and consider the perspective of a disabled person. They might also come to recognize their own prejudice, biases and limiting beliefs concerning disabled people. Task B adds discrimination-sensitive and social justice elements to such likely considerations in its essay “Handicapped people in our society” (79). It lists several questions that not only let students to reflect on their own experiences with disabled people, and what they have learned from them, but also what changes would need to be made for society to be fully inclusive, such as removing barriers to spatial accessibility and access to education, jobs. More critically, society itself is questioned in relation to its attitudes towards “outsiders/ minorities” (79) and its lack of direct involvement with these marginalised groups (“How many of our responsibilities do we hand over to organisations and institutions, how much can be expected from individuals or community work?”) (79). These considerations are in close relation to the concept of stigmatisation and disability, which could tackle basic S-CHL in some students, who dedicate themselves to deeper reflection of the issue, raising awareness on social injustice, a predecessor for CHL’s final stage of social activism.

Albeit in a marginalised position, the text, and corresponding tasks, provide brief, personal insights into the accessibility issues for people with disabilities, but also point towards issues with social attitudes towards the community. Though tasks are concerned about writing and the concept of stigmatisation is not addressed exclusively, they tackle basic awareness of social injustice related to disability a useful basis to further develop S-CHL and social activism skills. Only terminological issues resulting from the synonymous use of ‘disabled’ and ‘handicap’ remain to be contested, due to their lacking stigma-sensitivity. Despite not addressing such concerns, IE 1 (2013) takes on the matter of intergroup communication itself, a topic, which is generally underdiscussed in several coursebooks.

Among all other ELT coursebooks, *IE 1* (2013) pioneers a realistic discussion and representation of two teenage members of the d/Deaf community and communication strategies (Unit 2) as well as an awareness of disability assistive technologies (Unit 5), while also attributing them high value, by putting them into the front units. Yet it fails in critically acknowledging different stigma-sensitive terminological considerations for people in the d/Deaf community, such as ‘deaf’, ‘Deaf’, and ‘dDeaf’ (Pendergrass et al. 2019: 85). Furthermore, an ethically critical discussion of an ‘ableist’ perspective on disability in conjunction with the concept of assistive technologies is missing, not contributing to the development of S-CHL in this context.

Unit 2 (“Communication- Ways of talking”) includes a visual and textual representation of young people in the d/Deaf community, yet terminological considerations regarding stigma-sensitive language use for this diverse group or concepts of ‘ableism’ are not addressed. The article “Sharing Silence” (cf. 20) (see Extr. 18. in appendix, p. 16) is placed at the beginning of the unit and tackles the issue of educational opportunities for deaf people in mainstream schools. Though the title reproduces negative stereotypical associations with d/Deafness (cf. Munoz-Baell, Ruiz 2000: 40), as being

ultimately defined by outer and inner silence the content of the article shows that both teenagers have different ways of communicating with others and with each other. They are described as brave individuals overcoming obstacles in typical schools, yet sharing very typical wishes for their future, wanting to complete higher education, find jobs, and build families (cf. IE 1 2013: 20). Not just that, they appear to even be popular among peers and in their workplace, which proves that they are welcomed by society:

““The other kids didn’t understand us and we didn’t understand them. But we’ve all grown up together, and today, I’m popular because I’m deaf. Kids try hard to communicate with me.”
[...] “The other people who work here have been very nice to us,” Orlando signs. “They even sign sometimes. At first, we were nervous, but we’ve learned a lot and we’re getting better.”
(20)

This positive message may inspire further discussion concerning social and institutional stigmatisation and stereotypes, which need to be changed with the help of social activism, and stigma-sensitive language use in a S-CHL manner. Only some post-reading activities follow such a focus. The coursebook’s unexplained, synonymous use of both ‘deaf’ (defined as “taub” in the vocabulary section, cf. 177) and ‘Deaf’ emphasizes this need, as neither are defined in terms of their differentiated meanings, overlooking the diversity of the d/Deaf community. Such information is not discussed at any point, resulting in a very generalized perspective. But in the post-reading “discussion box” task (cf. 21) (see Extr. 19. in appendix, p. 16) a close consideration about inherent life challenges created through an ‘ableist’ society is induced, likely raising awareness on discrimination and stigmatisation: Though at first glance, the questions appear to follow a negative “problem” (21) pattern, the questions are intended for students to reflect on and realize practices of discrimination, such as exclusion from some jobs, which may often be caused through persistent stigmatisation of d/Deafness. The realizations from this speaking task help to better understand the ensuing listening task (task 2a, b, p.21) (see Extr. 19. in appendix, p. 16) on four communication tips with people from the community, such as not covering one’s mouth (21), among others. Such suggestions mentioned provide some means for respectful intergroup contact to take place in real life, though exploration into further options would be needed in order for S-CHL to be fostered in greater depth.

In Unit 5 (“Technology- Live forever”) the disability discussion turns to artificial intelligence (AI) to assist people with disabilities, such as a “seeing”, “listening” machine, in combination with artificial intelligence programs (62). Such potential developments, which were not yet widespread at the time of coursebook publishing, are described in the unit’s first text “Intelligent Machines” (cf. 62) (see Extr. 20. in appendix, p. 17) and their non-disabled creator Ray Kurzweil, who has made it his mission to create helpful computer technology. Here, a more critical discussion with regards to ethical issues, but also about involving people from the disability community in the production of such technology, according to the motto “nothing about us without us” (Jaeger, Bowman 2005: 111) existing since the

1980s, is not held. Contemporary (2020s) perspectives from disabled scholars, such as Peter and Laura Smith (2021) confirm this in their own AI usage experience. They emphasize that these issues need to be considered, since

“AI technologies have the potential to dramatically impact [...] lives [...]. However, widely deployed AI systems do not yet work properly for disabled people, or worse, may actively discriminate against them.” (82)

Especially in a technologically fast-advancing society, such considerations would have been needed in the unit.

Though the concepts of ‘stigmatisation’, ‘social activism’, and stigma-sensitive language use are not addressed with regards to the disability community, the students are cognitively sensitized towards inter-group contact and the need of maintaining respectful behaviour in communication with d/Deaf people in Unit 2. Such basic awareness may positively influence the development of S-CHL and social activism skills at a later learning stage. Yet the AI- disability discussion in Unit 5 lacks critical and ethical considerations, which could have contributed to S-CHL.

A few years later, these issues are taken up briefly in a segment on guidelines for respectfully interacting with a disabled person, as postulated by a woman with cerebral palsy (W2G 6 (2018)), to be discussed below.

W2G 6 (2018) is the first coursebook to have a focus on diverse marginalised groups, such as disabled or homeless people, but also youth in Unit 7 (“The story of my life”). However, an intersectional focus, linking these individually categorized groups is not observable, but rather isolated, ability-oriented discussions of disability (e.g., a blind judge, a woman with cerebral palsy, paralympic disciplines), which do not consider socioeconomic variables or social determinants of health. With regards to S-CHL, a unique approach is taken with ‘imaginary intergroup contact’ with a lady with cerebral palsy, following a set of proposed interactional as well as terminological guidelines. Together with explicit references to discrimination, bias and disability, some basic disability stigmatisation-awareness is tackled, yet concrete neither stigma-sensitive language use nor social advocacy skills are not pointed out. This renders the coursebook’s S-CHL developing potential to remain at a theoretical level.

As a starting point, various commonly marginalised groups, visually represented through signs (e.g., gendered restrooms, accessible parking, segregated sinks, prohibition of tattoos) (90), are reflectively discussed intended to arrive at an understanding of the concept of discrimination, yet more complex variables underlying the phenomenon are not considered. This signals some the above-mentioned issues in the upcoming disability discussion, which includes theoretical considerations on disability, and also accounts from people in the community.

In the individual section, “Living with a disability” an interview with a blind judge (task 18, p. 95), alongside brief considerations of the definition of disability (task 16, p.95), disability types (task 17, p.95), essential information on understanding people with disabilities (task 21, p.96), and Paralympics (task 25, p. 98) are included. Yet closer information on underlying disability narratives, such as the functional, or medical model, as well as (de-)stigmatisation strategies, such as stigma-sensitive language use is not given. (One exception is made, however, with a very concise text on important things to consider about disabled people, which is unique as well as the text’s assertion that they are the world’s biggest minority group (96).) Though several terms of disability, such as “blind”, “paralysed”, “hard of hearing”, “deaf”, and “mute” (95), are categorized briefly, appropriateness of terminological implications of use in the disability spectrum are not highlighted, which would have fostered greater linguistic sensitivity. Instead, these terms are considered in conjunction with potential ability- “problems” a “disabled teenager” might encounter in work life (“What kinds of jobs could be easy/ hard/ impossible/... to perform with these disabilities?”) (95) and in general. As a concrete example, insights from Judge Bernstein’s work life are presented in a listening task, which emphasizes unique perspectives blind people have in comparison with non-blind people, especially in relation to his personal profession as a judge, who is convinced that “Justice is supposed to be blind.” (95) (see Extr. 21. in appendix, p. 17).

This realistic portrayal is combined with another important piece of information on life with a disability given by a Robyn Lambird, a woman with cerebral palsy, in the text “What you should not about living with a disability” (96-97) (see Extr. 22. in appendix, p. 18). Lambird’s brief text is a unique, pioneering representation of people with disabilities, as it considers this community in the context of lacking representation and ongoing forms of societal discrimination, such as disability narratives, principles of interaction, sensitive language use, which other previous books have not done so far. Thus, it comes very close to tackling health-stigmatisation awareness, by addressing the effects of negative stereotypes of people with disabilities and the need for challenging corresponding attitudes and beliefs.

A fundamental introductory statement frames the text: “Disabled people make up the world’s biggest minority- that includes sensory, physical, mental or intellectual disabilities.” (96). Indeed, this fact has so far been overlooked by other ELT coursebooks. This also applies for the “unacceptable lack of visibility in mainstream media” and “issues regarding body positivity” (96), such as very few ads with people with disabilities as models (96). “We want to be seen. [...] But if we have representation, disability will be normalized, and negative attitudes (like fear and bias) can be changed.” (96). As Lambird herself has cerebral palsy, she contends for the community, but also for people with invisible disabilities who also face negative societal reactions. Most importantly, respectful intergroup interactions, where disabled people can share “stories and challenges” are essential for PWD to “feel valuable and empowered”, as they share the same common wishes and desires with typical people,

such as “employment”, “relationships” and the opportunity to go out and experience the world in the same way as our able-bodied peers” (97). (This wish is similar to that of the texts about Aine, the girl with Down Syndrome and the two deaf friends.) She also briefly indicates which terms and narratives should be avoided, as to not offend. For example, “brave” (97):

“Having a disability doesn’t make us exceptional or inspirational or brave. In fact, those words actually come across as careless and condescending. I shouldn’t be seen as remarkable because I use a wheelchair, but rather because of my achievement in athletics or because I work to raise awareness for my community.” (97)

The narrative of the ‘overcomer’ or ‘superhero’ she is referring to here, is still dominantly found in ELT coursebooks and the media (cf. Cameron 2018: 26), however, representations are increasingly becoming more ‘normalized’, due to gradually improving societal disability awareness. And such a focus is tackled by the following post-reading task (task 22, p.97) (see Extr. 23. in appendix, p. 19) intent on fostering disability sensitivity through actively working with the content of the text: Part a is concerned with assembling “five suggestions on how to respond to people with a disability” (97), creating a list of guidelines, which is, unfortunately, not discussed further. Part b involves students’ ideas and thoughts more practically, by asking three hypothetical questions in accordance with Lambird’s suggestions (“As long as you are polite and respectful, I’m more than happy to answer your questions about my situation.”) (97).

Considering the likely lack of intergroup contact between people with disabilities and non-disabled people in this ELT context, this theoretical, cognitive approach with regards to conversation could be a good basis for authentic, real life dialogues taking place outside of the classroom. For example, research done by Cameron et al. (2011), utilizing the intervention technique of “imagined contact” (Crisp, Turner 2009), or “mentally simulat[ing] a positive intergroup encounter” (231), suggests that it can already in itself have positive effects on “outgroup attitudes and reduced stereotyping” (231). Furthermore, “[i]t curtails intergroup anxiety and extends the attribution of perceivers’ positive traits to others” (231). This, however, does not render actual intergroup meetings ineffective, as suggested in Gordon Allport’s (1954) foundational work on prejudice and discrimination, centred around the “contact hypothesis”, which necessitates “optimal conditions of equal status, cooperation in order to achieve common goals, high degree of frequency and institutional support” (Cameron et al. 2011: 708). Though the task does not explicitly order to consider a full intergroup conversation, creating a few respectful questions out of genuine interest could be good starting point for developing S-CHL, also in this context.

Despite shortcomings with regards to an intersectional, socioeconomic focus of discrimination among marginalised groups, such as disabled people, W2G 6 (2018) is intent on authentic, discrimination-sensitive disability representation and employs (so-far) novel approaches to learning about PWD and discrimination. This is done through ‘imagined contact’ with a woman with cerebral palsy as well as

in conjunction with key guidelines to understand and interact with members of the disability community. Though disability stigmatisation is not explicitly mentioned, these tasks may still tackle basic understandings needed for S-CHL development, as students are made aware of lives, struggles, discriminatory situations, and wishes of two disabled people.

Over the years rather limited notions of disability have been portrayed in ELT coursebooks, contributing to stigmatisation, while also not actively developing S-CHL in students. Particularly in the 1980s very little discussion on the breadth of disability was to be found in coursebooks, with only *ETWO 2* (1984) briefly mentioning ‘visible’, physical “defects” (27). The 1990s contained a small contrastive focus on both academic success (*MYWWE 5* 1998) and euthanasia (*MYWWE 7* 1991) in relation to Down Syndrome only within one coursebook series, which would also carry on into the 2000s. Only the 2010s onwards established a broader representation of various disabilities, such as blindness, cerebral palsy, deafness, amputees, and learning disabilities (such as autism spectrum disorder), still without critically considering SDOH, ableism, disablism, and issues of stigmatisation in language use and dominant disability narratives. Health-stigmatisation is addressed only in one of the more recent coursebooks of the 2010s (*W2G 6* 2018), which includes an ‘authentic’ voice of a woman with cerebral palsy advocating for her community by pointing out the negative effects of stigma-insensitive language and behavioural choices towards disabled people. Even though positive developments regarding greater disability representation can gradually be seen from the mid-late 2010s onwards, most coursebooks still demonstrate lacking explicit stigma-awareness in their corresponding tasks, which frequently miss their potential to tackle S-CHL.

4. Disorders

Mental and physical disorders, which make up a broad spectrum of health conditions, have been commonly stigmatised throughout history. Though attitudes have changed over the past century, especially after the rapid societal developments in the post WW period (cf. Nasser et al. 2001: 2), bearing greater health-stigmatisation awareness, health disorder stigma was not eradicated and still is an issue within society. Analysed ELT Coursebooks appear to generally reflect this trend but are simultaneously lacking in stigma-sensitivity, particularly in the 1980s, until the 2010s.

For various substance use disorders, such as drug use, the 1980s constituted an important time with regards to public stigmatisation. The West (and Austria as well) fell into a deep drug crisis also frequently deemed a “drug epidemic” or “drug panic” (Ahrens 2013: 399), affecting predominantly teenagers and young adults of all social strata. Due to vast numbers of casualties among (young) drug users, high levels of drug use disorder stigma, especially heroin and later on ecstasy, was very much prevalent in society up until the late 2000s (cf. Ahrens 2013: 404)., with gradual changes occurring then due to greater criminalisation of use and distribution as well as due to health campaigns (404).

Though the ‘crisis’ has moved away from public eye and appears to have lessened over the past two decades, addiction stigma-awareness has only gradually occurred in some areas of society, such as within various substance use organisations, who advocate for stigma-sensitive language, such as the National Institute on Drug Abuse’s (NIDA) “Words Matter” guide (2021). In contrast to that, alcohol use disorder appears to be spread more broadly across society, yet not stigmatised as much (cf. Keyes et al. 2010: 1364). However, perceived stigma has been a frequent an obstacle for seeking medical treatment (cf. 1364) over the past 40 years. However, nicotine use disorder, despite being also widely prevalent within society and “glamorized” well into the 1990s (cf. Castaldelli-Maia et al. 2015: 24), has been more stigmatised within the health sector. Increasing medical research ever since the late 1950s (Roberts Harris 1980: v) had already pointed out a multitude of health consequences, which could have easily been prevented in both men and especially women, only discovered to not be “immune” to smoking-related health problems in the 1980s (cf. Roberts Harris 1980: vi). Today, health promotion strategies have increasingly come to question (gender-based) smoking-stigma, only gradually considering less-stigmatising alternatives (cf. Helweg Larsen et al. 2019: 2).

With regards to other mental disorders, those related to body image and weight, such as eating and body dysmorphic disorders, were the newest to be stigmatised, coinciding with sharp anorexia and bulimia nervosa increases in the female population throughout the 1980s (cf. Nasser et al. 2001: 1). Such developments are ongoing, though the most recent (2010s) paradigm shift includes the acknowledgement of even more stigmatised male eating and body dysmorphic disorders (cf. Strother et al. 2012: 346). Similar implications apply for mental health issues, such as personality disorders, depression, and anxiety, whose deeply rooted stigma is only now being tackled (2010s onwards) (cf. McHugh, Martinez 2021: 33) in society and the educational context.

In the following section the stigma-(in-)sensitive depiction of these disorders in ELT coursebooks will be analysed, as well as the strategies to develop S-CHL, starting with substance use disorders (drug, nicotine), then moving on to eating and body dysmorphic disorders and finally ending in a brief discussion on mental health disorders.

4.1 Drug Use Disorder: Drugs, War, Danger, Tragedy, Panic and Teenagers

In accordance with contemporary problems of drug-consumption (cf. Ahrens 2013: 400), upper secondary ELT coursebooks, especially from the 1980s and 1990s, have devoted themselves heavily to including a discussion on drugs and drug use disorders in their material. Various books, such as *MYWWE 6* (1990), *MIW 3* (1996), not only put an emphasis on basic understanding on the effects of drugs, but also show many perspectives of people involved, such as those on the side of law-enforcement, those using drugs, trading and/or selling them. Regarding stigmatisation of those with a drug use disorder, alternations of (non-) stigmatising language can be observed over time, with some terminological incongruencies. Simultaneously, CHL is fostered predominantly through conceptual project tasks that raise awareness on health-implications of drug use, however, they tend to leave out a

stigma-sensitive focus. In the following section the representation of drug use disorder will be looked at from various perspectives in *TESPW 1* (1981), *2* (1984), *MYWWE 6* (1990), *MYWA 6* (2005), *MIW 3* (1996), *PT 7* (2011 & 2018).

4.1.1 (Everyday) Drugs, Society, ‘Dangerous Addicts’, Teenagers, and Hope(lessness)- *TESPW 1* (1981), *2* (1984), *MYWWE 6* (1990), *MYWA 6* (2005)

In line with contemporary developments of the dramatic crisis of drug use, *TESPW 1* (1981) and *2* (1984) tackle the issues of substance use disorders in their coursebooks and companions. Yet stigma-awareness towards people with substance use disorders is not observable, instead textual representations adhere to negative narratives of drug, nicotine, and alcohol use disorder, such as that of the ‘drug victim’, the ‘mindless addict’ and the ‘societally dangerous addict’, instead of critically discussing concrete health implications or social determinants of health. But also drug traders are visually and textually depicted in stereotypical, essentialist ways with regards to foreign nationality, low socioeconomic status, bearing a stigma of their own.

TESPW 1 (1981) mainly discusses drugs in Unit 16 “The Desert War of a Lone Sheriff”, which is placed towards the end of coursebook, containing 19 units in total. Topic-wise it is also embedded in a USA-specific focus, though ‘drug-hunting’ experiences of a sheriff with a mission born out of personal drug tragedies are included at the unit’s forefront. Related discussion tasks, which do not prevent stigmatisation, are placed in the companion (1982). These topics are again tackled in *TESPW 2* (1984) and its companion, which now embark on a more critical, health-related discussion, yet without stigma-sensitivity because ‘addicts’ are presented as a threat to society.

The interview with sheriff Hank Turner from the Narcotics Division of L.A. Police Department tackles questions, such as geographical points of operation of drug dealers, the international structure of the trade, commonly affected social groups, financial aspects, and current interventions to help those affected (cf. 96). Here, drug dealers, are essentialised (and stigmatised) through associations of nationality and socioeconomic status (“from the poorer classes like the Blacks or Puerto Ricans” (96)) and depicted through the ‘evil pusher’ narrative, one of many theories of drug use (cf. Lettieri et al. 1980). South America, and Asia are painted as the main countries of origin for drugs (cf. 96), leading “poorer classes like the Blacks or Puerto Ricans”, who also have mafia representatives in the US to become dealers in “big cities like L.A. or New York” (cf. 96).

It is evident that *TESPW 1* (1981) and *2* (1984) adapt a negative, stigmatising view of those people with substance use disorders, seeing them as mindless beings enslaved to drugs: Though “drug treatment center” is used instead of “rehab” or “detox” centre, expressions considered offensive (NCDJ 2021: 43), compounds of the word “addict” are used throughout the text (mentioned above) and consecutive exercises in the companion. Since the text uses these expressions in a generalizing manner, not necessarily drawing upon a medical diagnosis, “addict” is considered offensive, as it “den[ies] [the] dignity and humanity of the individual” by equating person and substance use disorder,

“impl[ies] a permanency to the condition” (UISCE 2020: 2). Those using the drugs themselves are portrayed as hopeless victims (“For an addict life without drugs is hell. They’d do anything to get the stuff” (TESPW 1 1981: 96)), mindless “addicts”, who are cast out from society (“But treatment isn’t enough. The addict has to cooperate. And afterwards he has to be integrated into society” (96)). Though their individual motivation for drug use may vary, all of these young “addicts” are presented as “shar[ing] a lack of faith” (96). Such negative representation, concerned about young adults’ “early death” (96) and the bleakness of their situation, coincides not only with the black background of the page, reserved for only this article (cf. 96), but also with the lack of a critical health-related discussion on the substances themselves, not providing students with more concrete information on substances, side effects, health complications (and stories of recovery).

This previously mentioned lack of information on specific health consequences also extends to task 6 in the companion, the discussion of the “long-term effects of the drug nicotine” (TESPW 1, part 2 1982: 99), which, however, instigates a more socio-critical discussion in conjunction with smoking: Fear-inducing messages from Californian hotel rooms are discussed critically in conjunction with a contrastive image of a deceptive cigarette ad, which conveys a sense of flirtatious enjoyment connected with smoking in nature (see Extr. 24. appendix, p. 19). What is notable here is that smoking cigarettes appears to be put into a similar stigmatising category as “drug-taking” in this coursebook, a link that has not been explored by analysed coursebooks too often, though both disorders often co-occur (cf. AAP 2015: 1). Indeed if examined more closely, the term of ‘drugs’ could be explained more broadly as Breger-Bush and Kriesie (2020) suggest, namely that essentially “all of us, human and non-human alike, [are] revealed to be drug users” (487), as “drugs are not only natural to humanity but are themselves “vegetable”” and “are made from plants and animals and other natural things like rocks and water” (489). Originally ‘drugs’ were conceptualised in the 19th century as “a substance that has a physiological effect on a living organism” (Breger Bush, Kriesie 2020: 487). Yet such an understanding is not commonly applied, leading to the term becoming a tool for social stigma in the field of addiction, primarily of narcotics ever since the 20th century (cf. 487). *TESPW 1* appears to be informed about health consequences of both SUDs and addresses them in its health-related content, in conjunction with the experienced alarming increase of teenagers with various substance use disorders.

The focus of the tasks in the companion book (cf. TESPW 1, part 2 1982: 98-99) for this unit seems to be put on this age group, implying an intent of deterring students from smoking, by providing contrastive textual and graphic input, which is rather shocking. For example, “In 1980 more than 100,000 Americans died of lung cancer. 85% of them started smoking before they were 18.”, “The nicotine of one cigarette is enough to kill a mouse” and “Please, don’t smoke in bed. We don’t want you to make an ash of yourself”, all send across warnings of the (hidden) dangers of smoking, while not considering concrete consequences for personal health in line with health literacy. In contrast, the smoking ad (cf. 99) (see Extr. 24. appendix, p. 19) is presented as inherently deceptive, with the

reflective questions asking, “How does it try to make people smoke or buy these cigarettes?- Is it telling the truth?” (99)). Further inputs for peer-related smoking discussion follow, adapting a more critical stance (“Why do some young people start smoking? Do they really like it when they smoke for the first time?” (99)). This shows that while S-CHL is not fostered, some minor critical thinking skills are addressed.

TESPW 2 (1984) builds on this information, by adding alcohol to *TESPW 1*’s conceptual list of ‘drugs’, a more realistic extension of the frequently limited ‘drug’ concept. Described as a “most dangerous drug almost everywhere in the world”, critical discussion tasks mainly revolve around its common use, but also the resulting burden that ‘addicts’ “put upon the state and on all tax-payers” (*TESPW 2* 1984: 118) as well as their inherent danger for others (“not only endangers the drunk person, but also other people”) (118). A final reflective task (either an essay or a talk) with a rather extremely worded instruction based on quote from Geoffrey Chaucer’s *The Pardoner’s Tale* (“How disgusting a sight is a drunkard!”) (118) ensues, which may lead some students to critically tackle the previously hinted double standards of society with regards to alcohol.

Smoking and drug-taking, discussed in the previous book, are also included here in this section on health-harming drugs. The person consuming the substance is attributed inherent dangerousness for their surroundings: In the case of smoking, the introduction to task 3 asserts scientific proof of its health-damaging effects, still (just as in *TESPW 1* (1981)) without mentioning more concrete details (“Medical science has proved without doubt that smoking [...] can lead to several illnesses, even lung cancer” (*TESPW 2* 1984: 118)). This time, however, the problem of passive smoking is highlighted (“However, it is not only the “active” smoker who suffers; anyone sitting near a smoker is, whether he likes it or not” (119)). Thus, the creation of a campaign that primarily protects non-smokers in public spaces is given as a task to students. Though such as task involves finding arguments against smoking and designing representative ‘anti-smoking’ visual materials, which do not consider likely stigmatisation of smokers, it does provide some basic tendencies towards CHL, as it is concerned with promoting health conducive behaviours beneficial in a wider societal context in conjunction with problems encountered by non-smokers. With regards to narcotics, task 4 (see Extr. 25. in appendix, p. 19) is interested in discussing health consequences, but now primarily also pays consideration to critical reflection on power relations in this realm, suggesting that several higher-ranking ‘villains’ are at play not only on local, but on a global level, manipulating society’s understanding of “harmless” and “soft” (119) drugs. Such considerations may be helpful for students to understand the broader picture.

Contrary to many other coursebooks, *TESPW 1* and *2* tackle content on substance use (disorders) in a related manner, consecutively expanding the discussion. However, *TESPW 1* (1981) does not elaborately consider concrete substance use disorder health implications or use stigma-sensitive language. Furthermore, drug dealers are represented stereotypically, and people with DUD as

mindless ‘addicts’, waiting for impending death, a rather fear-based focus, not tackling S-CHL. *TESPW 2* (1984) expands this discussion by considering underlying power structures of the drug industry and societal relations to smoking and alcohol use, which are presented as widespread use of drugs. Though individuals with such disorders are also stigmatised here, the book’s widened concept of ‘drug’ may imply an awareness of societal double standards of types of addict-stigmatisation, which other most other books do not consider, pointing out the need for a greater focus on S-CHL also in future coursebook development. In contrast, *MYWWE 6* (1990) takes on a different stance, highlighting the experiential, namely personal stories of drug use.

In Extensive Unit 6 “Turn on, tune in, drop dead”, *MYWWE 6* (1990) instigates a change in the way people with drug use disorders are presented: The topic discussion now draws heavily on subjective experiences of young peers, is based around a popular, not uncontroversial novel (*Go Ask Alice* (1971)). It is combined with specialised health information on drugs, their visual and chemical properties, health consequences and historical considerations. Yet it portrays signs of little stigmatisation-awareness through terminological struggle between unexplained use of (non-) stigmatising language as well as of minimal activities to develop the active part of CHL in this context. Furthermore, dynamics and power struggles of (international) drug trade as well as socioeconomic aspects of the diverse community of people with substance use disorder are not addressed, leaving out CHL related issues of social justice and social determinants of health. Still, visually, and content-wise, this unit contains the broadest representation of (people with) drug use disorders so far (in comparison to *TESPW* (1981-1984)), opening up discussion on taboo issues of drugs and drug experiences, a step towards de-stigmatisation.

The unit’s centre text *Go Ask Alice*, used for as a discussion basis for drugs, though itself an interesting content choice due to its controversial nature⁵, paves the way for a focused experiential discussion of teenage drug use, related health challenges, drug properties, consumption modes and ‘trip’ experiences. With regards to S-CHL development, though the concept of health-stigmatisation is not explicitly addressed, it appears that *MYWWE 6* (1990) approaches the topic in a peer-focused, information-based manner, allowing for plenty reflection on the overall issue. A fear-based narrative of while- and post-drug use is apparent in the information given, but also simultaneously more insight into reasons of drug use riskiness, obscured in *TESPW*.

Strategically, the topic of drug-taking is discussed from different informational viewpoints, namely that of the protagonist, sociologists, medical experts, other (teenage) drug users and a man free of drugs. This constitutes an unprecedented diversity of informational sources, which aids students’

⁵ The novel has come under fire not only due to issues with content accuracy and extreme explicitness deemed unfit for teenagers, but also due to inaccuracies with regards to alleged authenticity and authorship (cf. Quillette 2022). *MYWWE 6*, however, continues to purport that it is “based on the actual diary of a fifteen-year-old drug user” (*MYWWE 6*: 83), which is a source issue of its own.

health literacy development, a positive sign towards de-stigmatisation. Together with a brief considerations of the 15-year-old protagonist's motivations for drug use, which appear to be mainly caused by heartbreak ("How could he have hurt me so much?") (83) and search of self- and peer-acceptance through an eating disorder ("just want to be someone important" (83), a general reflection on potential reasons for drug use (task 3 & 4) is initiated. To verbalize them succinctly, nine drug use theories (e.g., "Weak Personality", "Evil Pusher", "Pleasure", "Rebel") (84) (see Extr. 26. in appendix, p. 20) are introduced, which also match with similar, although more complex theories from the field of sociology (cf. Mosher, Akins 2021: 51). A leaflet of most frequently encountered drugs together with individual photos, and descriptions of their effects, modes of consumption, side effects follows (85) (see Extr. 27. in appendix, p.20). For example, amphetamines, cannabis, cocaine, crack, heroin and LSD are listed together with 'street names'. Furthermore, a list of general "dangers of drugs" is given, briefly discussing side effects and health consequences, which addresses different effects for the sexes ("Regular users may become constipated and girls can miss their periods.") (85). (This focus on female-specific drug health consequences, later recurs in a more detailed body mapping format in *MYWA 6* (2005)).

Other testimonies of (former) people with drug use disorder are included to give further insight into their reasons and experiences, aside from extracts leading up to Alice's tragic, yet mysterious death (cf. 90). Such information may aid students' cognitive and affective understanding of the issue, faced by individuals of different socioeconomic backgrounds. For example, the life stories of people aged 16 to 55 years old in different stages of drug-taking (cf. 86), six personal 'drug trip' experiences of teenagers aged 15-to 18-years old (88), the latter contains exclusively highly unpleasant ("hell", "no sense of reality", "feeling sick", "horrible" (88-89)) and horrific experiences ("hallucinations", "I saw this black hand, coming along and clenching and unclenching in front of me") of drug 'victims' (88). This provides a stark contrast to Alice's pleasurable experiences ("Each time is the best time") (88), which still lead her into the psychiatric hospital after all.

The end of the unit takes a more hopeful turn, with the story of an "ex-addict" (95) (see Extr. 28. in appendix, p. 21): As this married man with children successfully turned away from use of various substances by sheer willpower, his testimony switching to the previous drug narrative of victimisation to that of empowerment and transformation to a healthy life, a rarely depicted perspective so far. This not only completes the so-far incomplete and negative picture of drug users, but normalizes recovery and life change, as a part of a de-stigmatising move in a coursebook that struggles with stigmatising and de-stigmatising language use.

CHL development is only vaguely addressed in the unit's final task (#10, p.99) (see Extr. 29. in appendix, p. 21), disregarding realistic, personal advocacy skills appropriate for teenage students, by making them take on the role of a politician right away: This writing task instructs them to outline and select the general public's previously suggested solutions to the current drug crisis, such as fines,

capital punishment for dealers, advertisement bans (cf. 99). However, solutions to the underlying issues surrounding stigmatised drug use or necessary skills to do personal critical health activism as a young, responsible citizen are not at all considered. But also, awareness on stigma-(in-)sensitive language use is not raised explicitly.

Throughout the unit various terms are used to denote drug use disorder, which are, according to advocates (NCDJ 2021: 4), stigmatising, for example “problems with drugs”, “deal with this problem”, “problems like Alice’s” (88), “dangers of drug abuse” (94), “drug abuse habit” (96), “drug addict” (97), and “staying clean” (97). These terms are problematic because they convey an inherent negativity and danger regarding people having this disorder (“problems”, “danger”), but also a danger of inherent impurity and uncleanness associated with consuming drugs (“staying clean”). However, simultaneously, synonyms are also frequently used, which are non-stigmatising, in order to avoid word repetition, such as “drug dependents”, “hooked on drugs”, “caught by drugs” (88), “people who take legal or illegal drugs” (84) and “drug user” (82) instead of ‘drug addict’.

This mix of identity- and person-first language and its implications is not explained in the coursebook, possibly leading students to consider all of these terms direct synonyms for compounds of ‘addict’, without realizing terminological incongruencies. For example, ‘drug dependent’ is used interchangeably with ‘drug addicted’, a well-known and widely debated issue: Until APA’s (American Psychological Association) recent classification of substance use disorders as mild, moderate and severe instead adhering to the ‘addiction’- ‘dependence’ dichotomy (cf. Juergens, Hampton 2022: n.p.), it was commonly argued that the main difference between the two is of a mental and physical nature (n.p.). ‘Addiction’ “is marked by a change in behavior caused by the biochemical changes in the brain after continued substance abuse” which “becomes the main priority of the addict” (n.p.) Furthermore, it “encompasses both a mental and physical reliance on a given substance” (n.p.). ‘Dependence’ refers to bodily reliance and is “characterized by the symptoms of tolerance and withdrawal” (n.p.). Before this contemporary view, the definitions of these words were switched, attributing greater importance of bodily reliance to ‘addiction’, instead of ‘dependence’ (cf. Juergens, Hampton 2022: n.p.). Even in the 90s and several decades before that, however, ‘addiction’ was considered offensive, as the WHO had endeavoured to rather use ‘dependence’ in the 60s. Amidst these contrastive considerations it is clear, however, that both terms cannot be used interchangeably and should be used in consideration with the respective individual case. Thus, the coursebook authors not only reflect the existing terminological confusion, but also fail to address it in their teaching of vocabulary, since the words are defined vaguely (‘dependence’= “state of being dependent”; ‘drug addict’= “somebody who cannot do without drugs”) (MYWWE 6 1990: 92). This opportunity to sensitize students for linguistic issues, was not utilized, missing a chance to foster not only CHL, but also S-CHL, as language use significantly contributes to stigmatisation processes.

It can be concluded, that though not explicitly mentioned *MYWWE 6* (1990) tackles some CHL with regards to finding a solution for the drug epidemic among youth, albeit rather unrealistic, by adapting the viewpoint of a politician, which may be difficult for students. Stigmatisation is not explicitly mentioned in the unit, yet signs of terminological struggle show that non-stigmatising language use is being implemented, which would need to be discussed explicitly in order to foster topic-related stigma-awareness in students. All in all, *MYWWE 6* (1990) arguably sets off a discussion, which expands students' basic knowledge about drug use and its effects, yet still is limited in terms of a more socially, stigma critical perspective, which is also lacking in *TESPW 1* and *2*. Contrary to these depictions, *MIW 3* (1996) a distinct preventative and problem-solving focus, by predominantly looking at the US and local socioeconomic structures surrounding drug use, drawing a bigger picture of the topic.

4.1.2 “The War Against Drugs” in the US and Europe: Racialised Depictions- *MIW 3* (1996)

Of all other previously analysed coursebooks, the project resource book of *MIW 3* (1996), has the greatest textual (and visual) informational value with regards to properties of a broad variety of drugs, health and life consequences, (causes for) drug use among different social strata in the US and Europe and problem-solving considerations in Unit 2 “Drugs”, a contrast with the main coursebook's focus on solely communicative functions. Students are also sensitized towards terminological issues addressed in the previously analysed section 4.1.1, but also are instructed to critically combine all the medical, socio-political information to design an authoritative campaign to suit their peers and community. Though the topic of drug use disorders is dealt with in such an extensive manner, the notions of health-stigmatisation, social determinants of health, power struggles, and discrimination are not directly addressed. However, arguably, the presented information could evoke more focused discussions tackling these points, tackling S-CHL.

MIW 3 (1996) follows a chronological, holistic approach on the topic, focusing on factual, medical, socio-political information on drugs themselves rather than predominantly presenting individual experiences of youth with drug use disorder, as seen in *MYWWE 6*'s (1990) subjective approach. The unit is started off with a brief history of drug epidemics in the US, mainly revolving around the medical misuse of cocaine and opium in the late 19th and early 20th century. The information here, however, is of a highly graphic nature, directly depicting five modes of consumption and distribution, such as “hawking cocaine”, “shooting up”, “turning on”, “peddling acid”, as well as one fearful, cocaine-stigmatising health promotion poster from the 1930s (“Cocaine the Thrill that Kills”) to scare off youth (*MIW 3* 1996: 12) (see Extr. 30. in appendix, p. 22).

More importantly, this is combined with a reflection on the meaning of ‘drug’ itself, whose conceptual complexity other coursebooks have tended (and still tend) to disregard. The text “The Meaning of Drug” (12), discusses implications of ‘addict’, ‘tolerance’, ‘dependence’ (12). Similar to *MYWWE 6* (1990), ‘drug dependence’ is used as an alternative term. However, here WHO's explicit

recommendation for the term is explicitly addressed. A clear explanation that though ‘addict’ and its compound are “out of fashion”, coursebook authors use it “with reservations”, “since the word still popularly encapsulates the menace” (12), is given. Though the text only briefly addresses this issue, (which still is underdiscussed in more modern coursebooks), its critical perspective of society’s unexpectedly limited understanding of the pervasiveness of various ‘drugs’ could be a positive indication of some health-stigmatisation-awareness, which is similar to *TESPW 2* (1984), although explicitly defined here. For example, this is can be seen in the text’s initial statement:

“A drug is any chemical substance that alters mood, perception or consciousness and is misused, to the apparent detriment of society. People often don’t consider alcohol a drug, because our society is itself dependent on it.” (12)

It suggests latent societal arbitrary understandings of the ‘drug’ concept, which appears to foster practices of stigmatisation. But also, the ensuing discussion questions (“In how far is nicotine different from the other drugs mentioned? Would *you* consider it a drug?”) (12), indicate a similar understanding, directed towards S-CHL. This is also emphasized by the detailed categorization of four main types of drugs (that “depress the nervous system”, “reduce pain”, “stimulate the nervous system”, “alter perception”) (13), effects, consumption, and legal information. Furthermore, this is the only list that includes caffeine, tobacco, gases and sleeping pills (cf. 13) in it, to widen previous notions of ‘drugs’ even further.

Though a comic narrates the personal story of a young man using drugs is included thereafter (“Why do people take drugs?”) (14), the unit is mainly focused on exploring international solutions particularly for the US and Europe, such as increased health promotion, legalisation of drugs, and evaluating “[n]ew [t]actics for the [d]rug [w]ar” (17). As the majority of the material is US-specific, a racialised is shown, which is unique among other coursebooks. Similar to other coursebooks, the main reasons for drug consumption depicted are either boredom, relational or educational problems. But an even greater focus is put on drug trade caused by class-related struggles: Contrary to previous depictions, visual and textual representations of people of low socioeconomic status and almost exclusively of colour can be found in this book, a new development, which fits stereotypical associations regarding the issue. A focus on certain ‘drug narratives’, which are presented as related to the US, can be observed, such as of the evil, mysterious ‘drug pusher’, predominantly a person of colour (cf. 16) as well as predominantly families of colour currently being affected by drug consumption (cf. 17-19) in contrast to the previous historical overviews of the late 19th and early 20th century drug epidemic, which was presented as targeting primarily middle-class members of society. *MIW’s 3* (1996) racialised drug-use depiction also extends to suggestions for becoming free of this disorder by means of “prevention”, “treatment” and “codependency” (19), which either exclusively depict drug raids, anti-drug protests participants or family groups of colour, with members next to each other, signalling closeness (see Extr. 31. in appendix, p. 22). (Conversely, the very few people

not of colour are visually depicted exclusively in as being arrested, possibly as drug dealers, another interesting visual message, which highlights the global interconnectedness of this industry.)

All of this information forms the source basis for the “How to Beat Drugs” project (19) (see Extr. 32. in appendix, p. 23), which appears to primarily address health concerns (“the danger of drugs”) (19), but not a critical understanding of S-CHL. As the focus is put on creating a “drug-education programme at your school/ in your community”, primarily concerned with the inherent “danger of drugs” (19), the task may not focus on stigma-sensitivity or social advocacy in this context. However, the proposition of also inviting experts on the issue, such as “ex-addicts” (19), may open up a discussion towards this direction.

Though *MIW's 3* (1996) coursebook is focused on grammatical functions, its accompanying project resource book contains a wealth of information on ‘the war against drugs’ from a US perspective in Unit 2 “Drugs”. Contrary to previously analysed story-based discussions, *MIW 3* puts a greater emphasis on social class, associating primarily lower-class racial minorities with drug use and trade in the US. Though the understanding of the drug concept is widened and seen more critically in relation to society, stereotypical depictions of racialised drug narratives are not discussed with a stigma-sensitive focus. This also extends to the drug campaign task, which is fixated on tackling the dangers of drugs in the context of schools and students’ personal communities, a useful skill, which would need to also tackle stigmatisation awareness to move towards fostering S-CHL.

4.1.3 Teenage Ecstasy Panic: Female Health Consequences – MYWA 6 (2005)

MYWA 6 (2005) continues *MYWWE 6's* (1990) experiential, story-based discussion of drugs in a designated unit, however, now, moving it to a position of greater relevance (Unit 1 “The pursuit of happiness”) and changing some of the drug use disorder discussion tactics to draw on other interrelated aspects of youth, such as such as the search for happiness through clubbing, friendship and the use of other substances, such as nicotine and alcohol. Though discussion still does not explicitly recognize or critically discuss stigmatisation of people with drug use disorder, it briefly explicitly recognizes young people’s despair and inner turmoil, leading to drug use and repeats various drug use theories previously mentioned in *MYWWE 6* (1990). Furthermore, it maintains a focus on inherent drug properties as well as their bodily consequences of drug use, the latter of which, interestingly is presented only in female body mapping, a stark contrast to the coursebook’s now very limited visual representation of people with drug use disorder.

As a content basis, the previously discussed controversial novel *Go Ask Alice* (1971) is replaced by Irvine Welsh’s *Ecstasy* (1996), a collection of three novellas discussing drug use among young people. Though the extract given titled *Lorraine goes to Livingstone* narrates the pleasurable, escapist, but seemingly harmless drug experiences of Glen, and Martin, two friends ingesting ecstasy while clubbing, consecutive tasks mainly focus on another character, only mentioned by name. It is

suggested that Yvonne's experience of taking the very same drug on the same night as well as its effects on her body were life changing (cf. MYWA 6 2005: 14). This contrasts with the representation of the two young men, whose feelings and thoughts during the 'trip' are only considered shortly, otherwise implying no other negative consequences. However, Yvonne seems to be impacted severely. Aside from the diary writing task (task 5, p. 14), which addresses this issue, it appears that the coursebook particularly uses the female body to represent female ecstasy consumers in a stigmatising, fear-inducing manner: Task 6 about the "dangers of Ecstasy" (15), in a leaflet format by the "Health Education Authority" (15) depicts a young woman's reflection in the mirror (see Extr. 33. in appendix, p. 23), a body mapping of the different body parts affected by ecstasy.

What makes this image unique, and fear-inducing is that some of the affected organs are highlighted through her undergarments, showing a 'vulnerable' (or already damaged) inner body, in contrast to her outer figure. Her shocked face (indicated by her open mouth and serious eyes) conveys a similar sense of fear as some of the outlined health consequences across her body. Explicit warnings include the heading itself "Ecstasy- Know the Score" (15) or the warning message of "Even if you've taken E before and felt alright, that doesn't mean you'll be OK the next time." with an arrow pointing towards her brain (or also "Even if the E is pure, that doesn't mean it's safe.") (15). Though several of these issues also pertain to men, only the problems for the female reproductive system are described ("Girls could be prone to suffer from cystitis and heavier periods.") (15). A similar tendency can be observed in another ensuing information leaflet on drugs ("Regular users may become constipated and girls can miss their periods.") (17). Strangely, consequences for the male reproductive system, which several studies have specifically confirmed after the coursebook's publishing (Dickinson et al. 2008; Barenys et al. 2010), are neither indicated in this unit, nor anywhere else in the coursebook. This could be explained either through the tasks' specific focus on Yvonne or through an authorial lack of awareness of correlating scientific studies. In either way, the gendered-view of ecstasy health-consequences coinciding with a lack of critical discussion on such a depiction is apparent. Similar implications apply for the consecutive listening task (#7) on 17-year-old Sheena, who is presented as a former 'victim' of ecstasy, choosing to have an abortion, among other lifechanging events (cf. 16).

This unit appears to miss opportunities for developing S-CHL, by predominantly tackling the other two variants, namely functional and interactive HL instead, which is a minor improvement to MYWWE 6 (1990). Together with the presentation of drug-related facts and terminology in the leaflets discussed above, most exercises are concerned with the former type, such as summarizing and re-arranging information on UK drug statistics from 2003 (task 6, page 20). Both functional and interactive HL is fostered through a peer advice task related to an online teen health forum (task 9, p. 30). While the practical development of social advocacy skills is only briefly included in task 11 (31) and is identical with that of MYWWE 6 (1990) (previously discussed in section 4.1.1, page 57), a new text (see Extr. 34. in appendix, p. 24) is now introduced in the final position, which addresses the need for

a societal attitude shift regarding drugs (“Has the time come for a rethink?”), also pointing towards the de-stigmatisation of people with drug use disorder: The societal widespread use of drugs “of some kind” (33) is acknowledged only at this point, suddenly indicating an expansion of a narrow ‘drug’ concept understanding perpetuated in the unit itself. Suggested potential changes include drug educational measures for “journalists, politicians, teachers, doctors, parents and carers, and young people so that they understand the subject better and can face drug issues sensibly” (33). Together with other strategy ideas, such as changes in police and club owner attitudes towards ecstasy taking youth to provide counselling and (medical) help instead of punishment, first CHL reflections become apparent, a minor change to *MYWWE 6*’s (1990) exclusive problem focus.

Though most tasks from *MYWWE 6* (1990) are also included in *MYWA 6*’s (2005), the latter coursebook’s discussion of drugs and the representation of people with drug use disorder has changed little. Now considering teenager’s search for happiness in friendship and clubbing-related use of drugs, the visual representation of drugs themselves, such as ecstasy, and their physical consequences depicted in female body mapping, with its own unique stigmatising implications, visually unmatched by other coursebooks, still continue a fearful discussion of the issue. However, indications of a paradigm shift regarding greater stigma-awareness and the need for social activism, as well as critical considerations of the limited, socially arbitrary ‘drug’ concept are observable during the final tasks.

Regarding these examples of the past pages, it can be said that drug use disorder has been represented most extensively of all groups over the last four decades. Though depictions have varied with the severity of the drug crisis and have often reproduced stereotypes regarding sex and race, awareness of stigmatisation appears to only gradually set in (*MYWA 6* (2005)), signalling the need for stigma-sensitive CHL to be fostered.

4.2 Nicotine Use Disorder: Cigarettes, Women, and (Un)happiness

The relationship between cigarettes and humans is a long and fascinating one, marked by changes in purpose and use since colonialist times (cf. Castaldelli-Maia et al. 2015: 25). As tobacco was increasingly popularised among the masses, stigmatisation due to associations with low socioeconomic status and later on, also glamorisation in conjunction with media portrayals as a power symbol set in, only to be followed by stigmatisation once negative health consequences were discovered (cf. 26). Such developments are also reflected in the analysed coursebooks, which, similar to drug use disorder, discussed previously, appear to specifically highlight sex in their portrayals of smokers, such as *MIW 1* (1989), *MYWWE 6* (1990), *MYWA 6* (2005), except for *PT 7* (2011& 2018), which departs from a narrow, morally criticising view.

4.2.1 (Problematic) Female Smokers in the Limelight: Stressed, Unhealthy, but Happy? – *MIW 1* (1989), *MYWWE 6* (1990)

MIW 1 (1989) relegates the discussion of health-related issues to the project resource book, (as per the design of the coursebook series), which also contains a brief discussion on smoking. Unit 10 “Health” in the project resource book provides plenty of textual and visual materials to provoke critical discussion about (female) smoking and other related health-stigmatisation, tasks mainly display a mixed focus on interactive HL and CHL, without discussing health- stigmatisation or S-CHL: This is seen in the final project task, based on the public health SASH campaign concept, which revolves around designing a school-wide anti-smoking campaign to convince other students to adapt an overall healthier lifestyle (68), drawing upon personal reflection on smoking cessation (task 2, p.66).

Though the content is addressed to both sexes, it appears to criticise and even stigmatise women’s smoking behaviour through small visual elements and stories. This most likely is in line with societal developments of the time, which was characterized by a great influx of the discovery of smoking-related health problems, leading to a paradigm shift towards anti-smoking initiatives (Segrave 2005: 39).

Women’s smoking-related health problems are specifically emphasized in several reading tasks: One of them is a reading task “1.Think about stopping”, a plaidoyer, which insists on its numerous immediate and long-term benefits, such as increased fitness, better finances and health, greater life expectancy, as well as improved relationships with family and friends (cf. 66): Though the dangers associated with smoking young people face, such as premature death, are explained in general terms, only smoking , pregnant women are portrayed as encountering unique problems in terms of their reproductive system, such as “a greater risk for miscarriage” or problems with unhealthy development of the baby (66), yet no other, more detailed information on men or women is given. This singling out of women in the question of nicotine use disorder also becomes apparent in a comic (see appendix, p.), which shows a man advising his partner to stop smoking (“Oh Jane darling! It would be so much **nicer** if you didn’t smoke all the time.” (66)). But also a real example of a female ex-smoker is included close by, namely a text about 17-year-old Kathy Martin (see Ext. 35. in appendix, p. 25), who was compelled to stop smoking through remarks of her boyfriend as well as by through the American Heart Association’s “Save A Sweet Heart- Yours” campaign (SASH) hosted at her school on Valentine’s Day. Together with romantic promotion elements, such a pink “I’m kissable. I don’t smoke” badge (66) and the direct comparison of girl versus boy smoker rates (12.7%-10.7%), the unit depicts smoking as an issue particularly related to women.

Such tendencies of presenting female smokers negatively can be explained through chronological societal developments. At the time of the coursebook’s publishing in 1989, medical evidence of sex-based different effects of nicotine for women and men was found, with a specific focus on the female reproductive system. The Surgeon General’s Report, published in 1980 and titled “Health

Consequences of Smoking for Women” (cf. Roberts Harris 1980), provided pivotal information, which would propel efforts to further decrease smoking rates, continuously dropping in the 80s and 90s (cf. Dworak-Peck 2017: n.p.). Major health consequences listed in the report are not only commonly associated ones, such as lung cancer and premature death (cf. Roberts Harris 1980: vii), but also a “22-fold increase in the risk of subarachnoid hemorrhagic stroke” and a “20-fold increase in heart attack in heavy smokers” (viii) in conjunction with the use of oral contraceptives. Also, the discovery of various complications with fetal development, increased rate of miscarriages as well as health problems with newborns, made in research efforts focused predominantly on the female reproductive system leading up to the 80s (cf. 264). While these discoveries instigated a paradigm shift regarding female smoking in the medical realm, cigarette companies only weakened their advertising tactics geared towards their new consumer base of women, instead of cooperating in reducing smoking numbers. These tactics were clearly regarded as successful by these companies, who had ventured into this new consumer base in the early 20th century (cf. Dworak-Peck 2017: n.p.).

Female smoking numbers experienced great surges in both post WW periods, but especially after WWII, where women increased their fight for equality (cf. Dworak-Peck 2017: n.p.). Already during the early- and mid-20th century, numbers of female smokers increased as smoking became associated with independence and freedom (cf. Segrave 2005: 108), or as a 1920s *New York Times* reporter put it:

“By some queer alchemy the cigarette has become her symbol of freedom. It isn’t the cigarette that she wants. It is rather what the cigarette represents. And she is essentially honest. Since it isn’t honest to smoke when smoking is against the rule, she would alter the rule” (Segrave 2005: 108-9).

This was an interesting development, considering that female smoking had been particularly stigmatised only shortly before. As this quote suggests, opposition to female smoking was strong during that time, since smoking was inherently seen as “a dirty habit; characteristic of single, urban men” (Segrave 2005: 109). Contemporary critics also argued that “[t]obacco was one of the items that separated the morally superior world of women from the earthly world of men” (41). This “fleshly indulgence” (Willard 1889: n.p. in Segrave 2005: 41), stigmatised women of all socioeconomic groups and ages, especially young women (cf. 40), as it signified a “weak character”, a connection to the “red light strata of society” and a “sacrific[e] [of] their moral superiority” (Segrave 2005: 110). But female smoking also was purported to have negative effects on young men, as it is “demoralizing and tends to deprive the gentler sex of that refining, edifying influence which now, more than ever, is essential to the welfare of America’s young manhood” (110). Such was one of the opinions of the ‘Temperance Movement’, one of the movements spawned by the controversial smoking debate in the US already since the late 19th century, which held fast to more traditional female anti-smoking views due to moral and health concerns, favouring cigarette sale bans for women (cf. Segrave 2005: 40). However, despite such concerns, smoking became more common among women of all social classes up until the late

1970s, not only due to female icons leading the way, such as Eleanor Roosevelt, but also due to tobacco's touted weight loss effects, a groundbreaking marketing strategy targeting body conscious women and further legitimising female smoking (cf. Dworak-Peck 2017: n.p.). Despite simultaneously rising health concerns, such as the 1957 U.S. Surgeon General's report, a "milestone gesture that would solidify the public health community's position on smoking" (Dworak-Peck 2017: n.p.) and the Federal Cigarette Labeling and Advertising Act in 1965, up until the 1980s, cigarette ads continued to depict more feminine products in line with the current women's liberation movement, in order to maintain demand, such as Virginia Slims' "You've come a long way, baby" campaign (cf. n.p.).

This struggle between health concerns, cigarette marketing campaigns and ads, women's rights, equality, and historical stigmatisation of female smokers highlights the fundamental issues in the (stigmatising) depiction and discussion of (female) nicotine use disorder, found in not only in *MIW 1* (1989), but also in other ensuing coursebooks, such as *MYWWE 6* (1990) and *MYWA 6* (2005).

MIW's 1 (1989) Unit 10 "Health" embeds contemporary issues with nicotine use disorder into other considerations of health-beneficial behaviours, which ultimately form the basis of the final project task of an anti-smoking campaign, designed to foster CHL. However, in the rest of the unit the singling out of female smokers with regards to health consequences, also impacting (romantic) relationships, can be observed, reminding of similar developments of former times. Such factors, however, are not discussed in a stigma-sensitive manner. Similar implications apply for *MYWWE 6* (1990), which has a distinct emphasis on problematic, stressed female smokers.

MYWWE 6 (1990) is the second book to depict the women as particularly prone to smoking, dedicating the majority of its unit to visually and textually exploring the link between women and nicotine use. This was, as previously argued in the analysis on *MIW 1* (1989), a contemporary, widely debated issue, even though female smoking rates continued to drop significantly since the late 70s (cf. Dworak-Peck 2017: n.p.). Compact Unit 3 "Smoke gets in your eyes" is placed at the back of the book, as are the rest of the six compact units in total, suggesting that there is some significance to the topic, yet it is not necessarily a priority.

Right away, four cigarette ads, included in a task for analysis for persuasive features, depict the unit's underlying focus on (smiling, smoking) women in various fun-related leisure activities, but also some sexual appeal (see Extr. 36. in appendix, p. 25). This is a different message from *MIW 1* (1989), which portrayed smoking women negatively (see section 4.2.1, page 68). In *MYWWE 6* (1990) the four images show various settings: One of them (#4) includes a group of smoking and laughing women in a living room. The others (#1-3) show either heterosexual platonic or romantic relationship contexts, representing the versatility of cigarettes in different pleasurable situations, such as on a romantic seaside date (#1), a party cruise (#2) and during a swim with friends (#3). As these ads are clearly persuasive, students are sensitized towards critically noticing these features, but also their inherent

sexual appeal, as suggested in the discussion phrases (“Ad number ... is trying to exploit sex ...” (MYWWE 6 1990: 127)). However, none of the models are actually smoking, instead they represent positive emotions in conjunction with and effects of the advertised cigarette brands. This stands in stark contrast to the discussion of actual female smokers in the text “Women Smokers- Why do women find it harder than men to give up smoking?” on page 129.

Taken from *The Sunday Times*, the article centres around the image a young woman smoking a cigarette (see Extr. 37. in appendix, p. 26), put into a representative position for all women and highlights the “double standard” of magazines’ heavy use of ads to promote female smoking and simultaneous medical information against it (“She is an addict feeling miserable every time she picks up a magazine which tells her how dangerous smoking is. And she is also confused when she sees a tobacco ad on the opposite page inviting her to enjoy a cigarette.” (129)). Though the article is not contextualized in time, it appears that it was published in Great Britain sometime in the 80s, as statistical numbers from 1972 and 1983 are used to depict only gradually declining numbers of female smokers (as compared to their male counterparts) as well as the simultaneous surge of smoking-related illness, originally deemed “male” diseases, among women (cf. 129). Within the article, women of all ages are depicted as victims of nicotine, exploited in their addiction by cigarette companies, driven to continue smoking by stress encountered in daily life (“there is likely to be more stress for a 15-year-old girl than for her male counterpart” (129), “Studies have shown that 65% of unmarried mothers smoke- almost double the percentage of married mothers” (130)). Adult women appear to be using it as a means to “indulge” (“It’s a reward which unlike chocolates, I can’t share with the kids.” (130)) as well as a tool for weight loss to avoid the “traumatic” experience of “getting fat [...] in a society where they are bullied unmercifully to stay slim” (130)). Most importantly, especially teenage girls are described as naïve and easily impressionable in their consumption of nicotine due to ‘morally harmful’ male influence and as victims appear to not have much access to health-information on smoking. (The former was later on proven to be related to the smoking behaviour of all peers, not just male friends (cf. Robinson et al. 1997).)

“She is more likely to be exposed to smoking situations through older boyfriends and less likely to have been influenced by children’s anti-smoking campaigns which have featured “male” idols such as Superman” (129).

These examples imply that women of all ages are depicted, not only as victims of harmful influence of male peers, manipulative advertising, and of deliberately lacking health promotion efforts from society, but also simultaneously as culprits driven by their own desires, addiction and led by lacking/improper values and morals. Such features correspond with the fears of the Temperance Movement in the early 20th century, which, as previously discussed in section 4.2.1, regarded maintaining high-moral standards attributed to women, not men, as crucial. Smoking, or the “all-purpose crutch” (130), is described as a questionable strategy of female empowerment to cope with stress and weight issues,

caused by societal norms. The latter points towards the ongoing effectiveness of the purported 'slimness' marketing strategy employed by companies post WWII. But also at the same time the article sees in smoking a crippling addiction, which points towards an female inability to follow societal moral standards/ convictions ("Giving up has also, ironically, not been made easier for women [...] Most of these campaigns have used emotional blackmail- you'll be damaging your unborn baby, you're causing your children and pets to breathe in your second- hand smoke" (130)). Yet at the same time institutions, such as the Health Education Council, are blamed for actively contributing to a lack of HL among smoking women ("Not until this year has the Health Education Council invested heavily in a campaign which told women what smoking was doing to their own bodies.") (130).

This contrasting mix of stigmatisation awareness of female smokers within society, their victimisation and simultaneous villainization in smoking behaviour found within the article, continues to be discussed in subsequent speaking tasks, which aim to reflect on reasons for female smoking rates competing with those of males. Though opinion-related speaking points are kept short (p. 130) (see Extr. 37. in appendix, p.26), they enable more critical discussion of the presented facts on sex-differences in the age ranges of teenagers and adults, the latter of which is concerned with "US figures on smoking" from 1965 and 1987. They, too, show similar developments as in the text, namely that female smoking rates have competed with their male counterpart, yet are not significantly declining over time (1965: 52% men, 34% women; 1987: 34% men, 29% women). A role play with members with differing positions on smoking (task 6) (see Extr. 38. in appendix, p. 27), writing tasks in conjunction with the article (task 7) (see Extr. 38. in appendix, p.28), namely a summary, an opinion essay, and a silent dialogue convincing a fellow student to stop smoking, and a cigarette label translation exercise, which mentions key facts from authoritative Surgeon General reports on smoking, follow (task 8) (see Extr. 38. in appendix, p.28), moving towards a more general, less female-stigmatising focus on smoking. What is, however, missing is a stigma-sensitive discussion of smokers, especially women, who were extensively focused on in the beginning of the unit, tackling basic CHL of students, as deeper causes of this social phenomenon were outlined in the article.

These findings lead to the conclusion that *MYWWE 6* (1990) focuses on displaying female smoking as a 'problem' for individuals and society, but not addressing the general social stigma associated with it (cf. Castaldelli-Maia et al. 2015: 24) or tackling S-CHL. Though figures of the time suggest dropping smoking rates generally, due to heightened awareness of health consequences (cf. Timbrell 1981: 370), especially women are presented as being particularly 'irresponsible' and prone to developing a nicotine use disorder, and experiencing greater health consequences than men, whose health is not discussed. Ultimately, critical discussions revolve around general smoking opinions, yet not on stigma-sensitive solutions, which also cannot be found in *MYWA 6* (2005).

4.2.2 Searching for Happiness: Smoking Teenagers- MYWA 6 (2005)

15 years after the sex-specific smoking debate in *MYWWE 6* (1990), *MYWA 6* (2005) follows a different conceptual path, namely significantly shortening it, to amount to only one page and placing it into the discussion on teenagers' quest for happiness through partying and using various substances, and also smoking (Unit 1 "The pursuit of happiness"). Though this new version replaces *MYWWE 6*'s (1990) 'female-only' smoking discussion with more general smoking facts for teenagers, the accompanying illustration bears feminine undertones. Such gradual progress is also observable in some additional CHL developing tasks, which still do not consider stigmatisation.

In the text "Teenagers and smoking- the facts" (*MYWA 6* 2005: 12), the main textual source of information on smoking, this practice is deemed "a big problem" (*MYWA 6* (2005: 12) among teenagers of both sexes, frequently referred to as "children" (12), from medical, psychological, and legal points of view. Furthermore, reference to the social phenomenon of increasing numbers of female smokers is also made both explicitly through the text ("Girls are more likely to be regular smokers than boys.") and implicitly through an image (see Extr. 39. in appendix, p. 28) next to it. The latter is a close-up shot of the hand of a girl holding a lit cigarette, with the pinkness of her sleeve as well as her red gem ring, bearing stereotypical resemblance to a teenage girl's outfit. This observation, however, is not explicitly confirmed by the information in the coursebook, yet it still can be argued to be an interesting development, with regards to the previously outlined stigmatisation history of female smokers.

Though the text only briefly outlines health problems induced by smoking, a more critical, practical focus is taken with a health campaign design exercise in task 4 (cf. 12) (see Extr. 40. in appendix, p. 28), yet potential stigmatisation of smokers is not discussed. Students are instructed to not only consider their peers, but also the wider general public related to them (cf. 12). As this is done in group work, they can openly discuss facts listed in the text not only from their own perspective, but also from that of a "government health agency" (cf. 12). Basic elements of CHL are fostered here, which may offer the building blocks for later S-CHL development, tackling in concrete social advocacy skills, with a stigma-sensitive focus.

MYWA 6 (2005) shows signs of progress with regards to a neutral, non-sex-based discussion of smoking health consequences, as well as basic CHL tasks. However, a visual illustration of the act of smoking bears decidedly female aesthetics, which may imply negative associations with (teenage) female smoking, though this is not explicitly confirmed elsewhere in the book. Also, stigmatisation-awareness is not discussed in this context, which may limit the critical discussion potential of the unit.

4.2.3 Blaming the Cigarette, Not the Smoker- PT 7 (2011 & 2018)

Contrary to other previous depictions of people with nicotine use disorder, *PT 7* (2011), employs a novel, more neutral, factual non-stigmatising approach to discussing the subject, namely by focusing

on FHL and CHL, and not negatively describing individual smokers. This is done by presenting smoking health consequences in the form of body mapping, informational and critical speaking tasks, and the discussion of legal issues in conjunction with a US smoking ban violation example. (This also applies to the 2018 version, which includes the same, unchanged materials.)

Unit 2 “Health issues” is, as the title suggests, concerned with various behaviours and conditions that cause problems with health. The subtopic of smoking is included right after the initial, five-page long discussion of nutrition and diet. Without reflecting on potential underlying motivations to start smoking or numbers of teenage smokers, the discussion in task 1 heads ‘medias-in-res’ into the FHL consideration of detailed health consequences, visually depicted in a unisex-body mapping (see Extr. 41. in appendix, p.29), an approach that is not only new, but also changes previous predominantly female body mappings depicting consequences of other substance use disorders, as discussed on page 66, to follow a more unisex depiction. Furthermore, the information given on “harmful substances in cigarette smoke” (PT 2011: 28), such as “tar”, “hydrogen cyanide”, “[c]arbon monoxide” (28) is much more specific, pertaining to the entire body. The information revolves not only about the lungs and heart, but also about skin, heart, bones, oesophagus, throat, mouth, gums, and lungs (cf. 26). Also, the focus on the reproductive system is widened to include both sexes (“female smokers experience irregular or absent periods and fertility is compromised”, “Men face lower sperm count and more sticky sperm with decreased motility” (26). This is in contrast to the negative, stigmatising depiction of female smokers in older coursebooks analysed on pages 68-73, indicating a paradigm shift in smoking depictions, headed towards non-stigmatising health promotion.

Societal and personal smoking concerns are critically discussed in tasks, which increasingly address CHL in student-relevant, authentic ways, such as a letter-to-the editor writing task on smoking bans (task 5) (see Extr. 43. in appendix, p. 29) and a teenage house party debate related to smoking (task 3) (see Extr. 42. in appendix, p. 29). However, the widespread social stigmatisation of smokers or the duality of smoking bans, ranging between an effective tool for smoking reduction (cf. Castaldelli-Maia et al. 2015: 27) and simultaneously an identity threat to smokers, who face public and self-stigma (cf. 28), is not hinted at. This suggests that while the coursebook does not present smokers in a stigmatising manner, questioning their values and morals (as previously done in other examples), it also does not recognise or raise awareness on the issue of smoker- stigmatisation existing in society, as would have been done with a S-CHL focus.

PT 7 (2011 & 2018) differs from other coursebooks in its depiction of smoking, as it is primarily concerned with presenting health consequences in a neutral manner, not stigmatising either sex through unisex body mapping, but still emphasizing the inherent dangerousness of cigarette substances. While CHL is trained in student relevant tasks, potential stigmatisation of smokers through smoking bans or other measures is not discussed.

In conclusion, over the years the representation of people with nicotine use disorder has gradually moved away from discussing predominantly the influx of female smokers, towards a more neutral view that represents both sexes, though stigmatisation is still not explicitly tackled.

4.3 Body Dysmorphic & Eating Disorder: (Un)conventional Beauty, Stereotypes, and Agony Aunts

Body dysmorphic and eating disorders are one of the most recent disorders to appear on a major public scale over the last few decades. Media portrayals of culturally ‘ideal’, slim bodies are known to have considerable influence in impacting such disorders (Grogan 2016: 121), which especially applies for women’s bodies, and more recently those of men (cf. 75), a new field of scientific inquiry. Such developments are also reflected in the analysed coursebooks (MYWA 8 (2007), PT 6 (2011 & 2016)), some of which show tendencies of breaking stereotypical views regarding the sexes (EiC 6 (2013), PT 7 (2018)).

4.3.1 Health, Beauty, and Disorders: Inherently Female? – MYWA 8 (2007), PT 6 (2011 & 2016)

After two decades of lacking discussion on the issue, a paradigm-shift in beauty standards, still inherently deemed female, can be observed two decades after *TESPW* 2 (1984), namely the shift towards a more holistic of a healthy, fit body and outer beauty together with inner beauty, associated with character, in *MYWA* 8 (2007) Unit 5 “Mirror, mirror on the wall”. This unit tackles information revolving modern beauty standards, celebrities, historical developments of beauty, and the phenomenon of increasing plastic surgery and its downsides. Yet a critical discussion about body dysmorphia or stigmatisation of other closely linked disorders, such as eating disorders, among both sexes is missing, preventing greater discursive depth fostering S-CHL in students.

What is noticeable is that though finally the various ideals of beauty are represented, the focus is still rather narrow, as only women appear to be associated with such ideals, thus neglecting a focus on societal male beauty standards, which, too have caused increasing issues with body dissatisfaction and body dysmorphia among men (cf. Grieve 2007: 66). This becomes especially apparent in section 2, which is based on a *Times Magazine* essay (cf. MYWA 8 2007: 62) providing a historical overview of changing beauty standards. Though not explicitly stating so, beauty here is entirely focused on the female sex, as depicted not only in eight images visually accompanying the text (see appendix, p.#), but also in the text itself, which appears to criticize the viewing of female beauty through solely a ‘male gaze’ lens (cf. Mulvey 1975) ever since “primitive man” (60) throughout the ages. As a most recent development the text highlights a great shift of women, breaking with the idea of ‘pleasing’ male ideas of female beauty, instead adapting a healthy, active lifestyle in order to truly feel confident in their own skin (“[T]he current slim-hipped look amounts to a rebellion against male domination. [...] [T]he new ideal of beauty seems to be created by women themselves.” (61)).

Furthermore, the text advocates for this change, beneficial for female health, in order to achieve optimal fitness and beauty, yet only briefly touching on the topic of eating disorders: The eating disorder ‘anorexia’, only mentioned briefly in conjunction with the modelling industry continues to emphasize the “health is beauty” (62) narrative, also expanding the texts’ focus away from victimisation towards female empowerment with the help of increased HL. This brief discussion of this eating disorder is overly generalized and insensitive (cf. Weissman et al. 2016: 351), as it does not consider the medical specificity of the actual underlying type of disorder, such as ‘anorexia nervosa’ in contrast to ‘bulimia nervosa’⁶ (cf. 351), indicating a lack of stigma-sensitive language use frequently found in texts (cf. 351). However, the text also recognises the positive effects of increased access to medical information and levels of HL among women (“Her new sense of self-assurance has convinced her that strength- of the body, mind, and will- is beautiful”) (62).

The critical discussion following the article is short and not specific, missing a S-CHL focus on the variety of stigmatisation possibilities in the topic, such as stigma related to weight, specific ‘deviant’ bodily features. Instead, it focuses rather on basic comprehension (cf. 59), such as summarizing it, scanning the text for arguments. But some attention is given to considering future developments on beauty standards. However, the underlying issue of weight stigma, eating disorders is left unaddressed from an informational point of view. This also applies to the link between body dysmorphia and plastic surgery obsession, which is not explored in the respective section 3 dedicated to discussing statistical data, not potential reasons for undertaking such procedures. What, however, is considered is research of the frequency of botched surgeries in the US and/or Austria (task 5, p.69) as well as interesting “plastic surgery “horror” stor[ies] to tell next lesson” (69). (While such shocking information has entertainment value, it could also, however, also instigate S-CHL awareness on the marginalised group of failed plastic surgery ‘victims’, emphasizing the need for greater patient advocacy and protection in the medical and societal context.)

In conclusion, *MYWA 8* (2007) pioneers a more holistic approach to beauty, deemed primarily female, focusing on a healthy body. Yet issues regarding body dysmorphia, plastic surgery, weight stigma and that related to eating disorders are not discussed critically. Those issues are touched upon in *PT 6* (2011 & 2016).

Prime Time 6 (2011) and (2016), in its last Unit 10 “Beauty and Fashion Trends”, takes a different approach to discussing eating disorders and body dysmorphia, namely by basing it off extracts from *Uglies* (2005) a dystopian YA novel by Scott Westerfeld and linking it to the reflection of potential future trends in the global plastic surgery realm. However, similar to other coursebooks, the modelling industry also still serves as a source of information on unhealthy eating trends, without paying

⁶ Weissman et al. (2016: 351) in their guidelines on eating disorder- sensitive language use suggest the following: “We advise authors to use “anorexia” only if the authors do indeed mean to refer to loss of appetite, as for instance, in the literature on loss of appetite among physically ill or older individuals.”

consideration to other harmful influences, such as peers and family. Yet, the coursebook also has a limited view of people with eating disorders and body dysmorphia, textually and visually portraying them as inherently female. Furthermore, the disorders themselves are only vaguely defined and not discussed in relation to health information.

Though the book has included gradual sections on male beauty, such as make-up (task 1, p.142) as well as skincare for men (task 4, p.143), briefly pointing out the increasing frequency of male cosmetic procedures since 1997 (“10% of the total” procedures (cf. 139)), issues with body weight, eating disorders and body dysmorphia appear to not consider the male sex at all. For example, the ratio of female-male images alluding to such disorders is 5-1 (see Extr. 44. in appendix, p. 30) throughout the unit, with women being more likely to be represented as either skinny, non-smiling models or celebrities or considering plastic surgery. Just one photo shows a group of smiling women with diverse body types. In contrast, only one man is shown standing on the scale, appearing concerned, a gender specific focus, which is omitted in the ensuing discussion on plastic surgery trends in the 2010s (see Extr. 45. in appendix, p. 26). This goes against societal trends, which show that such issues also increasingly concern males (cf. Lin, DeCusati 2016: N78), as briefly pointed out in *EiC*’s 5 (2013) discussion on muscle dysmorphia (see p. 70).

Aside from such a narrow perspective, the informational value of the eating disorder & body dysmorphia discussion itself is very limited, with no information on types, medical implications and treatment options, or authentic stories from people in the community. In the vocabulary section the term ‘eating disorder’ is nowhere to be found, instead ‘anorexic’, defined as “magersüchtig” (cf. 187) is exclusively used adjectivally, which has been criticized by advocates due to its solely ascribing a person’s identity to a disorder (cf. Weissman et al. 2016: 351). ‘Bulimia’ is defined as “Ess-Brech-Sucht, Bulimie” (cf. 187) follows, with only a single sentence giving additional health information (“Bulimia is regarded as a disease which needs treatment.”). It is problematic that these two eating disorders are not specified in medical terms as “both anorexia and bulimia (without nervosa) have additional, established clinical meanings (loss of appetite; an abnormal and constant craving for food) whereas anorexia nervosa and bulimia nervosa unambiguously refer to specific eating disorders” (Weissman et al. 2016: 351). This lack of stigma-sensitive language use awareness is similar to that of other previous coursebooks, which vaguely discussed the issue at hand, without considering the necessity of fostering S-CHL.

Together with its positioning at the very end of *PT 6* (2016), these points lead to the conclusion that a stigma-sensitive consideration of eating disorders or body dysmorphia in terms of general HL is omitted. Instead, stereotypical associations of women and such disorders are visually and textually reproduced, without providing much disorder-preventative, health information. Though these observations are still not significantly considered in other coursebooks, *EiC 5* (2013) and *PT 7* (2018)

embark on a new journey towards representing a marginalised group, namely that of boys and men with muscle dysmorphia and eating disorders.

4.3.2 A New Focus: Male Muscle Dysmorphic and Eating Disorders- *EiC 5* (2013), *PT 7* (2018)

EiC 5 (2013) is the first book to not only have a varied discussion on female and male eating disorders and body dysmorphia, but also to briefly address the link between eating disorders and the necessity for social activism fighting against the promotion of health damaging behaviours as envisioned by the end-goal of CHL, namely social activism. Though these issues are extensively presented, a health-stigma awareness is not explicitly demonstrated, as shown by victimising language use and by the problematic relegation of the very unit (Unit 12 “Image and Self-Image”), which tackles this critical, personally relevant topic, to an extra CD, assigning it a peripheral position in the coursebook series.

Part of Topic 4 “Food and Nutrition” which is placed in the middle of the coursebook, this last one of three units embodies rarely discussed taboo-topics beneficial for fostering students’ basic S-CHL. Coincidentally, this one which takes on a particularly critical stance, that is personally relevant for students as it considers “Image and Self-Image”: Three subsections revolve around the topics of celebrities and problematic photo editing programs (section A: “Warning: Models May Not Be As Thin As They Appear”) (1-3)), male eating disorders, muscle dysmorphia, body builders (such as Arnold Schwarzenegger, and Charles Atlas) in relation to effects on (young) men (section B: “Bigorexia”) (3-5)), and finally a story of Olympic cyclist Joanna Roswell embracing bodily change following a chronic illness-diagnosis (section C: “Bald and Bold” (6-8)). While they contain images corresponding to the discussed people, some sections also include written or spoken tasks that critically engage with the content, such as section A’s blog comment writing task on retouched images and warning labels (cf. 3). Another example is the critical analysis speaking task of male bodybuilding ad in section B, which touches on the rarely discussed topic of male body dysmorphia.

The cartoon, “The Insult That Made A Man Out Of “Mac””, promotes Charles Atlas’ (“The World’s Most Perfectly Developed Man” (cf. 4) program which associates male ‘hero-instincts’ with a muscular build and promotes it to the current generation of boys and men (cf. 4) (see Extr. 45. in appendix, p. 30). Yet within the same topical discussion terminological inaccuracies arise, whose stigmatisation tendency is unaddressed: ‘Dysmorphia’ itself is defined having only muscle dysmorphia in mind (“disorder in which a person becomes obsessed with the idea of being not muscular enough” (5), which is a limited definition, discrediting other forms of male dysmorphia related to skin, hair, nose and genitals (Phillips, Castle 2001: 1015), for example. Furthermore, the book refers to people with this disorder as “sufferers”, prone to “risky behaviour” (5), which depicts a highly negative, stigma-insensitive picture as it primarily associates them with pain (cf. NCDJ 2021: 4). While it is true that this disorder can cause some serious (health) consequences, as mentioned here, the information provided disregards the fact that it not only “remains underrecognized and underdiagnosed”, but also that “[m]en and boys are often reluctant to reveal their symptoms and [...] typically do not recognise

that their beliefs about their appearance are inaccurate and due to a psychiatric disorder” (Phillips, Castle 2001: 1016). Since no concrete information is given on treatment or support options, the coursebook’s discussion on muscle dysmorphia remains vague and superficial, instead of showing ways to find personal and societal solutions for the issue in a (S-)CHL manner.

However, one example of a small, yet important instance of social activism concerning another common disorder among teenagers, namely eating disorders, is included at the end of Topic 4, within the coursebook itself. It is part of “Check Your Progress 4”, an optional section in which students can finish with what they have learned in the unit so far. Especially task 4 (see Extr. 46. in appendix, p. 31) a formal email writing task, is intent on students recognizing a health issue with wide reaching societal implications and learning a strategy to doing their part contribute to social change concerning celebrities’ harmful promotion of an eating disorder fostering lifestyle. Content-wise, it revolves around responding to a fictional TV interview with a favourite American celebrity, which turned out to be “little more than an advertisement for his/her new diet book and diet drinks which promise to help teenagers to ‘lose weight fast’” (103). Therefore, a polite email of complaint discussing the matter with relation to “the problem of eating disorders among teenagers” and recommendations “how the person should behave on TV in future” is to be written by students. This combines genre-specific practice of a formal email of complaint, needed in authentic life situations, but also reinforces the notion that young people can and should act in a S-CHL manner, in order to ensure that such public, health stigmatisation-unaware portrayals must be reversed in favour of ways that work against the promotion of unhealthy body ideals in people prone to eating disorders.

EiC 5 (2013) discusses health-related issues, such as eating disorders, however, relegates more critical dimensions of (male) body dysmorphia to an extra CD. This removes most of the critical, yet not explicitly stigma-sensitive discussion of these health issues, from the easily accessible coursebook units, which are more likely to be used. Though still not extensively discussed, *PT 7* (2011& 2018) is the second book to touch on male eating disorders within the coursebook itself, bearing first signs of S-CHL oriented tasks.

PT 7 (2011) and (2018) build on the lacking discussion on the topic in the previous coursebook *PT 6* (2011) and (2016) by following up with a more practical, interactional format to engage with the topic of eating disorders. This is combined with more specific terminology in order to foster FHL through productive language tasks. Health-related stigma or the necessity for stigma-sensitive language use is not addressed. However, the topic is placed towards the front of the book (Unit 2 “Health Issues”), possibly indicating the relevance of health-related topics, such as nutrition, and substance use disorders for students, and their linking with critical reflections on helping peers with their health. This is especially true for the discussion of eating disorders, which puts students into the active roles of advice givers, encouraging them to situationally use their functional and interactive health literacy instead of focusing too much on their passive role of consumers of health information, commonly

encountered in previous coursebooks. Furthermore, the concept of eating disorders is now extended to include both sexes, another contrast to prior findings.

Though eating disorders are only a small part of the unit, terminology is adapted to become gradually more specific in *PT 7* (2011) and (2018), including ‘nervosa’ with both ‘anorexia’ and ‘bulimia’, and referring to another option of “binge eating” (cf. 25). Also, the term ‘eating disorder’ itself makes it pioneering appearance in the vocabulary section (cf. 163), constituting a vital part in widening students’ vocabulary inventory. Furthermore, it is for the first time, albeit briefly, acknowledged that eating disorders may expand to the male sex (“Research shows that an average of 8.5% of the male population has bulimia nervosa”) (163). Such features provide a good basis for the ensuing tasks.

The revolving tasks involve speaking and writing, skills which are essential for the social activism part of (S-)CHL. The first task (task 6b, p. 25) (see Extr. 47. in appendix, p. 31) is a role play conversation between a teenager “worried that a friend of theirs is suffering from an eating disorder” (25) and a phone helpline counsellor regarding the “difference between a diet and a healthy diet”, “symptoms of an eating disorder”, “role of the media” and measures to help their friend. This is helpful to foster CHL on several levels, not just because both students learn to see the issue from a different perspective: First, the very fact that a concerned teenager seeks help for their friend, is a good indication of the necessity of critically considering the health status of close friends and family as well as seeking out reliable, authoritative sources of information and help. Secondly, basic health knowledge and HL are essential for helping others, in this case the student playing the helpline worker can draw on such information while (hopefully) also following a stigma-sensitive approach to talk about the topic. The latter, unfortunately, is not explicitly addressed.

The second task is of a similar nature, however, directly involving a teen boy with binge eating and body image issues. This writing task (#1) (see Extr. 48. in appendix, p. 31) is positioned in the “Check-out” section and instructs students to give teen magazine “Agony Aunt/Uncle” advice via email. Mike’s self-description not only points to issues with body image and weight (“rather short and fat”) (33), but also inherent lack of self-confidence as well as a desire for social acceptance among peers (“was bullied quite harshly in primary school”, “my “friends” are gradually drifting away from me”, “I try my hardest”) (33). His binge eating is fuelled by this perceived stigmatisation of his peers (“no one at all around school wants anything to do with me”) (33). Such situations are indeed very common drivers for eating disorders among youth, thus, the task, though positioned at the very end of the unit, has high significance for CHL, but also S-CHL, since awareness is indirectly raised on weight stigma and correlating social exclusion, leading students to consider the necessity of generally contributing to participating in social change.

PT 7 (2011) and (2018) shows signs of progress in terms of conceptualising eating disorders to now include both sexes and providing more accurate terminological information on these disorders themselves. Though the topic discussion is brief tasks focus on putting students’ HL into practice to

help peers in simulated situations, both factors of functional and interactional HL. Despite not raising stigma-awareness explicitly, such tasks could be adapted to incorporate S-CHL, by critically focusing on social advocacy skills in a more specific context.

4.4 Mental Disorders- the Shift Towards (Teenage) Mental Health

Mental disorders have been (and still are) frequently intricately related to stigma. Within the past few years awareness on these issues has increased on a general basis, corresponding with significant surges of cases of illness. Similar to segments on the drug epidemic in the 90s and 80s, coursebooks have only started to incorporate the topic during peak moments of the (youth) mental health crisis itself, as seen in the while-pandemic publishing of *W2G 8* (2020), to be discussed in the following section.

4.4.1 Youth Mental Healthcare Service Crisis: Class- Critical Considerations – *W2G 8* (2020)

W2G 8 (2020) not only pioneers the detailed discussion of (teenage) mental health, but also relates it to stigmatisation, an essential link that previous coursebooks have not mentioned so far, rather silencing a critical discussion of this ‘taboo’ topic. The relevance of the topic is indicated by its placement in the very first unit (Unit 1 “Healthy and happy”), which communicates a heightened awareness of its general importance, but even more so of the current situation of the intended audience of 12th form students, in their last, academically, but also mentally challenging school year.

Furthermore, this likely also relates to the immense mental health challenges for adolescents caused by the uncertainties of the COVID 19 pandemic, coinciding with the year in which the coursebook was published, namely 2020. The coursebook’s approach, however, still is limited with regards to the social activism part of S-CHL.

Various tasks build up the students’ knowledge on the interconnectedness of physical and mental health and their understanding of their relation to their personal life, peers, and society. Yet actual authentic stories from people in the community, as well as a critical discussion on stigma-sensitive language use is missing as well as an awareness of social activism in a practical manner is missing, a crucial part of S-CHL.

After an initial discussion (task 1,2 3, and 4) on strategies to improve overall health (“[f]eed your brain”, “[m]ove that body”, “[c]are for your mind”, “[g]et checked out” (*W2G 8* 2020: 9)) and a reflection on one’s personal lifestyle (task 4b), the focus is moved towards mental health specifically. Students are encouraged to share which academic and personal challenges this last school year brings with it (task 7). This conveys that their well-being is important, not just their educational achievements and establishes a sound basis for ensuing information on mental health: An FM4 radio segment about World Mental Health Day in conjunction with a pre-listening ‘statement guessing’ task on eight potential teenage mental health facts (for example, “Half of mental illness starts by age 14”, “It isn’t helpful to talk too much about mental health.” (10)), reactivates students’ previous knowledge on the topic. It also prepares them for the next task, concerned with widening their topic-related vocabulary

inventory with the help of inserting the words (such as “stigma”, “mental health disorder”, “psychosomatic”, “psychological support”, “detect early warning signs” (10)) into seven contextualizing sentences (“In order to remove the stigma associated with mental illnesses, they should be openly addressed.” (10)). Not only is ‘stigma’ explicitly mentioned here, but also several disorders, which in other coursebooks previously tended to be discussed individually, without interlinking concepts.

While these sentences mostly highlight actions that need to be taken in order improve the way (teenage) mental health disorders are handled by schools, and society, students’ personal responsibility in actively contributing to de-stigmatisation, either in their private life or via means of social activism, is addressed only vaguely suggested in two tasks. They embody a more creative nature of raising awareness on mental health issues: The first one, a writing task (task 12, p.11) (see Extr. 49, in appendix, p. 32), namely an email from the student of an international school, aims at advocating for a “Mental Health Day” there and giving parents advice on supporting their children’s mental health. It draws on the newly learned terminology as well as on the information from the previous listening task (task 11, p.11) involving four experts’ thoughts on handling young people’s problems with mental health. Though this is one important step towards de-stigmatisation and fostering S-CHL, an explicit language specific focus on stigmatisation is missing, an issue, which seems to have been overlooked in many of the analysed ELT coursebooks in this thesis. The second one, a planning task (task 13, p. 12), which is similar to previously analysed coursebooks’ preferred project design approach, is intent on student’s creating a school “Mental Health Day”, with various program choices for participants. Both of these tasks bear potential to not only foster CHL, but also S-CHL, as students might consider ways of mitigating stigmatisation, possibly resulting in a consideration for the previously called for stigma-sensitive language use.

This especially applies to stigma-sensitive language use in the form of either person- or identity-first language, or other personalized ways of referring to people in the mental disorder community. Language can actively work towards or against stigmatisation (cf. Martinelli et al. 2020; Foli et al. 2023), thus it would have been vital to also consider this in the intermediate/ advanced ELT classroom, as *PT 8* (2018) did by briefly outlining this with the example of commonly marginalised groups, such as the disability community. As increased sensitivity towards sensitive pronoun use, in accordance with a person’s wishes, has become a recent global phenomenon, especially with regards to inclusive pronoun use (cf. Bruckmüller et al. 2012: 210), students would certainly have also understood similar implications for commonly stigmatised mental health disorder communities (and many others).

However, another commonly overlooked subject, namely organizational and financial matters as well as related treatment options, in the mental health treatise is included and critically discussed, providing students with information that takes on a more intersectional approach, raising awareness on the social

determinants of health and correlating factors of injustice. A speaking task (task 10, p.11) (see Extr. 50. in appendix, p. 32) regarding the complicated relationship between the “tax-funded healthcare system intended to look after the medical needs of people of all ages” in Austria and the UK and treatment options for mental health disorders. Three questions are to be debated critically, regarding the possibility of mental health issue coverage by the public healthcare system, development of and reasons for increases in mental disorders among young people and finally, ongoing social stigma regarding the issue (cf. 11). Though no factual information is given about the Austrian situation, the next activity (task 14), an article (see Extr. 51. in appendix, p. 33) titled “Four in 10 GPs suggest seeking private care for mentally ill children” (p.12) gives insight into the alarming increase of youth with mental health disorders that are left untreated due to limited CAMHS (Child and Adolescent Mental Health Services) in the UK. As the title suggests, such suggestions by doctors, reflect a great, worrisome problem: It has “prompted concern that it results in a two-tier system [...] and leaves parents who can pay the fees involved confused as to which private mental health professional is best placed to help” (12). However, such problems are not limited to the UK, Austria also has its fair share of lacking youth mental health care services, as seen especially since the outbreak of the pandemic, which has exacerbated an Austrian-wide crisis psychiatric services for youth (cf. Dale et al. 2022) and increased the general demand for other mental health services (cf. Lueger-Schuster et al. 2022).

Though this coursebook is intended for high school seniors, the mental health stigma-breaking trend instigated by it may/can propel authors of future ELT upper secondary coursebooks to consider the necessity of including this topic in lower grades, not just the upper secondary, as this issue has recently become a widespread issue for many children, teenagers and young adults.

With regards to developments of this disorder in coursebooks, various topic discussion styles have been found. Most analysed upper secondary ELT coursebooks focus on mostly teenage drug use disorder from the 1980s until the early 2000s, with varying degrees of graphic input and stigmatisation-awareness in the texts themselves or corresponding (S-)CHL tasks. After that only W2G 8 (2020) very briefly mentions the topic in a peer health-related advice-giving task. Occasionally, this disorder is negatively linked with others, such as nicotine (e.g., *TEWSPW 1, part 2 1982*; *TESPW 2 1984*) and alcohol use disorder (e.g., *TESPW 2 1984*), the former of which is especially discussed in conjunction with women in the 1980s and 1990s (e.g., *MIW 1 1989*) corresponding with societal trends.

Other mental disorders, such as eating and body dysmorphic disorders are generally not extensively covered in the coursebooks and predominantly linked to young girls and women (*TESPW 1 1985*; *TESPW 2 1984*), except for *EiC 5* (2013) and *W2G 8* (2020), which associate these issues also with males, a pioneer move to discuss an underrepresented group (cf. Strother et al. 2016: 347). But also, with regards to mental health issues progress is visible in the most recent coursebooks: *W2G8* (2020)

dedicates significant sections to the discussion on teenage mental health treatment issues, linking them to the concept of stigma. Even here, however S-CHL development is rather limited.

5. Terminal Illnesses: On the Path Towards Death

People with terminal illnesses are another stigmatised group in Western society. Several scholars in the field (e.g., Aries 1974, Jackson 1980, Mellor & Shilling 1993) have highlighted the marginalization and “elimination” of death itself in modernized life, “since death and dying conflict with the prevailing ideologies of the modern society, such as science control, secularization, and bureaucracy” (Kang 2021: 318). But also, other theories to explain such ‘avoidance’ have been sought, such as the “pathogen hypothesis” (Kurzban & Leary 2001), which takes on a bio-evolutionary perspective on hygiene (cf. Kang 2021: 321) for example. In this “invisibility of death”, the ongoing “lack of contact with a dying individual may promote negative perceptions of the dying” (317), thus perpetuating the vicious stigmatisation cycle. Over the past 40 years the longstanding ethical debate on euthanasia has generally intensified, becoming reality in some countries, such the Netherlands, who decriminalized euthanasia in in 2001. Similarly, some studies, such as Cohen et al.’s (2016) suggest an “increase of euthanasia acceptance among the general public [...] over the last two decades, possibly indicating a growing support for personal autonomy regarding medical end-of-life decisions” (663). However, the Western hospice and palliative care movement have also grown since the 1960s (cf. Hermesen et al. 2002: 517) and experience similar challenges as the health care sector, with regards to economisation trends (Wimmer 2015: 24).

The analysed coursebooks show a similar picture: Terminal illness is the least represented and discussed topic among the three selected groups. Patient experiences or critical discussions thereof are almost non-existent. Some coursebooks only briefly mention terminal illnesses, predominantly unspecified forms of cancer (*PT 6* 2011 & 2016), and one mention of leukaemia (*EiC 7 & 8*). Only three coursebooks, namely *MYWWE 7* (1991)/ *MYWA 7* (2006), *ETWO 2* (1985), and *EiC 7 & 8* (2019), introduce the topic of death with varying depths regarding end-of-life care discussions and ethical considerations. However, they do not address issues of stigmatisation explicitly, with only some of them working on S-CHL development. In the following sections, these analysis findings will be outlined in starting with a logical progression of terminal illness, reaching from diagnosis to treatment and finally, death.

5.1 Patient Experiences: Reacting to a Diagnosis of Terminal Illness- *ETWO 2* (1985)

Very few coursebooks (albeit only briefly) include accounts of terminal illness in their sections on health. *English the World Over 2* (1985) can be counted among them, constituting the first textual representation of a man, whose reaction to a diagnosis of an unspecified terminal illness, resembling cancer, is processed into a fictional poem. Topic-wise it is positioned at the back of the coursebook with 22 units in total, namely in Unit 19 Hospital, which discusses not only the place of the hospital from a functional perspective, by focusing on its services, equipment, and staff (101-103), similar to

GB 1 (1985). However, also a list of common guidelines on keeping fit and healthy from a holistic perspective (e.g., “[p]osture and exercise”, “[s]leep and rest”, “[e]ating and digestion”, [c]leanliness” (104-106). The poem “Devonshire Street W.1” is placed as an ‘art piece’ between these two sections, giving the previous informational section on the hospital a more personal appeal, by relating it to a man, now devastated through his diagnosis provided by the hospital. Though rather used as a literary example of ‘high arts’ and not including any further discussion tasks which explicitly tackle S-CHL or stigma-related challenges faced by people with terminal illnesses, this non-authentic patient narrative fulfils a purpose of portraying a very realistic reaction to a devastating diagnosis, which other books rarely depict.

Written in 1958 by Sir John Betjeman, an accomplished English poet bestowed with knighthood and poet laureateship (cf. Johnson 2009: 1), this poem (on page 103) (see Extr. 52. in appendix, p. 34) is part of his growing poetic interest in mortality and gives unique insight into the relation of geographical surroundings and the consequences of receiving a terminal diagnosis in four stanzas following an ABAB rhyme scheme. Emotionally devastated, the man leaves his former hope behind at the hospital door (“the heavy mahogany door with its wrought iron screen shuts”), now having received medical confirmation that there is no hope (“No hope. And the X-ray photographs under his arm confirm the message”). As if already considering his imminent death, he notices his surroundings more intently, with all his senses activated, conveying a bitter-sweet feeling (“The sun still shines on the 18th century scene”). His inner turmoil leads to envy of inanimate objects (“And the iron knob of this palisade, so cold in the touch, is luckier now than he”, “The opposite brick-built house looks lofty and calm”), an external contrast to his emotions. He seeks to find answers to his predicament, seeking for human support in a fast-paced, neoliberal society, increasingly concerned with efficiency (“Oh merciless, hurrying Londoners! Why was I made for the long and the painful deathbed coming to me?”). His wife, not yet informed, joins hands with him, moving on as she usually does, showing a great contrast between their inner worlds. This moment, Devonshire Street appears to become a core memory for him, a place that is of great personal significance, pointing out a similar development, other people facing a terminal illness, experience: Wanting to take in as much as possible of the world and parting with it in peace, before breathing their last breath. Such a narrative of an overwhelmed person with a terminal illness presents an authentic affective picture, which may sensitize students to the diverse sentiments and thoughts in this context, a prerequisite for seeking to develop S-CHL.

Though *ETWO 2* (1985) does not address stigmatisation or S-CHL, it presents a lifechanging, vulnerable moment of an unspecific illness diagnosis, which may sensitize students to the individuality of people with terminal illnesses and their need for end-of-life- support. In contrast to this example, *GB 1* (1985) and *EiC 7 & 8* (2018) are concerned with the next step, namely treatment and its location.

5.2 Treatment- Pitiable Patients, Scary Places, Controversial Options- *GB 1* (1985), *EiC 7 & 8* (2018)

Unit XVI “Sister Webber’s patient”, placed in the middle of *GB 1* (1985), follows a functional perspective of the hospital. However, a distinct written narrative of the hospital being a place of fear, with in-ward patients presented as pitiable due to the severity of the condition, necessitating their stay there, can be observed. Though chronic and terminal illnesses, such as diabetes and cancer, are barely mentioned in the text, the associated health-stigma is apparent, especially with cancer being described as, “one of the biggest scourges of mankind” (*GB 1* 1985: 68) (see Extr. 53. in appendix, p. 34) with regards to research. Though the unit tackles functional HL, such as understanding of the NHS services for tourists, a distinct awareness on S-CHL, health- stigmatisation or social determinants of health is not observable in the text or tasks.

Though a personal picture story of a nurse having to care for her own critically injured brother, health information is rather limited, focusing on conveying a hierarchical doctor-patient relationship in terms of medical decision-making with regards to health. Simultaneously, the institution of the hospital itself is discussed with tourist information about British hospitals and the NHS, overly emphasizing their ‘harmlessness’ (“e.g., “Hospitals in Britain are neither frightening nor upsetting though”, “you needn’t worry”) (68). Such an appeasing undertone may imply an underlying fear of hospitals, which is insufficiently discussed in the unit. Though the hospital is described as primarily a place reserved for special, severe cases related to ‘suffering’ (e.g., “in-patients in the wards will be suffering from diseases”; “only serious illnesses need operations”) (68), it appears that only cancer is particularly stigmatised, as it is seen as a punishment: Though cancer undoubtedly is a terrible condition for humankind, ‘scourge’, used frequently in the context of incurable illness, unjust suffering, has an inherently negative meaning, which may cause people affected by it to be viewed as ‘punished’, ‘tortured’ bearing the resemblance of tools, used to inflict pain (cf. Webster’s New World Dictionary 2010). Since this concept of cancer is combined with the text’s inherent fearful attitude towards hospitals, and its staff, potential stigma towards the potentially terminal illness of cancer, patients with initial symptoms, as well as ill patients being treated, is being perpetuated in the unit.

Also, with regards to cancer research of the 80s, such a stigmatising view might not have been appropriate even at the time of coursebook publishing, as some research suggests reduced societal cancer stigmatisation already visible then, although not all cancers were stigmatised similarly (cf. Knapp et al. 2014: 1). Furthermore, widespread cancer research, although still slow-going in the 80s, had already been in place since Richard Nixon’s 1971 “National Cancer Act”, a declaration of “war on cancer” (Tiwari, Roya 2012: 393), which “affected lives far and beyond the U.S. borders and placed cancer at the fore-front of mankind’s struggle against diseases” (393). Thus, the coursebook shows a distinct tendency towards stigmatisation of cancer, as presented through its non-consideration of contemporary scientific or stigma-reducing societal advancements.

Though *GB 1* (1985) introduces the topic of health-issues, it stays stuck in a fearful, functional narrative of hospitals and some of their patients, such as those with cancer. They are particularly pitied due to ‘scourge associations’ with their condition, yet not discussed in a stigma-sensitive manner. Although contemporary cancer- stigma developments are suggested to have improved, they are not reflected in the book, resulting in a dismissal of S-CHL development with regards to taboo-topics of chronic and terminal illnesses, their respective narratives and health-stigmatisation itself. In contrast, *EiC 7 & 8* (2018) now places the focus on ethically complicated treatment.

EiC 7 & 8 (2018) includes a fictional account of a terminal illness, which creates an ethically conflicting situation for the patient’s sibling, a ‘designer-child’, exclusively made to save her dying teenage sister. Found in topic 7 “Science, Technology, and the Environment”, Unit 20 Genetics, section B “Born for a Purpose”, the extract of Jodi Picoult’s *My Sister’s Keeper* (2004), a famous young adults’ novel, is embedded in the critical, ‘cinemeducational’ discussion on modern medical technologies, human cloning and pre-implantation genetic diagnosis (PGD). It is intended for use in competence module 7 and is positioned in its front section. Though health-stigmatisation is not addressed, the unit’s discussion on the ethically controversial practice of PGD and embryo selection may be adapted to also awareness on problematic aspects related to eugenics, genetic defects and correlating stigmatisation, the latter which is not addressed here.

My Sister’s Keeper, as previously mentioned, presents a unique, fictional story of ethical concern and bodily autonomy, since one of the sisters was ‘designed’ to ‘save’ the other, providing basis not only for an intriguing storyline, but also for further discussion. Kate, the sister of 13-year-old Anna, has leukaemia, which prompted her parents to have a genetically healthy baby, Anna, who was conceived through in-vitro fertilization (“a scientist managed to hook up my mother’s eggs and my father’s sperm”) (212) and screened through PGD (“to create a specific combination of precious genetic material”) (212). This puts a great burden on Anna as her sister is dependent on her, a situation which lends itself to various discussions on ethics interlinked with the scientific background of such procedures, such as the PGD diagram presented in conjunction with medical terminology in the introduction (task 1, p. 211) (see Extr. 54. in appendix, p. 35).

This introductory part of the novel is combined with several pre- and post-reading tasks, which mainly contribute to fostering students CHL, but also could arguably contribute to S-CHL. Text production as well as comprehension and topic reflection questions together with an interview with the author build the main basis for critical tasks related to the topic: First, an optional writing task (#1c), outlining the process of PGD in relation to “prevent[ing]” the birth of children with unspecified “specific genetic defects” (165). Though this task verbalises the PGD diagram, there might be a chance that some students write more critically about issues related to eugenics and the value of ‘imperfect’ human life as well as of human biodiversity. For example, some students might be aware of stigmatisation of Down Syndrome and correlated high-abortion rates in Western countries. The second task (#2),

though mainly focused on information gathering from ‘cinemeducational’ content of a family consciously choosing PGD despite facing initial criticism from friends and family, provides medical and personal information, forming the basis of a critical debate on advantages and disadvantages, a necessary component for (S-)CHL.

Thirdly, a role-play (task 6, p. 214) (see Extr. 55. in appendix, p. 35) concerning “Anna’s decision not to allow her kidney to be used to save her sister Kate” (168), which may be particularly helpful for students’ later process of developing health advocacy skills in (S-)CHL. Here, four roles are assigned, namely a parent of Anna and Kate (Partner A), a lawyer hired by Anna (Partner B), Kate’s doctor (Partner C), a child psychologist (Partner D), of which two roles side with Anna, namely the lawyer and the child psychologist. Since students enact a certain role, they may discover and comprehend underlying social, ethical, and moral issues of the topic more deeply (cf. Khikmatova, Sattorova 2022: 2), this may widen their HL horizons and lead them to critically consider how matters of social injustice and discrimination in the realm of health and illness are dealt with, and what their own role as a young adult might be in actively contributing to change. From a CHL point of view, this role play may also lead to beneficial insights for students within the area of considerations of (forced) organ donation, bodily autonomy, and human rights, coping with terminal illnesses of loved ones and (ethically sound) treatment options of health conditions. For example, the discussion on Anna and Kate could be expanded to critically talk about other contexts in which such donations can occur, namely the sinister world of organ trading and other practices of human (body) exploitation.

Lastly, the extra task 7 aims to discuss “moral issues” concerning “the possibility that PGD could be used to eliminate embryos with other unwanted hereditary characteristics, such as obesity” or “select embryos with desirable traits, e.g., ‘saviour siblings’ chosen to donate bone marrow to an older brother or sister, or ‘designer babies’ created to their parents’ wishes” (168). This form of pre-natal screening growing in popularity is not without its criticism, especially considering its link to the early detection of children with chromosomal conditions and disabilities (Zhang et al. 2007: 515). Yet the very much related practices of pre-natal diagnostics (PND), a much more frequently used predecessor of PGD, and its implications for selecting ‘healthy’, ‘defect-free’ babies already in the womb are not discussed in the unit, which presents a highly unrealistic, limited view of PGD. Such a presentation is problematic, as the widespread practice of PND is of an ethically contested, yet societally underdiscussed nature, leading to the in-womb termination of the lives of vast numbers of babies diagnosed with Down Syndrome (or other chromosomal irregularities). For example, various studies suggest a steady increase in Down Syndrome related abortions since the widespread implementation of PND in the 1970s, with numbers alternating between 90% (cf. Lindeman 2008: 1088) and 99% (cf. Lou et al. 2018: 1228) in most Western countries in recent times. Though this issue itself is of a complex ethical nature, which needs to be discussed from various standpoints, such findings still imply that Down Syndrome is still strongly stigmatised in- and outside of the womb, yet most modern

(ELT) coursebooks do not address this topic in their ethical discussions. (Thus, in the created S-CHL coursebook material in the appendix, will include this issue.)

Despite the observation that health-stigmatisation is not addressed in *EiC 7 & 8* (2014), basic aspects of CHL, such as considering various personal standpoints to a difficult health-related situation as well as an ethically challenging medical practice in a societal context, are tackled with the discussion of the ethical issues of PGD and ‘saviour siblings’, inspired by the popular novel *My Sister’s Keeper*. Yet the more widespread, not uncontroversial practices of other forms of PND are not interlinked in this ethical discussion, which causes the general debate on embryo selection to be rather limited, with regards to the real-life status quo. Such issues have yet to be discussed in other coursebooks. The same applies to the consideration of other related topics, as for example end-of-life- experiences, to be discussed in the following.

5.3 Death- Economisation of End-of-Life & Health Care: Isolation, Stigmatisation, Euthanasia and Three Dying Women – MYWWE 7 (1991 & 2006)

As previously mentioned in the section of disabilities (see p.35), *MYWWE 7 (1991)*, pioneers the discussion on active and passive euthanasia in analysed ELT coursebooks, by including a text from a nursing magazine in Extensive Unit 5. The text arguably has rather vague and incomplete textual and visual information, which contributes to its stigmatising character. This is also where terminal illnesses make their first (textual) appearance after the discussion of responses to the cases of babies with Down Syndrome, experiencing internal blockages, and (in theory) are subjected to attitudes of stigmatisation by doctors and survey respondents. However, it can be argued that the same applies to the two women in the last stages of terminal illness, one of which is denied future active euthanasia (or other forms of support, which could lessen her suffering).

In “Euthanasia- What do YOU think?” (see Extr. 3. in appendix, p.2-3), the two cases of terminal illness presented, differ from the previous ones not only with regards to the nature of the problem, but also with regards to the length and nature of the responses discussed, which is where stigmatising attitudes come to light, affecting both groups, as discussed previously on page 35f.. From a contemporary view, the move of denying life-saving surgery is a highly discriminatory and stigmatising response. Yet also the second woman with a terminal illness is treated unfairly from a health care perspective: She is described to “have come to the conclusion that she wants the means with which to kill herself should her circumstances become unbearable” (80). Though her “incurable disease” (80) is not specified, it appears that she is so terrified of her suffering becoming too much that she sees active euthanasia as the only way out, but she would still depend on the help of medical staff. The vast majority (92%) of survey respondents would be unwilling to hand her the necessary drugs, due to their common perception of “a moral difference between allowing a patient to die and administering a lethal dose” (80), also linked to “the distinction between adopting ordinary but not extraordinary interventions” in the case of terminally ill or “very disabled” patients (80). Contrasting

these results with those of the case of the other terminally ill woman with cancer who was given active euthanasia by a doctor, to which 49% of the respondents agreed, it becomes clear that both are treated differently in their impending death (cf. 80). Yet both need some form of (medical) support, which only one receives.

This points to a bigger issue relating to the manner in which terminally ill people are treated in the healthcare realm and viewed within society: Namely the missing S-CHL discussion within this coursebook of the necessity of reducing those patients' suffering following approaches differing from active euthanasia, while also valuing the dignity of the individual and their need for physical or psychological support (among others) in this last phase of life. In both cases of other end-of-life care options are not discussed, such as palliative care, which would take a different approach, providing pain relief and could be suitable for the second woman seeking ways to escape her potential future suffering. This even more striking since the concept of hospices with palliative care had already been in existence for centuries at that point, namely since around the 11th century (cf. Connor 2017: 5), with the first one coming to North America 1971 (6), for example, signalling the start of the hospice & palliative care movement, which was included in public health care services shortly thereafter (7). Similar developments apply to the situation in Austria as well (cf. Wimmer 2015: 69), as hospice and palliative care have increasingly been discussed in conjunction with euthanasia over the course of the past decades (cf. 69).

As this coursebook was published in a time of neoliberalism, such a discussion also bears marks of tendencies to make the health care system more efficient in the tradition of economist's Vilfredo Pareto's (1906) 'homo oeconomicus'. Though the validity of this behavioral concept, which is seen as the ideal of liberals and neoliberals (cf. Wimmer 2015: 22), has been questioned over time, its utilitarian nature has been influencing daily life and has had a direct development on how dying and terminally ill patients have been treated in the healthcare system (cf. 24). This can partly be explained through the increase in costs Western health care systems have been facing since the 1980s, which follow practices of financial restructuring due to greater life expectancy and significant advances in medical technology in order to increase efficiency (cf. 24). Such efficiency-gearred restructuring in health care also echoes in another text in the unit, concerned with a professional meta-critique of a terminally ill student nurse, which particularly would offer a meaningful basis for raising awareness on patient advocacy and the need for broader social activism as necessitated by S-CHL.

The text, whose authenticity is unclear, (see Extr. 56. in appendix, p. 36), was taken from the *American Journal of Nursing* and describes her own critical thoughts, feelings as a patient as well as those she attributes to her colleagues in an open letter format to nurses-in-training: Right away she addresses healthcare tendencies striving for efficiency, stating "Nursing must be advancing, but I wish it would hurry. We're taught not to be overly cheery now, to omit the 'Everything's fine' routine, and we have done pretty well. But now one is left in a silent void" (85). In this situation she feels left alone

with her fears, yet also recognises that medical staff surrounding her may also feel similarly, yet those fears are not communicated due to a wall of professionalism:

“Don’t run away- wait- all I want to know is that there will be someone to hold my hand when I need it. I am afraid. Death may get to be a routine to you, but it is new to me. You may not see me as unique, but I’ve never died before. [...] You whisper about my youth, but when one is dying, is one really so young any more? I have lots I wish we could talk about. [...] If you really care, would you lose so much of your valuable professionalism if you even cried with me? [...] Then, it might not be so hard to die- in a hospital- with friends close by.” (85)

Though her experienced stigmatisation and marginalization is not mentioned in the text or ensuing text comprehension tasks, some critical post-reading questions could be argued to work towards a greater awareness of violations against patient dignity and respect (e.g., “Why do you think the dying patient is “not seen as a person?”, “What should those who want to help be capable of?” (86)). Furthermore, task 3 includes five adjectives associated with chronic illness, dying and caretakers (“sympathetic”, “depressed”, “preoccupied”, “fatal”, “consoling” (86)) to be inserted into various sentences, which are unrelated to each other. However, a deliberate discussion, actively working towards S-CHL, is not instigated in the book, which presents yet another missed opportunity for developing this type of HL.

MYWWE 7 (1991) is the first book to discuss implications of terminal illness in conjunction with euthanasia, an issue which even modern ELT coursebooks tend to avoid. However, as previously noted in section on disability, the discussion of euthanasia is limited and lacks accuracy as well as alternative views to critically assess available options. The fact that two out of three narratives of terminally ill women are connected with the concepts of death, active euthanasia as well as combined with a negative view on death, fails to acknowledge the complexity of highly individual end-of-life narratives, wishes and lifestyles. Though the last text hints at the issues of cuts in the healthcare system, negatively affecting end-of-life patient care and attitudes, attempts of critical discussion in tasks is only minimal, without much focus on raising awareness on stigma-sensitive advocacy skills.

New Version: *MYWA 7* (2006)

In the new, Matura-updated version of the book, *Make Your Way Ahead 7* (2006), the previously rather vague euthanasia discussion has become more critical, adding a section on a death expert, specialised in working with terminally ill people (cf. 93). Yet the book still has not included the concept of stigmatisation or information on euthanasia alternatives or other representations of terminal illness unrelated to euthanasia, which paint a distinctive, rather negative picture of terminally ill patients, likened to exclusively considering death. Thus, it discredits both the person in the photo and other terminally ill patients, whose representation is limited also in this book.

Section 4 Euthanasia is included once again in Extensive Unit 5, now titled “Do not go gentle into that good night” and has the same front-to-mid position as in the previous coursebook. A couple of

changes have been made, which involve the manner in which death and dying are discussed: The content presentation now focuses on the relevance of the topic for students by considering their personal conceptions of “[l]ife after death” (section 1), an expert’s experiences of and bits of wisdom after “dealing with death”, “poems of death” and tips on handling grief well and “grave humour” .

This time the article (“Euthanasia- What do YOU think?”) is worked with more intensively, following a more critical focus, by letting students be involved in hypothetical decision-making processes, which have a greater potential to foster S-CHL than in *MYWWE 7* (1991). Though the post-reading summarisation task (task 3, page 100) and the previously addressed visual and textual mismatch remain the same, a pre-reading discussion (task 1&2, page 99) and another post-reading task (task 4, page 101) have been added, a new development arguably one step closer to S-CHL.

Task 1 and 2, both pre-reading tasks, require students’ readiness to make and justify (hypothetical) decisions, which are ethically challenging. This is done through a change of perspectives, similar to a role play, as students are invited to imagine being a doctor, working with six different cases, which all are connected with difficult decisions. Four of them are mentioned in the text later on, of which two are the two terminally ill women and the other two the babies with Down Syndrome. Cases 5 and 6 about two suicidal, but otherwise healthy, individuals, most likely were added to the list because their problems constitute very different from the previous cases. While the brief description of the two terminally ill women overlaps with those of the text, the description of the two babies is radically different as previously explained. No further explicit discussion on the two women (or any of the other cases) ensues. However, task 2 (cf. 99) gives students an opportunity to consider further ethically complicated cases, which might result in students discussing more chronic or terminal illnesses in conjunction with that. After the text itself, writing task 4 challenges students to voice and justify their position on euthanasia following a quote by the author Pearl S. Buck (“Euthanasia is a long, smooth-sounding word, and it conceals its danger as long, smooth words do, but the danger is there, nevertheless”) (101): Not only should they write a “statement of opinion on the quote”, and find “at least two examples that support [their] position”, but they also should outline “the consequences for society if your opinion was reflected in the Austrian law” (101).

As these exercises are linked to students’ ethical understanding of the issue of euthanasia, their views on the mentioned groups are bound to be challenged. This is especially true for the two terminally ill women, who thematically relate to the previous discussion on Dr Elisabeth Kübler-Ross’ obituary and her advocacy for the terminally ill in section 2, task 2 (cf. 93) (see Extr. 57. in appendix, p.36-37). Her influential work, such as the concept of the “five psychological stages of dying” (93) and her ground-breaking book *On Death and Dying*, as well as her work ethic (“never scared of controversy” (93)), have inspired many scholars (cf. 93). But even more so her involvement with terminally ill patients would provide a great basis for a critical discussion on the marginalization and stigmatisation of these people:

“She was particularly concerned by the way dying patients were treated- ignored, as if no-one wanted to get involved. She made a point of sitting with them and listening to what they wanted to talk about. She began giving lectures based on her experiences and featuring terminally ill patients who talked about their dying experiences. “My goal was to break through the layer of professional denial that prohibited patients from airing their innermost concerns,” she wrote.” (93)

Her focus on the neglect of these patients highlights this common social injustice, which needs to be solved, which is presented for students to see before considering the previously addressed concrete cases of euthanasia in section 4. Yet such a stigma-sensitive perspective is not proposed in the article on euthanasia (on page 100-101), neither in consecutive tasks. It is unclear whether these patients have received forms of psychosocial support as suggested for their last days. Instead, these cases are only discussed in the context of active and passive euthanasia, barely addressing other end-of-life care options, such as palliative care in hospices (task 1, page 92).

It can be concluded that *MYWA 7* (2006) this new version of the book has made slight progress in including voices that are stigma-sensitive in the context of euthanasia in the centre of the book, yet opportunities to deliberately work on S-CHL are missed in the design of the tasks. The representation of people with terminal illnesses remains limited and negative, as they appear to only be considered in the context of death itself, a rather excluding move from the authors of the book.

Overall, terminal illness appears to be one of the least discussed topics in analysed ELT coursebooks. Though hospitals and cancer as a whole appear to be less stigmatised after the 80s, accounts of other terminal illnesses or end-of-life experiences are still rare in consecutive decades indicating a need to further break taboos of the topic and engage in S-CHL fostering activities in the future.

6. Discussion of Findings, Limitations & Implications for Material Development

The analysis of coursebooks has shown diverse findings over the past 40 years. Despite that some general tendencies can be observed, also with regards to disability, disorder, and illness representation as well as coursebook task design.

Concerning the representation of disability, disorders, and terminal illnesses, the findings are multifaceted and unexpectedly complicated, since progress made does not extend to all investigated areas or coursebook levels (however, it can generally be said that the representation of most ‘taboo’ topics has gradually increased until now.) It can be observed that most coursebooks appear to represent (or ‘favour’) certain topics over others in specific time periods, generally missing out on stigma-sensitive foci: This is especially the case for sensationalist issues, such as teenage health crises (e.g., drug epidemic (1980s-2000s), mental health crisis (2010s-ongoing)), unique, inspirational stories about extraordinary abilities (e.g., autistic savants and (2010s)) or health issues, which have particularly complex ethical implications (e.g., creating ‘designer’ babies for organ replacement purposes (2010s)). Though some of these issues, such as the very first certainly pose currently relevant

topics for teenagers, some of the others may be problematic. Coursebooks appear to frequently single out very specific aspects of bigger health-stigma related topics, which go widely unaddressed in terms of practical S-CHL relevance, such as everyday institutional stigmatisation of people with intellectual disabilities or moral implications of a variety of common prenatal selective techniques and consequences. This results in a predominant emphasis on disorders, particularly those related to substance use for the first two decades, with various disabilities only gradually being represented since the late 2000s, and chronic and terminal illnesses still majorly overlooked as commonly stigmatised groups.

With regards to the prominent disorder group, various substance use disorders, gendered and racialised perspectives are often to be found as well as sensationalist tendencies, all of which are presented in an unreflective manner, which generally reflect risk-based, fearful public narratives of the respective time. Coursebooks unanimously represent the most relevant aspects of major teenage health-related crises are represented over the years, such as the substance use epidemic from the 1980s- 2000s or the onset of the mental health crisis since the late 2010s and early 2020s. Especially with regards to the former, most coursebooks are dedicated to extensively covering the topic. Yet this is done in very varied ways that generally do not address stigma-awareness and instead mirror the public panic narrative regarding health consequences, high death tolls. In the early 1980s, stigmatisation of various ‘addicts’ was apparent in initial brief segments on the drug use issue, even going so far as to assimilate their characteristics perceived as inherently dangerous to others with those of other marginalised groups, such those with smoking and alcohol use disorder (e.g., *TESPW 2* (1984)). This not only indicates the severity of the drug epidemic, but also widespread public stigma concerning many forms of substance addiction then. In the following years, representation of such disorders rises, perpetuating stereotypical views without critical afterthoughts. For example, several coursebooks continue promote fatalistic views on drug-use, without giving much room for the possibility of recovery (*MYWWE 6* (1990), *TESPW 1* (1981)), only with the exception of *MYWA 6* (2005), which briefly hints at a successful, drug-free life at the very end of the unit. Such findings indicate a narrow, one-sided informational perspective, which may imply authorial lack of information. Though authentic sources are included, such as health information leaflets (e.g., *MYWA 6* (2005)), coursebook discussions frequently do not reach a depth that critically examines social determinants of health on a wider societal scale, though some fictional personal cases are investigated, such as that of Alice, whose drug using story stems from a popular, yet not uncontroversial novel.

Some individual coursebooks also include racialised information on drug dealers and takers (*MIW 3* 1996), and present health consequences from a gendered view, indirectly conveying negative moral implications of drug-taking or -distributing for particularly women and people of colour (*MYWWE 6* (1990)). Textual information in most coursebooks until the 2000s distinctly emphasizes negative health effects on women, not so much on men. On one occasion, this is also translated into the visual, as

health consequences are illustrated through the means of female body mapping (MYWA 6 2005). This is a striking find, especially, since a seemingly gender-biased presentation of smoking health consequences is comparable during these decades. These observations could be explained in two ways. Recent medical discoveries (since the 1980s) of female-specific health consequences of drug and nicotine use and the lack of targeted health promotion efforts (cf. de Walque 2010: 696) could have influenced this distinct focus. A second possible explanation could be that this approach was utilized to convey pre-existing negative moral implications, such as those from the Temperance Movement era, associated with female use of these substances, thus reinforcing traditional gender notions.

Such considerations are also interesting in conjunction with coursebook's depiction of teenage and adult female smokers, whose smoking habit is presented as especially problematic for health, until the late 2000s. However, compared to the discussion on drug disorders, sexism critical elements with regards to the visual representation of women are found on a basic level, as one coursebook recognizes problematic aspects of 'sex-sells' in cigarette advertisements from a consumer-based perspective. Other smoking-related discussions only focus on designing anti-smoking campaigns, which, due to their holistic health-approach, show some progress towards a more neutral, stigma-sensitive view, though still not explicitly addressing the topic of smoking-stigma. The striking shift in the 2010s, however, towards a more neutral discussion of related health consequences indicates progress with regards to gender equality, and a reduction of the previously existing implicit female smoking stigma. This again mirrors the decreasing societal smoking trend since then (cf. Dai et al. 2022: 129). Still, until the late 2010s and early 2020s discussions around smoking, predominantly occur from a FHL perspective, concerned more about nicotine risks than about those brought by smoking stigma, which, for example, can negatively affect treatment-seeking behaviours and contribute to health disparities (cf. Larsen et al. 2019: 13).

The shift from substance use disorders focus amidst a teenage health crisis to an increasing mental health focus since 2010s, shows an increasing focus on the interior world of humans, highlighting a mind-body connection that had previously been neglected by public discourse (cf. Patel 2012: 9). Such is indicated by the taboo teenage-health issue of eating and body dysmorphic disorders taking in a new-found place in ELT coursebooks since the 2000s. However, despite this positive development, stereotypes, such as affecting only middle-class young females, are perpetuated well into the late 2010s, in which small, individual acknowledgements of male eating disorder and body dysmorphic disorder come into play. This is intricately related to developments in the societal realm, which until recently has frequently perpetuated such a limited view (cf. Pope et al. 1997: 548). But also, with regards to the newest teenage-health crisis, namely that of mental health problems, coursebooks continue improvements by not only displaying no gender bias, but also addressing the issue of mental health stigma as well as critically discussing inequalities in access to mental health care services,

moving closer to components of S-CHL development, though even more critical engagement would be needed. Similar implications apply to the representation of disabilities, only occurring after the late 2000s, mirroring societal trends of widespread disability marginalization in previous decades.

Though some disabilities (such as blindness, deafness, cerebral palsy, Down Syndrome) are represented since then, only the some of the most recent coursebooks include limited explicit awareness on stigmatisation and interactional guidelines. For example, drawing on an authentic voice from within the community, a move of empowerment (cf. Ramcharan 2005: 284), which criticises dominant disability narratives, such as use of ‘special’. Otherwise, positive disability narratives of overcomers, superheroes are included since the late 2000s, albeit frequently only showing small parts of the community and giving unrealistic, potentially even damaging outlooks on the whole. This is true for the superhero narrative, which is to be found with different kinds of disabilities, rendering the depiction of people with autism spectrum disorder as exceptionally artistic (cf. IE 2 2013). Such characteristics do indeed apply to some individuals but does not represent the variety of people with this disorder. Despite the ‘empowering’ properties of this narrative for various disabilities, it is a complicated matter, which, according to disability advocates, can do more harm than good by promoting further disability discrimination and stigmatisation due to unrealistic standards of people ‘overcoming’ their conditions for the sake of fitting in to societal participatory norms (cf. Smart 2009: 6). Together this inherently ‘ableist’ perspective, a functional understanding of disability is widely observable, up until the late 2010s, predominantly including testimonies of disabled people who try hard to ‘fit’ into a non-disabled society and overcome their whatever hinders their role as a ‘functional’ member of society. Though such stories are inspirational, they still promote narrow perspectives on disability, possibly indirectly devaluing individuals who do not reach such achievements or produce societally useful output with artistic, educational, or financial value. However, findings within some of the most recent coursebooks (e.g., the W2G series (2018-2020)) do indicate a gradual positive change towards a more sociopolitical model, which values the diversity of disability and is concerned with social justice and human rights being implemented for this community. This also points towards task progress over the years.

Various changes in the Austrian AHS ELT curriculum as well as general societal trends and developments are reflected in coursebook content and tasks, which over time show positive indications for a focus on critical content reflections. Since the 1980s a shift away from literary ‘fine-arts’, centered on the UK and the US, and paired with more ‘traditional’ ELT approaches (e.g., Grammar Translation Method), towards increasing discussion of global social justice issues (e.g., humanitarian concerns, racism, sexism) in a more communicative fashion is observable in tasks, which start to also consider their relevance for students and overall society. This Communicative Language Teaching (CLT) approach focus continues throughout the following years, resulting in an emphasis of linguistic skills and competences (as necessitated by the various task formats of the centralised school leaving

exam ('Matura') for the subject of English since the late 2000s. For potential S-CHL development, these changes are fertile ground as ELT's great potential for enhancing social justice and health-discussions (cf. Banegas, Lauze 2020: 200) (initiated by other school subjects) is increasingly utilized, possibly resulting in students' greater awareness of the necessity of contributing to social change. Yet despite a discernible increase in "Gesundheitserziehung" since 1995 (AHS Curriculum 1995: 7625), manifested in tasks designed to tackle functional aspects of HL, (S-)CHL development is unevenly distributed across different coursebook series.

Most tasks in conjunction with health-related topics appear to be intent on fostering functional HL, which emphasizes observations about predominant risk-based perspectives on health as well as discussing measures prevention and cure of various ailments over health-discrimination, -stigmatisation and social justice issues of the three commonly stigmatised, analysed groups. With regards to developing CHL, in many cases coursebook tasks do not live up to their potential to develop a variety of social advocacy skills (for marginalised groups), though some of them do promote critical discussion of ethical problems in research and other issues in health policy development (such as a smoking ban debates in the 2010s). Additionally, most of them appear to prefer campaign planning tasks, concerned about illness prevention measures within schools, as well as occasional health-advice giving tasks, which both aim at dispersing health information to peers. These developments have several concrete implications for future coursebook development.

Though the measures discussed above consolidate basic health-knowledge, further advancement of advocating for the rights of stigmatised people (and together with them) as a social justice ally in a S-CHL manner needs to be worked on in future ELT materials. This also goes for further developing de-stigmatisation of these groups themselves within educational discourse and ELT as well as encouraging more imagined (or possibly actual) intergroup contact with them, which still is generally underdeveloped in current ELT coursebooks (though the initial stigma-sensitive discussion of mental health in *W2G 8* (2020) is promising in that regard). However, an increase in textual 'patient-narratives, both authentic and fictional, already marks positive developments in this direction, though tasks need to be adapted to active intergroup engagement, as a measure of working on stigma-awareness. Such applies to the necessity of including intersectional and/or socioeconomic considerations regarding social determinants of health and stigmatisation, which is still vastly lacking. Other improvements with regards to fostering greater research literacy in terms of gathering reliable (non-)print health information from authoritative sources and organisations as well as critically assessing this data through a lens that is sensitive to SDOH and stigma are also relevant for future material development. Reasons for this are the striking lack of information on Austrian accessible key health resources for teenagers given in health-related units throughout the past decades, which may have impeded practicality of health-related discussions. The Austrian curriculum itself would also

need to specify these needs for ELT, related CLIL content and other subjects, as well as instigate more research into this undiscovered field itself.

Designed exemplary materials (see appendix C. p. 38) resulting from these overall findings try to incorporate such suggestions in practical ways following suggestions from *JustHealthAction's* (2004) CHL developing framework as well as proposed social advocacy skills outlined in Mogford et al. (2010: 11). As Down Syndrome was identified one of the continuously marginalised groups in the coursebook analysis, it constitutes the central focus of S-CHL materials, which particularly emphasise stigma-sensitive language use, critical consideration of individual, publicly known cases of recent Down Syndrome stigmatisation as well as of selected social advocacy tools Austrian students are encouraged to employ in their social justice ally-walk. These materials are tentative and several work steps in the complex coursebook development and publishing process (cf. McGrath 2013: 30) need to be taken, thus, they are not yet illustrated: After necessary piloting, reviewing, revising and expert feedback rounds (with Down Syndrome (self-)advocates, for example), they still need to be adapted to fit the context of a revised or newly designed Austrian upper-secondary ELT coursebook.

Though these findings are multifaceted, the study itself has several limitations that would need to be addressed by further research. As only coursebooks themselves were analysed, meaningful input from users (e.g., students and teachers) is missing. To arrive at a deeper practical understanding of representation of disabilities, disorders, and illnesses (whose complex interrelatedness was not considered due to organisational purposes of this thesis), as well as health-stigmatisation and stigma-sensitivity in ELT throughout these decades, it would have been interesting to draw on their lived experiences with these coursebook materials (and possible in-use modifications by teachers) and contrast them with the findings of this thesis. This also applies to intricate production processes of coursebooks themselves, influenced by decisions of authors, editors, and other participants. Another limitation is constituted by the non-discussion of visual representational components in this thesis, which was omitted due to its scope. It would be of relevance to factor in these elements in order to arrive at a fuller picture of processes of (de-)stigmatisation in these materials, an interesting focus for further investigation. But also conducting more research on health-(de-)stigmatisation of the three groups in conjunction with fostering S-CHL in the educational sector and in ELT itself, can be counted among aspects to be investigated by research.

7. Conclusion

The past four decades have been eventful times consisting of not only health-crises, but also of societal, medical, and educational progress with regards to the recognition of social injustice, discrimination, and (health-)stigmatisation of disabilities, disorders and illnesses. This has not left Austrian AHS upper-secondary ELT coursebooks, which have been marked by an increasing emphasis on health literacy since the 1990s, untouched. It can be concluded that though progress has occurred, especially with the variety of represented disabilities, most coursebooks have failed to use their

potential to discuss health-stigmatisation or foster S-CHL, or social advocacy skills linked to it, alongside an increased social justice issue focus occurring since the 1980s. Coursebook tendencies to employ stigmatising language gradually decrease over time, however, explicit stigma-awareness is virtually non-existent even in most recent coursebooks of the 2010s and 2020s currently in use, such as the *EiC* (2013-2020) series. This manifests itself in ongoing ableist and arguably stereotypical dominant narratives (also frequently with regards to sex, race, and socioeconomic status) of disabilities, disorders, and also very much of underrepresented chronic and terminal illnesses. It appears that throughout the years these groups' representational value is continually viewed in relation to either extraordinarily inspirational or frightening sensationalist stories. Such narrow views, only undergoing change in the last few years, have tended to emphasize means of overcoming role failures as seen by the 'functional' perspective in order to fit in to society, instead of attributing value to human biodiversity itself, which ultimately points towards deeply held biases and stigmatising beliefs towards illness as well as 'untypical' health- and body experiences. As of recently, only mental health disorder stigma is actively being addressed by the latest coursebook series (*W2G* 2018-2020), which indicates the necessity of not only highlighting other types of health-stigma and doing related preventative work, but also using ELT's social justice enhancing qualities in the Austrian high school context to tackle the most complex, yet socially relevant form of HL, stigma-sensitive CHL.

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9. Appendix

Abstract

(Health-)Stigmatisation is a longstanding practice, extending into numerous realms of Western society and taking on many overt and covert forms, among which representation and language-use are central. It also affects people with various disabilities, disorders, and terminal illnesses, which are frequently discriminated against. Though the destructiveness of (health-)stigma has come to be widely acknowledged in theory, halting it entirely in societally important institutions, such as schools, has been a challenge for a while, as ELT coursebooks for Austrian AHS from 1980 to 2020 show. These past 40 years, particularly abounding in several public health-related crises, constitute eventful times for moves towards de-stigmatisation of the above-mentioned groups, since policy makers have put greater focus on public health, going hand in hand with the birth of the health literacy concept. This thesis argues that such developments have positive indications for not only health-related school subjects, but also ELT, which can elaborate on interdisciplinary content from a linguistic and a social justice lens. Hereby critical reflections on socially disadvantaged groups, opportunities for advocacy and implications for stigma-sensitive language use are instigated. Working with the tool of critical discourse analysis, concrete textual examples found in 10 Austrian ELT coursebook series for the upper-secondary are investigated, seeking to detect examples of stigmatisation, de-stigmatisation as well as activities fostering stigma-sensitive critical health literacy, the most complex, yet simultaneously unexplored and societally relevant variant of the concept. Findings suggest that these coursebooks have gradually multiplied and improved their authentic representations of some of the above-mentioned groups, such as people with disabilities, and with mental health disorders. However, much is still left to be desired with regards to stigma-sensitivity and a critical health literacy, rarely present within tasks. Instead output-oriented, neoliberal views are frequently replicated, which devalue groups, such as people with terminal illnesses and intellectual disabilities, who contribute to society in their own, unique ways. Based on the findings, ELT materials were created, suggesting change for future coursebooks, by focusing on a stigma-sensitive critical health literacy and advocacy curriculum with regards to the marginalised topic of Down Syndrome.

Zusammenfassung

(Gesundheits-) Stigmatisierung ist eine langbestehende Praktik, die in zahlreichen Bereichen der westlichen Gesellschaft in offenen und latenten Formen stattfindet. Dabei spielen besonders Repräsentation und Sprachgebrauch eine zentrale Rolle. Stigma betrifft auch Menschen mit verschiedenen Behinderungen, Störungen, und unheilbaren Krankheiten, welche häufig diskriminiert werden. Obwohl die zerstörerische Kraft von (Gesundheits-)Stigma auf theoretischer Basis Großteils anerkannt worden ist, beweist sie sich praktisch dennoch als schwer aufzuhalten. Solches ist besonders zutreffend für gesellschaftlich wichtigen Institutionen, zum Beispiel Schulen, wie österreichische AHS-Engischlehrbücher im Zeitraum von 1980 bis 2020 zeigen. Dieser 40-jährige Zeitraum, welcher von

verschiedenen Krisen im Bereich der öffentlichen Gesundheit gekennzeichnet ist, stellt, aufgrund des besonderen politischen Fokus auf letzteres und gemeinsam mit dem Aufkommen des Gesundheitskompetenz-Konzeptes, eine ereignisreiche Basis für Entwicklungen zur Destigmatisierung der oben genannten Gruppen dar. Diese Arbeit argumentiert, dass diese Veränderungen positive Indikationen für gesundheitliche Schulfächer sowie für den Englischunterricht haben, welcher fachfremde Inhalte von einer linguistischen Perspektive, als auch einer der sozialen Gerechtigkeit elaborieren kann. Dabei können kritische Reflektionen in Bezug auf sozial benachteiligte Gruppen, Möglichkeiten für Interessensvertretung und Bedeutung von stigma-sensiblen Sprachgebrauch entstehen. Auf Basis des Werkzeuges der kritischen Diskursanalyse werden konkrete Textbeispiele aus 10 österreichischen AHS-Engischlehrbüchern für die Oberstufe in Hinblick auf Beispiele von Stigmatisierung, Destigmatisierung, sowie Übungen, welche stigmasensibel, kritische Gesundheitskompetenz, die komplexeste, und zugleich am wenigsten entdeckteste und gesellschaftlich relevanteste Variante des Konzeptes, fördern, untersucht. Die Ergebnisse legen nahe, dass die analysierten Lehrbücher schrittweise ihre authentischen Repräsentationen von einigen der erwähnten Gruppen, wie beispielsweise Menschen mit Behinderungen und mentalen Gesundheitsstörungen multipliziert und verbessert haben. Allerdings ist im Bereich von Stigma-Sensibilität und kritischer Gesundheitskompetenz, auf welche in Übungen selten das Augenmerk gelegt wird, noch einiges zu wünschen übrig. Stattdessen werden produktorientierte, neoliberalistische Ansichten verbreitet, welche Gruppen entwerten, die zur Gesellschaft auf ihre eigene, individuelle Weise beitragen, wie Menschen mit unheilbaren Krankheiten und intellektuellen Behinderungen. Auf der Grundlage dieser Ergebnisse wurden Englisch-Lehrmaterialien zum marginalisierten Thema Down Syndrome entwickelt, welche Vorschläge für zukünftige Schulbücher in Bezug auf ein Curriculum mit einem Fokus auf stigma-sensiblen kritischen Gesundheitskompetenz beinhalten.

Appendix A.

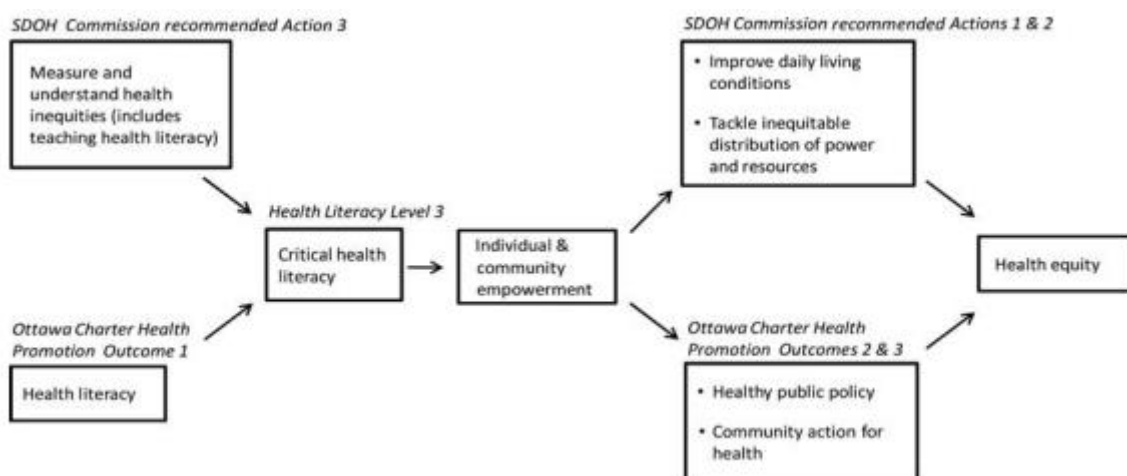
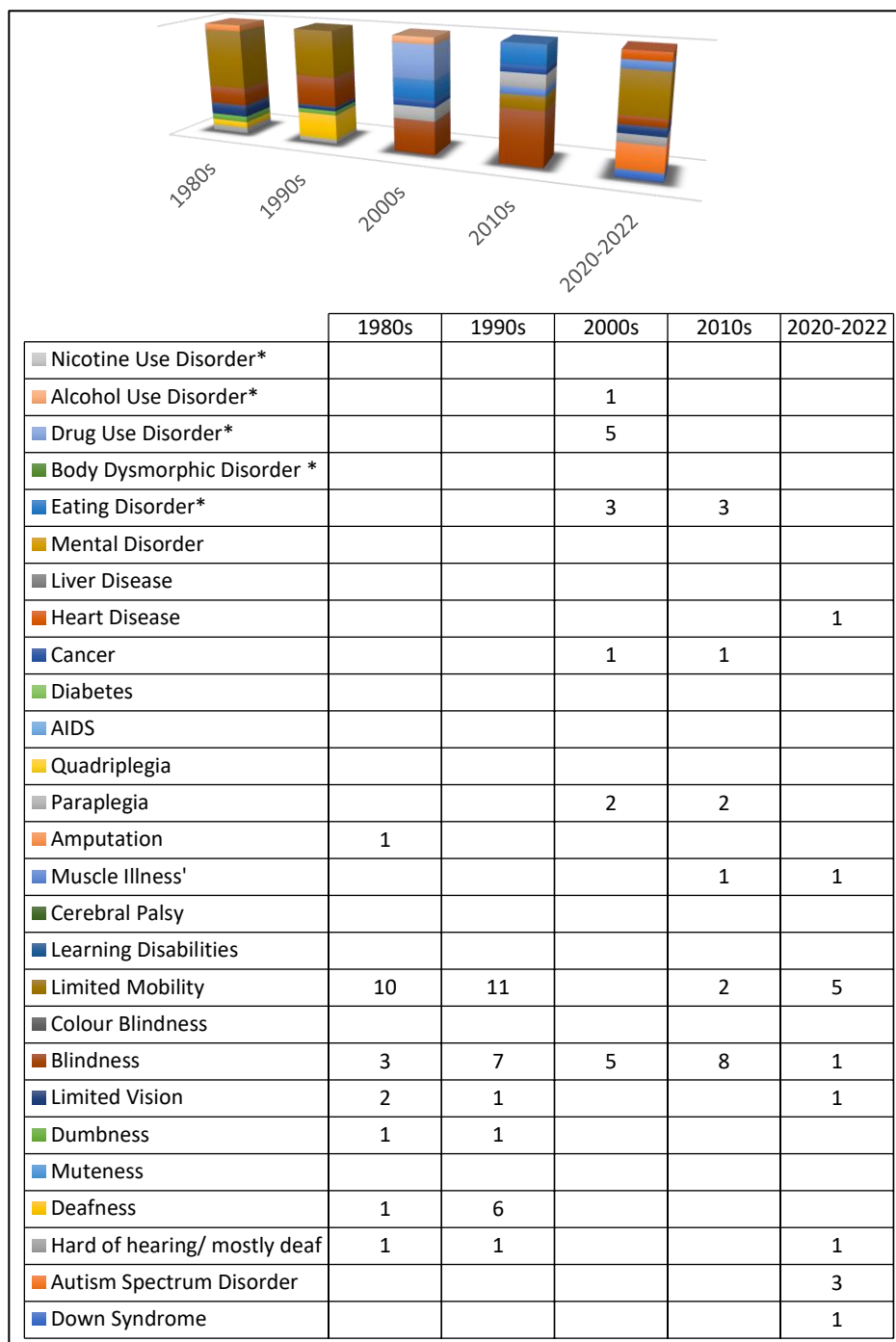


Figure 4. “Nexus Between SDOH Commission recommendations and Ottawa Charter Health Promotion Outcomes to Achieve Health Equity” (cf. Mogford et al. 2010: 6)

Figure 7. Diachronic Representation of Disabilities, Disorders and Illnesses⁷ in Lower Secondary Austrian ELT Coursebooks (N: 50)

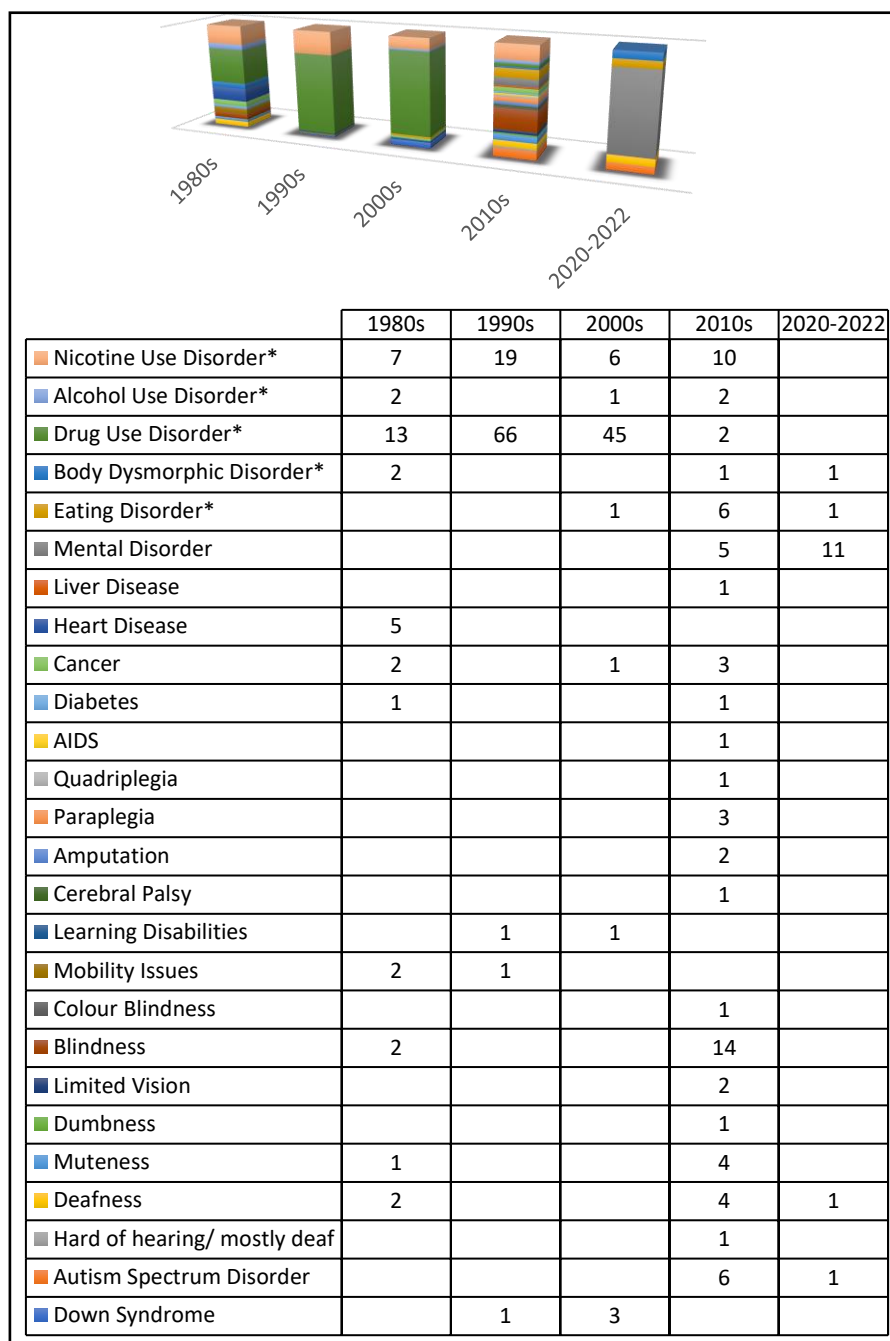
Visual+ Textual Representation of Illnesses, Disabilities, Disorders in Lower Secondary ELT Coursebooks



⁷ includes both chronic and terminal forms

Figure 8. Diachronic Representation of Disabilities, Disorders and Illnesses⁸ in Upper Secondary Austrian ELT Coursebooks (N: 56)

Textual+ Visual Representation of Illnesses, Disabilities, Disorders in Upper Secondary ELT Coursebooks



⁸ includes both chronic and terminal forms

Appendix B. Primary Sources

Ad Disability

Extract 1. ETWO 2, part 2 1984 (page 27)

THE RICH

Yet there are some cases in which DEFINITE ARTICLE + ADJECTIVE can be used in English.
A sentence from "Spending Time and Money", Coursebook, p. 31. "A shopping mall is fun for **the old** and for **the young**."

Def. art. + adj.: PLURAL MEANING

the old = the old people	The actor was popular with the old and the young alike.
the young = the young people	Robin Hood was not an ordinary robber. He took from the rich and gave to the poor – or so the story goes.
the rich = rich people	
the poor = poor people	

NOTE that "the old" are now often referred to as "our senior citizens".

the blind	There are special schools for the blind. The mute are usually born deaf, therefore they don't learn to speak.
the deaf	November 2nd is a day on which we remember the dead.
the mute	She has devoted her life to helping the sick.
the dead	There is little hope for the unemployed in that region.
the sick	Everything is much more difficult for the (physically) handicapped.
the unemployed	Even today the British are proud and fond of their Queen.
the handicapped (e.g. people who can't walk)	The Scots are British, too – but they aren't English.
the British = all British people	The Chinese used rockets long before we invented them in Europe.
the Scots	The French have produced great writers and painters.
the Chinese	
the French	

Extract 2. ETWO 2 coursebook 1984 (page 107)

Other illnesses/defects

• a cold, the flu; tonsil trouble, bronchitis, various kinds of inflammation – antibiotics like penicillin have made these illnesses less dangerous	I've got a cold/a cold in the head. I've lost my voice. I've got a cough. My nose is running.
• constipation::diarrhoea [ˌdaɪəˈrɪə], i. e. bowels cannot be emptied::are emptied too often – if this state continues, a doctor should be seen	I've got a sore throat. It hurts when I swallow. I've got a headache. I've got toothache. My back aches.
• rheumatism [ˈruːmətɪzəm]	I feel like vomiting.
• heart/liver/kidney disease OR complaint OR trouble	I've lost my appetite.
• diabetes may already occur in young people	I suffer from hayfever.
• normal/high::low blood pressure	I feel a bit dizzy.
• allergies – hayfever; asthma – certain types of food may cause a rash in some people	"How are you?" "Thanks, fine" — "None too well."
• a bruise will disappear if left alone, broken bones usually heal quite easily	I feel hot::cold.
• some people have speech defects – they may lisp or stutter	I'm shivering.
• people may squint, be shortsighted::longsighted, blind, deaf, hard of hearing, deaf mute, mute; lame	My heart's beating like mad. The children are well-fed and healthy. You look (much) healthier now than you used to.

She hasn't fully recovered yet.
She was taken to hospital for a thorough examination.
You don't feel well? Why don't you have a check-up?
She had to be operated on (for appendicitis).
The doctors are sure they can pull him through.
Of course you'll get well again.
She is recovering fast.

Extract 3. MYWWE 7 1991 (pages 79-80)

Listen to a conversation between two people about dying. Make notes in answer to the following questions:

- What was the most difficult phase for the man's family when his mother was dying?
- Why is the man less frightened of death since he experienced his mother dying?
- How did she die?
- What is a hospice?
- Why does the man feel that dying people are treated less appropriately in a hospital than in a hospice?

The article below on the topic of Euthanasia is taken from *The Nursing Times*. Read it and write a paragraph summing up what the article says. Make sure you mention

- passive and active euthanasia
- life-prolonging measures
- one or two concrete examples for clarification
- the main results of the survey carried out among nurses

EUTHANASIA

What do YOU think?

Last November we asked you to complete our questionnaire on euthanasia. This week, *Nursing Times* assesses your responses.

On life and death issues it is seldom possible to divorce head from heart. The professional and personal are apt to merge. And so it is with euthanasia. Your responses to our questionnaire (November 11) reflected the difficulty we all have in answering the question: 'Whose life is it anyway?'

What we asked you to do was to assess the merits of 13 fictitious cases or propositions, and to decide whether or not euthanasia—passive or active—was appropriate. There was a huge response—over a thousand questionnaires were returned.

Euthanasia literally means 'good death', but has come to mean a 'hastened' or 'assisted' death. Most respondents seemed to support the concept of euthanasia—in certain cases, but generally drew the line at personal involvement in assisting in someone else's death.



Two of the scenarios involved babies with Down's Syndrome. In the first, the baby had severe handicaps and had been rejected by his parents. 'He is discovered to have an intestinal blockage which requires surgery. Without this the baby will die.' The question was: 'Should the operation be performed?'

In the second example the choice was not between life or death, but what sort of death. 'The clinical team is discussing the case of a Down's Syndrome baby with a digestive tract blockage. It is suggested that the baby should be allowed to die, although it is recognised that this is likely to be distressing for all concerned, including his parents, nurses and doctors.'

We asked you whether you would be prepared to advocate that the team should adopt a more active approach to hasten death. Eighty per cent of you said you would. Only 13% said 'no' to what would amount to 'active' euthanasia.

It would be interesting to know what the 'yes' voters were responding to. Staff and family in this example face the prospect of watching the baby die a slow and painful death. Was the 'yes' vote a reasoned choice for active euthanasia, or an emotional response to the suffering of all involved?

Certainly, what was acceptable here was found unacceptable when two women actively sought euthanasia. In the first case 'a patient in the final days of her life, dying of cancer and in great pain, pleads to be administered a lethal dose of drugs which the doctor

appropriate, but would not then administer the necessary drugs themselves.

Forty-nine per cent then said there were circumstances in which they would be prepared to administer a lethal dose if instructed to do so by a doctor (as compared with 46% who said there were no such circumstances). But it is hard to imagine what circumstances these would be—if a woman dying in agony does not represent such a circumstance and such action is anyway deemed a crime.

The second woman was suffering from an incurable disease and had only a few months to live. 'After much thought she has come to the conclusion that she wants the means with which to kill herself should her circumstances become unbearable. She asks you to help.'

The response was unequivocal. Ninety-two per cent said they would not help her in this way, only seven per cent would. But this tells us very little. Is the 'no' vote out of fear of breaching the code of professional conduct—or a considered rejection of the patient's request? Would you, for example, tell the doctor of your conversation and leave it in his or her hands? Certainly 82% of you were not prepared to help the woman if she decided to take the drugs (having got hold of them), which suggests respondents were actually against active euthanasia in this instance.

Over three quarters of respondents agreed there was a moral difference between allowing a patient to die and administering a lethal dose. And more than half of respondents found that, when caring for terminally ill or very disabled patients who have additional medical complications, it was an 'appropriate and helpful' guide to make the distinction between adopting ordinary but not extraordinary interventions.

Public opinion is behind euthanasia—as many as 69% of the population feel doctors should be permitted—with approval from the family—to end the lives of the terminally ill. However, as the law stands in this country, the participation in active euthanasia is a crime—and if proved can carry a prison sentence. Passive euthanasia—the withdrawal or renunciation of life-prolonging measures with or without medical assistance—particularly with the consent of the patient, is not strictly an offence.

Making the distinction between passive and active euthanasia can be terribly difficult and your responses to our questionnaire...

agrees to write up'. We wanted to know whether, as a nurse, you would agree to administer the drugs. Fifty-five per cent said you would not, 44% said that you would. Forty-nine per cent of you did, however, think the doctor was justified in prescribing the drugs (46% thought he was not). However, according to the BMA report 'the deliberate taking of human life should remain a crime'. This perhaps explains why some respondents appeared to agree active euthanasia was

to our questionnaire show that the only way health professionals can approach the issue of euthanasia is case by case. The right decision will not always be made and the law may not always be upheld—but judging each case on its merits at least ensures patients are seen as individuals. Death is personal—hospital policy and the law must respect that and, where death is inevitable, help the individual to meet it with as little suffering as possible.

NT

Extract 4. MYWWE 7 (1991) page 81

Prepare your own arguments for a whole class discussion about death and euthanasia. For your preparation, you could go once more through the main arguments in the conversation in [5] and the article above. Here are a few more questions that could help you with your preparation:

Is death in your opinion still a taboo topic in our society?

What arguments and examples do you have in support of your position?

Do you think euthanasia can be justified?

If you were a nurse or a doctor, would you be prepared to administer the medication necessary to actively help somebody to die?

Extract 5. MYWA 7 (2006), page 99

SECTION 4 | Euthanasia

1 Language for discussion | Making hypothetical decisions

Imagine you are a doctor. Read through the situations and decide what you would do.

Case 1: A baby with Down's syndrome and several severe mental and physical handicaps that has been rejected by his parents needs an urgent life-saving operation. Should the operation be performed?

Case 2: A baby with Down's syndrome has an incurable disease. Should the baby be left to die a slow but natural death or should death be assisted?

Case 3: A female cancer patient in the last painful days of her life asks you for a lethal injection. Would you give it?

Case 4: A woman with an incurable disease but a few months still to live asks you for drugs that she can use when her pain becomes unbearable. Would you give them to her?

Case 5: A teenage girl loses her boyfriend in a car crash. She feels that her life is no longer worth living. She approaches you and asks if you know which ways of committing suicide are easiest. Do you tell her?

Case 6: A middle-aged man wants to end his life. He asks you for assistance and you explain you can't help. However, you know of an internet site that instructs people how to take their own lives painlessly. Do you tell him about the site?

I could never do that.

No one has the right to play God.

I wouldn't have to think twice ...

I don't really see that there's much of a choice.

It would really depend on the circumstances. I mean if ...

I would need to know more before I could make a decision. For example, is the woman ...

It would be extremely difficult but I think ...

I think we all have the right to decide about our own lives so ...

2 Working in pairs, think of some more situations where a doctor might have to make an ethical decision and put your questions to the rest of the class.

People with special needs

1 What are special needs?

a) With the help of the word bank on the right, complete the definition of "disability" by the World Health Organisation.

Disabilities is an umbrella term, covering impairments, limitations, and participation. An impairment is a problem in function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or; while a participation restriction is a problem experienced by an individual in involvement in situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives.

WORD BANK

Special needs and disabilities
activity limitation • assistive
equipment • blindness • body
function • cognitive disability •
communication methods •
deaf • to execute a task or
action • hard of hearing •
hearing aid • hearing loss •
impairment • to be involved in
life situations • lip reading •
low vision • non-visual media •
paraplegia • participation
restriction • physical disability •
to require assistance • sensory
disability • Sign Language

b) Rephrase the paragraph in your own words.

c) In a mind map, collect examples for:

- an impairment
- an activity limitation
- a participation restriction



2 Reading: How to live well on wheels

a) Read the text below, then complete the sentences (1-5) using a maximum of four words. Write your answers in the spaces provided. The first one (0) has been done for you.

How to live well on wheels

Admittedly, being a teenager who uses a wheelchair can be tough. Whether you've grown up in a wheelchair or this is a new thing to your life, you may seem different to other teenagers. However, since you cannot change that situation, you can change how you see yourself and your chair in everyday life.

First it's important to acknowledge that you are a little different from other teenagers. This may be not always fun, but it is a reality. Trying too hard to ignore it can make you in the end seem more different than you are. On the other hand, ensure that you live your life 100%. If you want to go to a rock concert, go to that rock concert! Yes, you will probably be different in some ways from every other person in the arena. But you also have things in common with every one of them!

FACT FILE

False assumptions about people with special needs

- The lives of people with disabilities are totally different from those of nondisabled people.
- People with disabilities are more comfortable "with their own kind".
- People with disabilities always need help.
- There's nothing one can do to help eliminate the barriers confronting people with disabilities.
- Curious children should never be allowed to ask people about their disabilities.
- All persons with hearing disabilities can read lips.
- It's all right for non-disabled people to park in accessible parking spaces for a short time.

Focus on the fun and excitement. Relish the things you enjoy in life. Have fun doing what you love to do. Investigate new ways to do things, and explore new things that you haven't tried before. You could discover the world of art, or play a sport. Even activities that seem

impossible to do in a wheelchair can often be adapted.

Second, make sure that you feel good and look good even if some people want to make you believe that it's only inner beauty that counts. Find your balance between being comfortable and being well dressed. The extra effort may pay off with more confidence and a brighter mood. In everything you do, let your personality shine. Be yourself. Sit tall, make eye contact, and engage people in conversation. You could even consider learning safe wheelchair tricks if it makes you feel cooler.

If something troubles you, express yourself. Everyone feels down sometimes. Schedule a vent session with a friend or therapist, where you can rant about what's bugging you. Try expressing your emotions through your artistic or creative side when it seems that life sucks. Write in a journal, paint, whatever.

Third, stand up for yourself. If someone leans on your chair or says something that makes you feel uncomfortable, speak up. Don't allow people to tell you what to do or how you should think. On the other hand, don't be embarrassed to ask for help. If you need help – especially if you've fallen or are in a health-threatening situation – don't be afraid to ask for assistance.

And be patient. Not everyone knows how to act around you. Yeah, this is frustrating and stupid, but a little patience goes a long way. Most people just need to understand that you're a normal person. Keep in mind that it really is OK to be in a wheelchair. Remember: Most people with disabilities lead normal, successful lives.



Teenagers in a wheelchair should work on ... because they can't do anything about it.

their self-image ✓

Q1 The example with the concert shows that people with special needs are in fact ... other people.

Q2 It's ... that only inner beauty counts, especially for people with a disability.

Q3 It might be a good option to ... a friend or therapist in case of worries.

Q4 The article advises people in a wheelchair to ... if other people do something they don't like.

Q5 It's important not to be ... if people are not sure how to deal with a person in a wheelchair.

b) Which information from the article was new to you?

c) Which aspects might change the way you see people with special needs from now on?

Extract 8. PT 7 (2011), page 31

3 "If ... cloning could cure us"

a) Watch this video clip on stem cell research and make notes on the following:

- Andrew Holland's problem
- ideas for a possible cure
- controversy between supporters and opponents of stem cell research

b) Find out more about two works of art that deal with this issue: Kazuo Ishiguro's novel *Never let me go* (2005) and the film *The Island* (2005). What do these two works of art have to do with stem cell research?

c) Do you agree or disagree with the following quote? Give reasons.

"The best that can be said about embryonic stem cell research is that it is scientific exploration into the potential benefits of killing human beings."

(Tom DeLay, * 1947, former member of the US House of Representatives)

Reality bites ★ Reality bites ★ Reality bites ★ Reality L

"My family's so proud of me"

Aine Rathwell, 16, (below) may have Down's syndrome, but she's proved it doesn't have to be a handicap...

SECRET OF MY SUCCESS

I've had to change schools 10 times in my life, 'cause my dad has worked all over the world. It can be very difficult when you're different like me, I always get nervous on the first day, 'cause I worry that the other pupils won't like me. But usually I make friends just by talking to people and being myself. Most people are nice, but I do get bullied sometimes – like pinching my cheeks or teasing me because I'm chubby. Because I've got learning difficulties, Mum had a hard time finding schools in England that would accept me. I think the schools were worried I wouldn't do very well or that they'd have to pay for the extra help I needed. When I was 12

Mum took me to three schools and none of them would have me. I was really bothered by it at the time – I thought it meant they didn't like me. But when we moved to Preston two years ago, our local school Longridge County High, accepted me straightaway. They made sure I had a teaching assistant who was with me for most lessons to help take notes or explain anything I didn't understand. Without her I don't know if I'd have coped.

Missing out
School's been brilliant, but I know I miss out on some things. I can't do much sport because I get tired quickly and I don't go out very often. Sometimes I feel left out because most of my friends have boyfriends. I've got lots of boy mates but I've never gone out with anyone. Most of all though, I'd just

like everyone to treat me normally. Sometimes people don't know what to say when they meet me for the first time, so they act as if I don't exist, or talk to me as if I'm a little girl rather than a teenager, which makes me feel awful.

Top class
That's why I was over the moon when I got my GCSE results. I had five passes in English, double science, French and art, and although the grades were on the low side it meant I'd won a place at college. My family went mad celebrating and I made it into the papers. It wasn't easy, but I was really proud that I'd proved all the people who doubted me wrong."

Fay Bailaye, 14, Aine's friend
"She's a mate in a million. Before I met Aine I never knew anyone with Down's syndrome and I thought she wouldn't be as bright as other people – but I was so wrong. She's very open and affectionate and not afraid to speak her mind. I've known Aine for two years now and she's the best friend you could ever want. It makes me really angry when people won't give her a chance or tease her 'cause she's different. Some teenagers might feel nervous about talking to a Down's syndrome person, but I'd say, 'Make the effort – if you ignore someone like Aine you'll be the one who's losing out.'"

Aine's mum is dead proud
"Five GCSE passes for a person with Down's syndrome is a major achievement. Aine was refused a place at three UK schools, and on one occasion I was told privately that it was because the school didn't want to jeopardise its league table results. Aine is proof that kids with learning difficulties can do really well in mainstream education."

Advice
Down's syndrome:
● Affects one in 1,000 kids. It's caused by a genetic accident at the time of conception which creates an extra chromosome (47 instead of 46) and disturbs a baby's development.
● Traits include distinct physical characteristics, learning difficulties, and increased chance of heart, sight or hearing problems.
● Sufferers may be different, but you don't have to treat them differently – we're all entitled to bully-free friendship. For more information, contact The Down's syndrome Association, 115 Mitcham Road, London SW17 8PG (tel: 0181-662 4001).

Best mates: Fay and Aine

Fay, Aine and her Mum

to tease: ärgern
chubby: pummelig
bothered: beunruhigt

to be over the moon: to be extremely happy
affectionate: showing that you like someone
to lose out: etwas versäumen; den Kürzeren ziehen

1 Education Super brains

Read

1 a What do you think the two boys in the pictures have in common? Read the texts to check your ideas.

In 1850 an American lawyer, James N. Bethune, bought a slave to work in his home. The slave, a woman, had a small child called Tom, who was blind and autistic. One day, Bethune was walking around his garden when he heard music coming from the house. He went inside to investigate and found young Tom playing on the family piano. Bethune realised that the boy, who was only four, had special abilities. He hired a band of musicians to come to the house and play in front of him. Tom reproduced perfectly the music he had heard. This confirmed Bethune's suspicion – Tom had the ability to memorise and repeat pieces of music after hearing them just once.

In 1857 "Blind Tom", as he was called from then on, took part in his first public performance. The reviews were so good that Bethune took him on a tour of the US. Three years later, Blind Tom was invited to the White House, where he performed for the president. Over the next forty years, Tom performed shows all over the US, as well as visiting Canada, the UK and several South American countries. His concerts were a mixture of classical music and his own compositions. They also featured a section called the "challenge" when members of the audience played a piece of music on the piano which Tom then had to reproduce. He never failed. Blind Tom died in 1908.

Stephen Wiltshire

Stephen Wiltshire was born in 1974 in London. He was mute (unable to speak) and, at the age of three, was diagnosed with autism, a developmental disorder* causing difficulty with social relationships and learning. However, Stephen has a remarkable talent. Since the age of three, he has been creating the most amazing drawings. He is an "autistic savant" – a person who, in spite of his autism, has an extraordinary ability in a certain area. When his mother sent him to school in London, some of his teachers began to realise that Stephen was "communicating" through his drawings. At the age of eight, he was drawing detailed pictures of architecture, cars and imaginary post-earthquake cities. By the age of nine, Stephen started talking. At the age of ten, he produced a series of pictures which he called London Alphabet. Each drawing featured a London landmark* – one for each letter of the alphabet.

After Stephen and his work were the subject of a BBC programme called *The Foolish Wise Ones* in 1987, many viewers phoned the BBC. They were fascinated by Stephen's ability to look at a building once and reproduce it in incredible detail, and wanted to know where they could buy his drawings. As a result, Stephen published his first book, *Drawings*. Since then, Stephen has become an extremely popular artist, and has published a number of other books of his drawings and paintings. Stephen is quite famous these days. Because of Stephen and others like him, people are starting to take autism more seriously.

Glossary: *developmental disorder – Entwicklungsstörung
*landmark – a building or place that is easily recognised

C Read and circle the correct form of the verb.

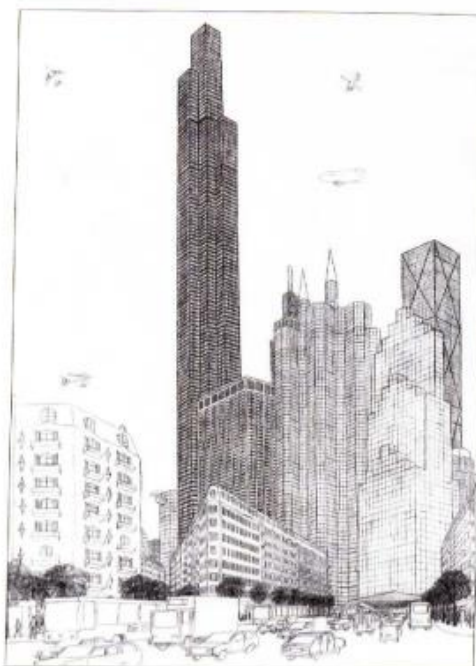
Joshua Whitehouse

Joshua Whitehouse ¹ has just turned / has just been turning 15 and he has an incredible gift for art. Joshua ² has / has had Asperger's Syndrome. He is classed as an 'autistic savant' which ³ is meaning / means he has a rare aspect of autism and is extraordinarily talented in a particular area. Josh ⁴ is drawing / has been drawing since he was a toddler* and ⁵ has been taking / has taken part in many exhibitions both in Britain and abroad. Josh's paintings ⁶ are selling / sell for up to £1,000. Famous owners ⁷ include / are including the popular artist Rolf Harris and Her Majesty the Queen. Joshua ⁸ has also published / has also been publishing a book of line drawings, each one annotated* by Joshua's thoughts. He ⁹ is wanting / wants to become a famous artist like the New York artist Keith Haring, another autistic savant.

Glossary: *toddler – young child, usually learning to walk; *annotate – add a short explanation to a text or image

Extract 12. IE 2 (2013), page 8

b Read and complete the text with the correct form of the verbs.



Gilles Trehin was born in 1972. His family
 1. moved (move) to the USA. While
 they 2. _____ (live) in America,
 doctors 3. _____ (diagnose) Gilles
 with autism. Since he was a young child,
 he 4. _____ (develop) great talents for
 music, mental calculation and drawing. He
 5. _____ (begin) to draw plans of his
 imaginary city Urville in 1984 and by 1987
 he 6. _____ (create) detailed drawings
 of the city's buildings and streets. While he
 7. _____ (work) on the city's present
 plans, he 8. _____ (start) creating
 a culture and history for it. Gilles says that
 the Romans 9. _____ (give) Urville
 its name but that it was founded by the
 Phoenicians who 10. _____ (call) it
 Sea Horse City before the Roman invasion.

Extract 13. IE 2 (2013), page 9

b Complete the text using the correct form of the verbs in brackets. Use the tenses in 3a and 5a.

When Brittany Maier was born she was blind and autistic. By
 the time she was five, she still 1. _____ (not
 learn) to speak, but she suddenly 2. _____
 (begin) to sing while she 3. _____ (listen) to
 a song on her parents' stereo. Brittany is now a young adult.
 Over the years, she 4. _____ (learn) to talk
 a little, but she still 5. _____ (find) it difficult
 to communicate through language. Her music teacher, a
 professor at the University of South Carolina, 6. _____
 (work) with Brittany for five years now. He says that
 she is unique*. She 7. _____ (play) with only
 six fingers, but she has the musical qualities of Beethoven,
 Mozart and Chopin.

Glossary: *unique = unusual or special



Stuck in Neutral

by Terry Trueman (a novel)

This is the story of Shawn, who has severe cerebral palsy*. He has no control over his muscles, no means of communication. Yet – physically powerless, his internal life is full of unseen pleasures.

Glossary: *cerebral palsy – irreversible brain disorder

a Read and find out what special ability Shawn has. Why does no one else know about his talent?

M

b Read the text again, then decide whether the statements (1–7) are true (T), false (F) or not given (NG) in the text. Put a cross **X** in the correct box. The first one (0) has been done for you.

	Statements	T	F	NG
0	Shawn has met only one other person with his special ability.		X	
Q1	His ability took a few years to develop completely.			
Q2	Shawn is a fan of TV quiz shows.			
Q3	Shawn remembers sounds as well as conversations.			
Q4	Shawn is proud of his ability.			
Q5	Shawn believes people are either good or bad.			
Q6	No one believes Shawn is intelligent.			
Q7	Shawn attends a special school.			

I have this weird – I don't know what you'd call it – ability? Gift? Power? Whatever name you want to give it, the thing is that I can remember everything I ever hear, perfectly, with total recall. I mean everything! Perfectly! Totally! I don't know of anybody else, anywhere, who can do this. Most people remember bits and pieces of things they've heard in life, but I've got it all, every sound, ever.

This started when I was three or four years old. At first I could only remember most of what I heard. But by the time I was five years old, everything I heard just stayed in my head. I can remember people talking, TV commercials, every melody I've ever listened to from boring, brain-dead country music to nasty rap lyrics, to the theme music from Jeopardy! to – well – everything: lines from movies, overheard conversations that strangers were having in the street, like – "Well, do you still love him or not?" I heard one lady say this to another lady while they were waiting for the bus in front of our house, and swoosh came the sound of the bus along the wet road, and its brakes went squeel ... eekkk and the other lady answered, "I don't know. I haven't eaten turkey since he left on Thanksgiving."

I hope I'm not coming off as conceited* here. I'm sure I am. I mean, I do think that my hearing memory is kind of amazing, but it's not like it's made me rich or famous. I just happen to have this one talent that I know makes me gifted* and special – yuck! I hate that word "special" when it's applied to people. As in "he's a very special person." Jeez! Who isn't! But the other side of people is true too. Everybody has negatives about themselves, stuff they wish wasn't a part of them. The bad news about us.

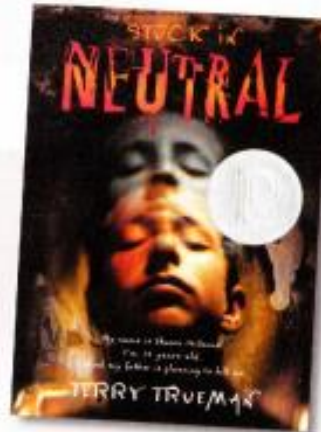
Glossary: *conceited – too proud of yourself and what you do;
*gifted – clever, with a special ability

One bad news deal is that in the eyes of the world, I'm a total retardate. A "retard"*. Not "retard" like you might use the word to tease* a friend who just said or did something stupid. I mean a real retard. Real in the same way that total means total. As in total retard: everybody who knows me, everybody who sees me, everybody, anybody who even gets near me would tell you I'm dumb as a rock. Let me illustrate through the wonders of science.

Every year the school district sends out a school psychologist (scientist) to test me for IEPs (Individual Educational Plans). And every year since I was six, the psychologist gives me a bunch of tests ('scientifically normed and standardized'), which are mainly intelligence tests filled with shapes and colors, square pegs* and round holes, and "Who was George Washington?" and "What's two plus one?" And every year I sit there and miss every question, fling the blocks into the air or drop them all over or smack* myself in the eye with one. Then the shrink* goes in and gives my mom a number: IQ = 1.2, or mental age 3 to 4 (that's months, not years). Then the psychologist packs up his scientific garbage and moves on to the next dummy.

This has gone on for eight years now. Every year, year in and year out. Yep, according to the world I'm as dumb as a fence post*. I've heard the docs explain why they think I'm so stupid to my parents and my parents explain it to their friends about a trillion times. They think it's because my brain doesn't work. They don't know that is only partially true.

Glossary: *retard - a mentally slow person; *tease - to mock or annoy; *peg - a short piece of wood or metal used for hanging things on; *smack - to hit someone with the flat part of your hand; *shrink - a psychiatrist; *as dumb as a fence post - stupid



c Discuss the questions in pairs.

- 1 What kind of person is Shawn? How would you describe his personality?
- 2 Would you like Shawn's ability? Why / Why not?
- 3 What do you think he means when he says it's only partially true that his brain doesn't work?
- 4 How do you think this story develops?

d Look at the picture and write a text of around 200 words describing what the man is thinking. Consider the following points:



- Who is this man?
- Where is he?
- Why is he there?
- What did he do when he was younger?
- What does he think people think about him now?
- Where would he like to be?
- What would he like to be doing?

READING 6 Read the short introduction of an English world traveller. What do you think he is like?

Tony Gales is a traveller from the southwest of England. He has been to over 120 countries of the world and has written books about his travels. But he is not like most other travellers you might meet. In fact, he is blind and mostly deaf, which makes backpacking across the world that much more challenging. Nevertheless, having his backpack and cane ready for the next adventure, he has no intention of stopping.



SPEAKING 7 Discuss the following questions with a partner:

- 1 How do you think Tony manages to travel around strange places without the ability to see?
- 2 Why do you think he travels the world even though he can't hear or see?

2. a) Reading texts and visuals as impulses for text production

Read through the text and then do either section A or B:

Handicaps – Spare a thought

What I'm writing now is not for architects, city planners, or people like that. It's a few words to give some practical help to those who have disabled friends or relations. As I am disabled I do know what I'm talking about. I have been in a wheelchair for 26 years. One of our most frustrating problems is getting to the toilet. If you invite someone disabled to your house, make sure there is access to your loo and somewhere to wash. It may just be a question of moving a bit of furniture. But do it in advance. It's awful waiting while people flap about moving this and that saying,

'oh dear ... so sorry ... just a moment ...'. You feel guilty and embarrassed, which isn't fair.

Do try to ensure that everything necessary is within reach – a mirror, coat-hangers, hooks, and so on.

Remove small rugs in advance. They are real obstacles. If you try to wheel over them, or turn on them, they ruckle up and render you immobile. If you put a stick or crutches on them they slide away.

One last word. We all know it's more blessed to give than to receive. Let your disabled friend do things for you, too. Be on the receiving end sometimes.

The Sunday Times

1 Imagine that the parents of a handicapped boy/ girl are trying to persuade the headmaster of a school to accept their child as a pupil. Write their letter.

2 Write an inner monologue: a woman/man in a wheelchair is watching people on a beach on a beautiful summer day.

3 Write a narrative account finishing with the following sentence: I would never have thought that a blind person would be able to do something like that.

"Handicapped people in our society". Write an essay on this topic including consideration of the following questions and adding further points of your own:

Have you got any personal experiences with handicapped people? What have you learned from these experiences?

Have town planners/architects etc. in your area considered the needs of disabled people? Give examples.

What facilities would you recommend be created so that handicapped people can feel comfortable?

Can you imagine integrating handicapped people into regular school-life?

Where would the limitations be? What could be done about them? What would be the advantages for all students in an integrated school?

What does the way we deal with outsiders/minorities reveal about our society?

How many of our responsibilities do we hand over to organisations and institutions, how much can be expected from individuals or community work?

2 Communication Ways of talking

Read

1 a Look at the words in the box. How do they communicate?

whales people and their animals deaf people

b Read the article quickly to find the answers to these questions.

- 1 How long have Orlando and German known each other?
- 2 What job do they do?

Sharing Silence

1 Deaf teenagers Orlando Chavez (16) and German Resendiz (17) have been friends since kindergarten. Together the two boys, who go to Escondido High School in California, have had the difficult job of learning in schools where the majority of the students can speak and hear.

2 Orlando lost his hearing at the age of one when he got meningitis*. German was born deaf, and his parents moved from Mexico to find a school where he could learn sign language. He met Orlando on their first day of kindergarten.

3 "We were in a special class with about 25 other deaf kids," German remembers. "Before then, I didn't know I was deaf and that I was different."

4 "Being young and deaf in regular classes was very hard," signs Orlando. "The other kids didn't understand us and we didn't understand them. But we've all grown up together, and today, I'm popular because I'm deaf. Kids try hard to communicate with me."

5 Some things are very difficult for the two boys. "We can't talk on the phone, so if we need help, we can't call an emergency service," German signs. "And we can't order food in a drive-thru."

6 Despite their difficulties, the two boys have found work putting food in bags at a local supermarket. They got their jobs through a "workability" program, designed for teenagers from local schools with different types of learning disabilities.

7 German has worked in the supermarket since August, and Orlando started in November.

8 "The other people who work here have been very nice to us," Orlando signs. "They even sign sometimes. At first, we were nervous, but we've learned a lot and we're getting better."

9 The opportunity* to earn money has been exciting, both boys said. After high school, they hope to attend the National Technical Institute for the Deaf in New York.

10 "We want good jobs, to get married, have children and to be able to provide for our families," German said. "So we are aware that we need to continue with our education." Orlando wants to work on computers and engines. German would like to be a contractor*. He likes building and painting, and woodwork is his favourite class.

Glossary: *meningitis - Hirnhautentzündung; *opportunity - chance; *contractor - Bauunternehmer/in



Discussion box

- 1 German mentions two problems he has. What other problems do you think deaf people have?
They must find it difficult to ...
I imagine they have trouble ...
It can't be easy for them to ...
- 2 How do you think deaf people deal with these problems?
They might ... *They would probably ...*
They overcome the problem of ... by ...
They deal with ... by ...
- 3 What jobs do you think would be easy for deaf people, and what would be impossible?
They could never ...
... would be no problem at all.
They could have a good go at ...
I'd imagine they'd have difficulty ...

Listen

2 a Listen and take notes of four things to do if you want to communicate with a deaf person.

b Listen again. Complete the following sentences.

- 1 Most deaf people can't
- 2 When you want to communicate with a deaf person, make sure
- 3 Covering your mouth while talking means that
- 4 It makes a lot of sense to use
- 5 It is easier for lip readers to understand you if
- 6 When deaf people "talk" and someone interrupts

b Read the text to check your ideas.

Intelligent Machines

0... Medical scientists are already putting computer chips directly into the brain to help people who have Parkinson's disease, but in what other ways might computer technology be able to help us?

Q1... Ray Kurzweil is author of the successful book *The Age of Intelligent Machines* and is one of the world's best computer research scientists. He is researching the possibilities.

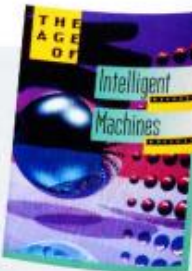
Q2... Kurzweil gets computers to recognise voices. An example of this was Ramona, the virtual hostess* of Kurzweil's homepage, who was programmed to understand what you say. Visitors to the site could have their own conversations with her, and Ramona also danced and sang.

Q3... Kurzweil uses this technology to help people with physical disabilities. One of his ideas is a "seeing machine". This will be "like a friend that could describe what is going on in the visible world", he explains. Blind people will use a visual sensor which will probably be built into a pair of sunglasses. This sensor will describe to the person everything it sees.

Q4... Another idea, which is likely to help deaf people, is the "listening machine". This invention will recognise millions of words and understand any speaker. The listening machine will also be able to translate into other languages, so even people without hearing problems are likely to be interested in using it.

Q5... But it is not just about helping people with disabilities. Looking further into the future, Kurzweil sees a time when we will be able to download our entire* consciousness* onto a computer. This technology probably won't be ready for at least 50 years, but when it arrives, it means our mind will be able to live forever.

Glossary: *hostess = female presenter; *entire = whole; *consciousness = your mind and your thoughts; *immortality = never having to die


Living with a disability

SPEAKING 16 What does it mean when a person is disabled? Talk in pairs.

LANGUAGE 17 a **Disabilities**
The box below shows a range of expressions connected with physical/sensory disabilities. Sort the words into four categories.

L	blindness	paralysed	hard of hearing	deaf
	hearing	mute	vision	amputated
	amputee	deafness	blind	muteness

b Discuss in pairs what life must be like for a person with these disabilities. Take notes.

- 1 What problems might occur?
- 2 What might being a disabled teenager be like?
- 3 What kinds of jobs could be easy/hard/impossible/... to perform with these disabilities?



READING 21 a Before reading the article below, take notes on the following questions:

- 1 What mental disabilities do you know of?
- 2 What do you think are right or wrong ways to respond to people with a disability?

- b Read how Robyn Lambird describes what it feels like to live with a disability and complete the sentences (1-6) using a maximum of four words. Write your answers in the spaces provided. The first one (0) has been done for you.

What you should know about living with a disability

Disabled people make up the world's biggest minority – that includes sensory, physical, mental or intellectual disabilities. As a young woman living with cerebral palsy, a neurological condition affecting movement and muscle tone², I often notice that disabled people could benefit from more meaningful representation. Because there's such an unacceptable lack of visibility in mainstream media, disabled people are still very much misunderstood. I recently shared my feelings about the disabled identity on the wonderful *Body Pos Project*, an online platform for sharing stories about overcoming issues regarding body positivity. People responded with so much love. Still, there are some things I wish they knew.

First of all, we can't be summed up with a wheelchair symbol. Although a wheelchair is the universal symbol for accessible facilities, this is not suitable as the actual community is so much broader than that! Some disabilities are visible, some aren't. A disability might be the result of an accident or illness, or people may have just been born this way. Having the wheelchair symbol represent the entire disabled community is unhelpful as it often means

that individuals who have 'invisible disabilities' face discrimination. Many of my disabled friends, when not using mobility aids, have received negative comments and stares when taking a priority seat on public transport. This is because we appear to be young able-bodied individuals, and our mobility and balance problems aren't obvious, so please be careful what you say.

As long as you are polite and respectful, I'm more than happy to answer your questions about my situation. I understand the natural curiosity, and the more you understand about my disability, the more I actually benefit. If people are willing to sit and listen to our stories and challenges, that goes a long way in making us feel valuable and empowered. We want to be seen. It's validating to see someone who looks like you on screen, on a billboard or in a magazine. Unfortunately, this rarely happens for disabled people. But if we have representation, disability will be normalized, and negative attitudes (like fear and bias) can be changed. Some brands are including disabled models in advertising, but there is more work to be done. Still, I'm hopeful.

²muscle tone: Muskelspannung

Please, don't call us 'brave'. Having a disability doesn't make us exceptional or inspirational or brave. In fact, those words actually come across as careless and condescending. I shouldn't be seen as remarkable because I use a wheelchair, but rather because of my achievement in athletics or because

I work to raise awareness for my community. Disabled people are reasonable, we just want the same things as everyone else: employment, relationships, and the opportunity to go out and experience the world in the same way as our able-bodied peers.

0	Disabled people represent _____.	the world's biggest minority
1	In Lambird's view, people with a disability should _____.	
2	The wheelchair is not a suitable symbol for the community of disabled people because _____.	
3	Sometimes when people with a 'hidden' disability occupy priority seats, they _____.	
4	Disabled people are willing to share their stories because they _____.	
5	Companies should show people with a disability in advertisements because this _____.	
6	People with a disability don't want to be called 'brave' because it _____.	

WRITING 22 a Work in pairs. Use the information from the article to write down five suggestions on how to respond to people with a disability.

b In the article, Robyn Lambird says, "As long as you are polite and respectful, I'm more than happy to answer your questions about my situation." Come up with three questions you would like to ask her.

1 _____

2 _____

3 _____

Ad Disorders

6 Discuss the long-term effects of the drug nicotine /ˈnɪkətiːn/

STAMP OUT OLD AGE
Smoke cigarettes

Notice in the rooms of a hotel in California:

Please, don't smoke in bed. We don't want you to make an ash of yourself.

In 1980 more than 100,000 Americans died of lung cancer. 85% of them started smoking before they were 18.

The nicotine of one cigarette is enough to kill a mouse.



What does this advertisement of a cigarette smoker suggest?

Have a good look at it: How does it try to make people smoke or buy these cigarettes? — Is it telling the truth?

What do you think:
Why do some young people start smoking? Do they really like it when they smoke for the first time?

4 Answer this drugs quiz

1 Drug taking

- (a) gives a long, happy life of pleasure;
- (b) may lead to illness and early death;
- (c) can be given up at any time.

2 "Soft" drugs such as marijuana or hashish

- (a) are no threat to your health at all;
- (b) cost almost nothing;
- (c) usually lead on to "hard" drugs.

3 International drug dealers have built up a world-wide organization to

- (a) make you "happy" when you feel sad or bored;
- (b) help opium-producing farmers in Turkey, Afghanistan, Pakistan, Mexico and so on;
- (c) make themselves rich and powerful.

4 How much heroin is necessary to make how many people addicts?

- (a) 1 gram for 4 people;
- (b) 100 gr for 200 people;
- (c) 0.5 kg for 3000 people.

5



"I make money selling pot¹ to send my son to public school and he goes and gets thrown out for smoking it!"

Tell the story behind this cartoon.

¹pot — slang for marijuana

Punch

Extract 26. MYWWE 6 (1990), page 84

- 5 Now compare your group findings with the following theories from a leaflet about why people try drugs for the first time.
Discuss the reasons given in the leaflet:
Which is the reason you agree/disagree most with?
Is there any reason given which you would not have expected?

There are all kinds of theories about why people start taking drugs and none of them have been proved.

The "Weak Personality" Theory: Some people believe that people take drugs because they have a weak personality and because they are inadequate in some way. This theory says that drug-takers take drugs in order to escape from their problems.

The "Evil Pusher" Theory: This theory says that people take illegal drugs because a "pusher" tricks them into trying drugs so that he or she can make them addicted and then sell them drugs for a high profit. (Most people do not seem to think of people who make and sell cigarettes or alcohol as pushers; why is this?).

The "Pleasure" Theory: This theory suggests that people take drugs because they like the effects.

The "Rebel" Theory: Other people believe that young people take drugs in order to rebel against their parents and against the rest of society. This theory says that people take illegal drugs just because it's not legal.

The "Curiosity" Theory: This theory suggests that some people are just curious about the effects of drugs and want to know for themselves what it is like.

The "Doesn't Know Any Better" Theory: Some people believe that only stupid people and people who don't understand the facts take drugs.

The "Fashion" Theory: Some people believe that people take a drug because it's the fashion to take it. (If there are fashions in clothes and music, then there can be fashions in drugs too).

The "In-with-the-crowd" Theory: Another theory

says that people take a drug if they want to belong to the crowd. Some people don't like to feel "different" and like to take part in what other people are doing.

The "Because-it-is-offered" Theory: Do people really have to have a strong reason to take a drug? Does everybody who takes alcohol or a cigarette have a reason? Sometimes people do something just because they get the opportunity – so they might take a legal or illegal drug just because it is offered to them, even though they were not looking for the drug.

Some of these theories may be right for some of the people who take legal or illegal drugs, but no theory gives the whole story. And quite often the reason that people give is a reason that they have thought of after they took the drug, not what they were thinking at the time. And the reason they give may depend on who they are talking to.



"I have reason to believe that you are pushing dope."

Extract 27. MYWWE 6 (1990), page 85

Read the following basic briefing from an information leaflet on drugs.
(Use the dictionary if necessary.)

DRUGS **A BASIC BRIEFING**

Amphetamines **(Speed).**

Commonly a white or brown powder but can be in pill or capsule form. Usually sniffed or injected. Makes people lively, giggly and overalert, but depression and difficulty with sleep can follow. Heavy use can produce feelings of persecution.



Cannabis (Pot, Dope, Hash, Grass).

Heroin (Smack, Skag).

White or speckled brown powder. Usually heated on silver foil and fumes inhaled. Can be sniffed or injected. Produces initial alertness followed by drowsiness and "drunken" appearance. Overdose can produce unconsciousness. Regular frequent use produces dependence. Abstinence in a regular user can result in physical withdrawal symptoms similar to flu.



Heroin is made from morphine, an addictive drug used in medicine for stopping pain and making people calmer.

LSD (Acid).

Tiny coloured tablets. Microspots on blotting paper. Small impregnated stamps. Taken by mouth. Produces glazed eyes and sometimes over-excitement. Heavy use can produce acute confusion and ideas of persecution.



Hard brown resinous material of herbal mixture. Smoked in a reefer or pipe, sometimes with tobacco. Distinctive "herbal" smell. Users may appear "drunk" and talkative. Risk of accidents when intoxicated.



What can be the dangers of drugs?

The main dangers are as follows:

- * Having an accident while under their influence.
- * Some drugs may depress or stop breathing.
- * Accidental overdose can lead to unconsciousness or even death.
- * Addiction or dependence, after regular use.

In addition to these dangers, drugs can also have nasty side effects.

They can bring on confusion and frightening hallucinations.

They can cause unbalanced emotions or more serious mental disorders.

First time heroin users are sometimes violently sick.

Regular users may become constipated and girls can miss their periods.

Later still, there may be more serious mental and physical deterioration.

And if a drug user starts to inject, infections leading to sores, abscesses, jaundice, blood poisoning and even AIDS virus infection may follow.

Cocaine (Coke).

A white powder, commonly sniffed. Can be injected or sometimes smoked. Similar effects to amphetamines but more likely to lead to dependence.



Crack (Rock).

A recently used form of cocaine. Smoked rather than snorted. Effects like cocaine, but more addictive than any other form of cocaine.



Extract 28. MYWWE 6 (1990), page 95

3 The lines of the following text from *The Reader's Digest* have been jumbled. Put them into the correct order.

An ex-addict about how he stopped taking drugs.

children, a happily married man and the founder of the Palmer Drug way to live. In the sixteen years since my last high, I've shown I asked myself over and over, Why am I here? I blamed my parents, years and spent three years in prison. People have tried to get me truth: I'm here because I put myself here.

in jail again. And for the first time ever my parents did not help me. Abuse Program in Houston. I used to smoke pot, sniff cocaine, thousands of teenagers and parents what I've learned. Most of these shoot heroin, drink alcohol - sometimes all at once. I used to rob kids are not dependent on drugs any more. I used drugs for ten people. I no longer do these things, because I have found a better off drugs 31 times without success. But at age 27, I found myself the schools, the police. But after several weeks, I admitted the I'm a drug addict and an alcoholic. I'm also the father of two

Extract 29. MYWWE 6 (1990), page 99

3 People frequently say that "something ought to be done about drugs". Others expect politicians to solve the problem. Here is a list of things that some people say ought to be done:

- heavier fines and prison sentences for people using or selling drugs;
- a ban on all cigarette and alcohol advertising;
- making it legal to use cannabis and to buy it in special shops, like cigarettes and alcohol;
- more tax on alcohol and cigarettes;
- capital punishment for drug dealers;
- ...

Write a text of about 150 words. Start like this:
If I were a politician ...

capital punishment: *Todesstrafe*

4 Imagine that you are working for an advertising agency which is producing material for campaigns against various forms of drug addiction. Write a leaflet to support the campaign.

Create a layout that you think helps to attract young people's attention (pictures etc.). Use statements, arguments and examples that you think would really help to prevent young people from becoming addicted to drugs. If you think that black humour is a suitable form of influencing young people, you may try to work it in.

The Meaning of Drug

A *drug* is any chemical substance that alters mood, perception or consciousness and is misused, to the apparent detriment of society. People often don't consider alcohol a drug, because our society is itself dependent on it.

In many people's minds, the most important and dangerous quality of a drug is its *addictiveness*. To begin with semantics: there has been, and still is, a woolly debate about the proper words to apply to drug abuse. "Addict" and its compounds are now out of fashion; but since the word still popularly encapsulates the menace, we will have to use it, but with reservations. Strictly speaking, "addict", "addictive", "addiction" and so on are only applied to drugs that cause physical changes in the body, perpetuating their use. That is, "tolerance" is established in the "addict", and he needs more of the drug to hold off withdrawal symptoms or to reach the same intensity of effect.

The common addictive drugs are: alcohol, morphine, heroin, cocaine, and barbiturates.

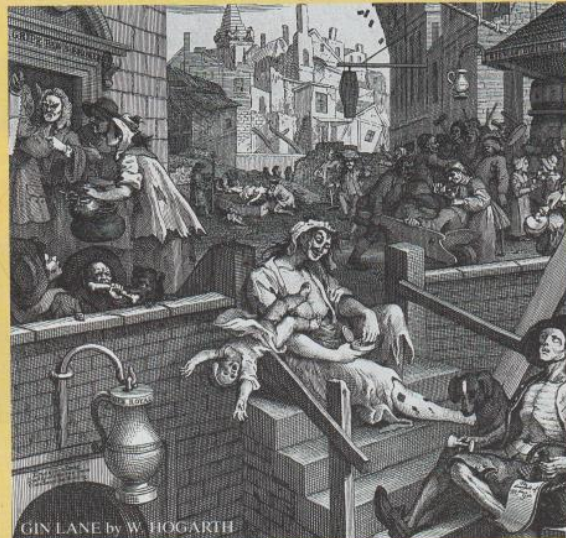
There are also examples of people who become extremely dependent on drugs that cause no long-term changes in the body at all, like cannabis. But the distinction between physically addictive and non-addictive drugs is still worth making.

The World Health Organization recommend saying "drug dependence" instead of addiction.

Individuals may become dependent on

a wide variety of chemical substances covering the whole range of pharmacodynamic effects from stimulation to depression. All these drugs have in common: they are capable of creating a state of mind in some individuals which is termed *psychic dependence*. This is a psychic drive which requires periodic or chronic

administration of the substance for pleasure or to avoid discomfort. Indeed, it is the most powerful factor involved in chronic intoxication with psychotropic drugs. With certain types of drugs it may be the only factor involved, even in the most intense types of craving and compulsive abuse.

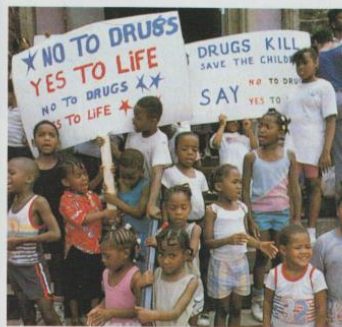


TASKS

- 1 Why is the term "drug dependence" used instead of "drug addiction" by the WHO?
- 2 In how far is nicotine different from the other drugs mentioned? Would you consider it a drug?
- 3 How does the picture show the demoralising effect of liquor on human society?

PREVENTION

To keep your kids off drugs, stop denying, know the dangers and get involved



Young protesters demonstrate against drugs in north Philadelphia

TREATMENT

Getting the right help for an addiction can mean the difference between recovery and relapse



After four years, Edna Watts of San Francisco beat drugs. She is candid with Ezell, 10, and her three other children. "They've got something to stand on. The truth."

CODEPENDENCY

Living with the craziness of addiction can be as destructive to you as it is to the addict you love



They're a family again, but their trials go on

PROJECT HOW TO BEAT DRUGS

You've decided to start a drug-education programme at your school/in your community.

- Collect relevant material, keep a fact-file, e. g. statistics, visual material, slogans, striking case studies, medical research, etc. and compile an informational pamphlet.
- Think of other steps that could be taken to inform your peers about the danger of drugs (e. g. guest lecturers, ex-addicts).

Devise a programme of action. Perhaps some of the information in the unit has already given you some concrete ideas.

6 What are the dangers of Ecstasy? Look at the leaflet from the Health Education Authority and write down the three worst dangers.

ECSTASY
KNOW the SCOPE

Ecstasy's effect on your brain can make you feel happy but could cause periods of depression and anxiety and even brain damage. Taking Ecstasy doesn't guarantee you a good time.

The long term effects of Ecstasy are still unknown. If you take E you're a human guinea-pig. Even if you've taken E before and felt alright, that doesn't mean you'll be O.K. the next time.

Tiny blood vessels can rupture or block. If this happens in the brain it can lead to paralysis or coma.

Ecstasy could be pure or it could be cut with all kinds of stuff. You just don't know. Even if the E is pure, that doesn't mean it's safe.

Taking E could damage your liver and kidneys.

Girls could be prone to suffer from cystitis and heavier periods.

National drugs helpline:
0800 77 66 00
If you'd like more information about drugs or just a talk, give us a call free and in total confidence.

Dehydration when dancing on Ecstasy can be another danger. To combat this sip about a pint of non-alcoholic liquid an hour to replace lost fluids. Include fruit juices and energy drinks to keep sodium levels up. Remember to chill out.

13 Choose the correct word for each of the numbers from the lists below the text and put them into the correct forms.

Has the time come for a rethink?

Drug use seems to be increasing, despite attempts to restrict it all over the world. Is it time to change our approach to the issue?

Despite the efforts of governments and other organisations to reduce drug use and sale, drug-taking (1) to increase. Police, customs, strict laws and attempts to scare people about drug abuse have all failed to make an impact. It may be time to (2) that drugs have been around for many centuries and will not go away.

Most people take drugs of some kind. Perhaps we should increase our efforts to educate journalists, politicians, teachers, doctors, parents and carers, and young people so that they understand the subject better and can face drug issues sensibly.

Many people (3) that drug laws are unfair. In the "war" on drugs, there has been much destruction of the homes and crops of the farmers who grow marijuana, coca and opium poppies, while those who produce hops (for beer), grapes (for wine) and tobacco are (4) alone. Users who (5) for taking drugs often need advice and support, rather than punishment, to help them face their problems.

Clubs adopt a sensitive approach

Around the world, many places for young people, from rave clubs to youth clubs, (6) their attitudes to drug use as more young people try them. Some rave club owners now (7) that many club-goers will take

drugs before or during the evening, and have developed new methods of tackling this problem, such as (8) teams of safety advisers. Dancers who have taken Ecstasy can get very hot and dehydrated

(short of water), and may even die. The advisers are on hand to make sure that they get rest, water and advice.

Youth clubs provide opportunities for young people to talk with others about their views, feelings and worries, and youth workers will often (9) discussions about the local drug scene. As long as drugs continue to be available, youth workers help to prevent health problems and other dangers by providing information and

advice, and by being friendly and supportive both to users and non-users.

Police take a new attitude

Nowadays, many police forces are choosing to help rather than (10) those who use drugs rarely. They may check for drugs among people queuing for clubs. If club-goers overdose or become ill on drugs such as Ecstasy, many forces (11) to help them. They might take the users to the police station, where they offer them water and advice about sensible drug use. This is partly due to the fact that several young people (12) recently from the effects of Ecstasy. More and more police officers are working together with teachers to provide balanced, reliable information about drugs for young people in schools.



- 1 last, continue, want
- 2 recognize, tolerate, ban
- 3 demand, argue, discuss
- 4 send, sell, leave
- 5 inject, jail, offer

- 6 change, leave, praise
- 7 realize, prove, trade
- 8 report, televise, provide
- 9 pass, lead, forbid

- 10 punish, welcome, understand
- 11 refuse, believe, prefer
- 12 discover, die, drink

Ad Nicotine Use Disorder

Extract 35. MIW 1 (1989), page 66

TASKS

1. **Save a sweet heart – yours**
What do people who join the SASH-program have to do? Where and when did the campaign take place?
2. **Think about stopping**
 - a) What health risks does smoking involve?
 - b) Of the many reasons for giving up smoking which *three* would have the most influence on you?

Save a sweet heart–yours

Kathy Martin, 17, smoked a pack of cigarettes every day for three years. "I was coughing all the time and getting sick. I didn't smell good, and my boyfriend hated it."

The day she quit was February 14—Valentine's Day and pledge day for the Save a Sweet Heart (SASH) program at her high school in Brewster, New York.

SASH began in Wisconsin in 1978, when that state's student council association asked the American Heart Association for help in getting kids to stop smoking. By then everybody knew that smoking had been linked to cancer and heart disease. Even so, 12.7 percent of all girls and 10.7 percent of all boys are regular smokers. Other teens wanted to help them save their hearts—and their lives. The program is now held in more than 30 states.

This year the campaign climaxes on Valentine's Day, when smokers pledge not to smoke for the day and nonsmokers pledge not to begin smoking for at least one year. Participants wear T-shirts and buttons that say "I'm kissable, I don't smoke."

"Last year almost everyone at my school quit smoking for the day," says Martin. "The way we look at it, if we could stop smoking for one day, we could stop smoking forever." —Karen Glenn

Watch for SASH day at your school. If there isn't a program already, contact your local Heart Association chapter for help in starting one.

I. THINK ABOUT STOPPING

The big question is: do you *really* want to stop? Because this is the key to success. Make up your mind you are going to stop, and you will. Lots of people have been surprised how easy it was to stop once they had really made up their minds.

To help you make your decision, think about what you gain by stopping.

RIGHT AWAY

- ☐ You will be free from an expensive and damaging habit.
- ☐ You'll have another £7-£12 a week to spend.
- ☐ You'll smell fresher. No more bad breath, stained fingers or teeth.
- ☐ You'll be healthier and breathe more easily—for example, when you climb stairs or run for a bus.
- ☐ And you'll be free of the worry that you may be killing yourself.

Think of the money you'll save.

Another 200 yards and... I'll be home...

FOR THE FUTURE

- ☐ You will lose your smoker's cough.
- ☐ You will suffer fewer colds and other infections.
- ☐ And you will avoid the dangers that smokers have to face.

Many people killed by smoking could have lived 10, 20, even 30 or more years longer. On average, people killed by smoking lose 10 to 15 years of their lives.

Among 1,000 young people who smoke, about 6 will be killed on the roads but about 250 will be killed before their time by tobacco.

Women who smoke when they are pregnant run a greater risk of miscarriage or of their baby being born premature or underweight.

If you stop smoking before you have got cancer or serious heart or lung disease from smoking, then you will avoid nearly all the risks of death or disability from smoking.

FAMILY AND FRIENDS

Once you stop smoking, your family and friends gain too.

- ☐ They can enjoy fresher air.
- ☐ You'll be nicer to be with. Remember the slogan 'Kiss a non-smoker and taste the difference'.
- ☐ Children who live in smoke-free homes are much less likely to get colds and even pneumonia.
- ☐ If you don't smoke, your children are less likely to start.
- ☐ And although the main risk of smoking is to the smoker, non-smokers who live with a smoker have a higher chance of getting chest diseases.

For you, your family and friends, the benefits of stopping start on the day you stop smoking, and go on for good.

Extract 36. MYWWE 6 (1990), page 127

THE PERFECT RECESS

Benson & Hedges

Salem Spirit

The Thin Red Line

WOMEN SMOKERS

Gail Kemp investigates
Why do women find it harder than men to give up smoking?

Pick up any women's magazine and flick through it. In between the articles on health, beauty and sensible lifestyles, you will find a whole range of cigarette ads. Some mistake? Well, not really.

Last month's government statistics on smoking showed that although fewer women smoke cigarettes than men – 32% as opposed to 36% – women aren't giving up cigarettes as fast as men are. Since 1972, smoking among men has dropped by a third and among women by only a fifth. The cigarette manufacturers have not been slow to realise that women form an extremely profitable source of income. Lung cancer is now killing nearly as many women as breast cancer, and more and more women are suffering from "male" diseases of the heart and chest – in 1983, nearly 34,000 British women died from smoking-induced diseases. And women are still failing to give up, although research indicates that three-quarters of female smokers have tried.

Even more disturbing, studies among young people show that more teenage girls are taking up the habit than boys. In Sheffield, for instance, one in four 15-year-old girls is a regular smoker compared with one in seven boys.

Most schoolchildren say they smoke to relieve stress, and there is likely to be more stress for a 15-year-old girl than for her male counterpart. She is more likely to work harder at school, more likely to be concerned about her weight and to use fags as a "control", more likely to worry about exams and personal relationships – and death seems a long way away. She is more likely to be exposed to smoking situations through older boyfriends and less likely to have been influenced by children's anti-smoking campaigns which have featured "male" idols such as Superman.

When the teenage girl leaves school and finds work, she usually has enough money to buy cigarettes. She believes that she can give up whenever she wants to.



to flick through: to turn the pages quickly
smoking-induced: caused by smoking
disturbing: causing sb. to feel anxious

to relieve [ri'li:v]: to get rid of
fag (slang): cigarette
tense: nervous, worried

you're hungry they suppress the appetite and when you're full they provide a relaxing end to a meal. In short, they can become an all-purpose crutch. But nothing in this world is perfect, and the catch with cigarettes is that they kill you.

So why do women continue to smoke even when they know that they are shortening their lives?

It seems that in Britain in the 1980s, a lot of smoking is still stress-related. Studies have shown that 65% of unmarried mothers smoke – almost double the percentage of married mothers. If you're trapped at home, living on the breadline with a couple of kids, life isn't much fun. A cup of coffee and a cigarette punctuate the day, creating a few moments when a woman can indulge herself in what is still a fairly cheap habit. As one smoking mother recently admitted: "It's an excuse to take a deep breath. It's a reward which, unlike chocolates, I can't share with the kids. Women live their lives for their kids, for their husbands – it's a way of having something that is all mine." Another added: "Smoking stops me hitting the kids."

Getting fat is also traumatic for women in a society where they are bullied unmercifully to stay slim. That's why many reformed female smokers quickly reach for a packet of 20 as soon as they gain a little weight. Giving up has also, ironically, not been made easier for women by the advertising campaigns warning them to stop. Most of these campaigns have used emotional blackmail – you'll be damaging your unborn baby, you're causing your children and pets to breathe in your second-hand smoke, and so on. Not until this year has the Health Education Council invested heavily in a campaign which told women what smoking was doing to their own bodies.

The HEC plans to run a harder-hitting campaign for women next year. But it is up against a filter-tipped Goliath. Last year, the HEC spent £1.5m warning people against smoking. By contrast, the cigarette companies jointly spent some £100m advertising and promoting their wares. Generally, however, adult smoking is on the decline in Britain. And we all know what can be achieved with a sling and a few pebbles.

(The Sunday Times)

crutch [krʌtʃ]: Krücke
the catch: here: hidden problem
to live on the breadline: to be very poor

to indulge oneself [ɪn'dʌldz]: to allow oneself to do something one enjoys

blackmail: Erpressung
wares [weɪz]: articles for sale

Find the facts:
What do statistics tell us about women smokers?
Why is there more stress for a fifteen-year-old girl?
What is meant by "This double standard in magazines"?
Fags work. How?
Why do women go on smoking although they know that it is bad for their health? Find the reasons which are given in the text.
Campaigns warning women to stop smoking have used "emotional blackmail". What is meant by that?
Why is Goliath mentioned?

Give your opinion
Do you agree that there is more stress for a 15/16-year-old girl than for a boy of the same age?
Do you think that more teenage girls take up smoking than boys?
Why do you think young people start to smoke?
Do you think ads influence them?

Grammar note
There is likely to be more stress for a 15-year-old girl.
She is more likely to work harder.
She is less likely to have been influenced by anti-smoking campaigns.
German translation: wahrscheinlich
Similar items:
She used to smoke two packets a day.
German translation: früher einmal
He happened to look at that ad.
German translation: zufällig

US figures on smoking 1987

Year	Men	Women
1987	34%	29%
1965	52%	34%

6 A simulation

The radio programme "Heads On" has invited several people for a discussion on smoking.

They are: Sandy RUSSEL, chairwoman of the discussion (25)

Jim SWEENEY, representing the advertising industry (40)

Alan THORPE, vice-president of SMOFIB (Smokers Fight Back) (40)

Sharon LOCKE, secretary of CAWAS (Campaign for Women Against Smoking), (28)

Steve RUDD, student, non-smoker (16)

Cathy TRENT, student, heavy smoker (16)

Study the role-cards below, assign roles and do the role-play.



SANDY RUSSEL

As the chairwoman of the discussion you start the programme by saying what it is about and introducing your guests. You have to intervene when the discussion gets stuck or too heated. Occasionally you sum up the main ideas that have come up.

You are a smoker yourself ("not more than ten to fifteen") but you are thinking about giving it up altogether.

JIM SWEENEY

You are the public relations officer for an advertising agency that handles a lot of tobacco advertising. You think that tobacco is like any other product on the market and that advertising is perfectly OK "in a free country". Countries with restricted advertising do not have fewer smokers, you say, and there is a health warning on packets and in ads, especially those that aim at women smokers. Incidentally, you are a non-smoker.

ALAN THORPE

Your line of argument is that smokers are often friendly, relaxed and talkative people. (This is because they smoke – which makes them less nervous.) It was necessary to found SMOFIB because of the increasingly unpleasant consequences of anti-smoking campaigns: attacks on smokers in restaurants, inflammable liquids in ashtrays etc. You fear a new puritanism, a dictatorship by dull health freaks who can't enjoy the good things in life. Campaigns against smokers are a threat to personal freedom.

You smoke 5–7 pipes a day and the occasional cigarette or cigar.

SHARON LOCKE

You explain all about CAWAS and its aims. You are against tobacco advertising, against smoking in public places, against an industry that presents women who smoke as chic, cool and successful. You point out the dangers of smoking when pregnant – even if it's only passive smoking. You think it's in the interest of women to quit smoking and to find other ways of coping with increasing stress. You also argue that smokers cost the state millions of pounds a year and that they should be made to pay the bill for all this.

inflammable liquids: liquids that catch fire and burn easily

STEVE RUDD

You are a non-smoker but like everybody else you've tried smoking. It gave you little pleasure though. You feel accepted by your friends even though you are a non-smoker and many of them do not smoke anyway. You think smokers are insecure, want to impress others, start because of peer pressure. You are surprised that so many young people have got the money. You are strictly against smoking in or in front of schools (you think even teachers shouldn't smoke there), you would not have a girlfriend who smoked. Moreover, you fear that (passive) smoking causes all sorts of illnesses and as somebody who likes sports you are very much against smoking anyway.

peer pressure: *Gruppendruck*

CATHY TRENT

You are a heavy smoker and you see yourself as a "dedicated and passionate" smoker. Unlike so many others you do not want to give it up. It helps you to cope with stress situations and problems. It makes you feel good, it is a way of communicating with people. You think that non-smokers often come down with psychosomatic illnesses because often they are awfully tense people who can't cope with stress. You believe that smoking will only harm you if you smoke and have a bad conscience about it.

In your opinion smokers are "the nicer people" because they don't show any signs of "battlemania".

psychosomatic: concerning the relationship between the mind and the body in illness

- 7 a Write a summary of the article in 4.
- b Schools should (not) allow their students to smoke during breaks.
Use this sentence as the beginning of a paragraph in which you develop the topic.
- c Silent dialogue. A complains that so many people want to persuade him to give up smoking, B is a non-smoker herself/himself. A writes the sentence below. B writes an answer and passes the paper back to A. A reads the answer and writes his answer in turn; etc. . . .

A: Why do other people worry about my health? They are getting on my nerves.

B: . . .

- 8 Use your dictionary and translate the following labels on cigarette packets.

Warning: The Surgeon General Has Determined That Cigarette Smoking is Dangerous to Your Health.

SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.

SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, And May Complicate Pregnancy.

SURGEON GENERAL'S WARNING: Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, And Low Birth Weight.

Surgeon General ['sɜːdʒən 'dʒenrəl]: der im Rang höchste Arzt im amerikanischen Gesundheitswesen
emphysema [emfɪ'si:mə]: Aufblähung von Organen oder Körperteilen

Extract 39. MYWA 6 (2005), page 12

Teenagers and smoking – the facts!

The figures

- By the age of eleven ___ % of children have experimented with smoking. By the age of 16 this figures has risen to ___ %.
- In Britain, about ___ children start smoking every day.
- ___ % of 11- to 16-year-olds smoke regularly
- Girls are more likely to be regular smokers than boys.

Why do they do it?

- Children are ___ times more likely to smoke if both of their parents smoke.
- Most young smokers are influenced by their friends and older brothers and sisters.
- Surveys show that children tend to smoke the brands that are most advertised.

What's the damage?

- Children who smoke are two to six times more susceptible to coughs and shortness of breath than those who do not smoke.
- Children who smoke are ___ times more likely to have time off school.



- ___ % of regular smokers aged between 11 and 15 say that they would find it difficult to go without smoking for a week.
- ___ % thought they would find it difficult to give up altogether.

But isn't it illegal?

- It has been illegal to sell any tobacco product to anyone below the age of 16 since ___.
- Most teenage smokers buy their cigarettes from shops or newsagents.
- It is estimated that the UK tobacco industry makes an annual profit of £_____ from teenage smokers.

Extract 40. MYWA 6 (2005), page 12

- 4 Work in groups of four. You work for a government health agency. Design a campaign to help fight the problem of teenage smoking. Use your own ideas and the information in 3, and the questions below to help you.
- 1 Who are the targets of your campaign? (Not just the teenagers)
 - 2 What message do you have for each of your targets?
 - 3 How are you going to get your message across to each group?
- Now present your ideas to the rest of the class.

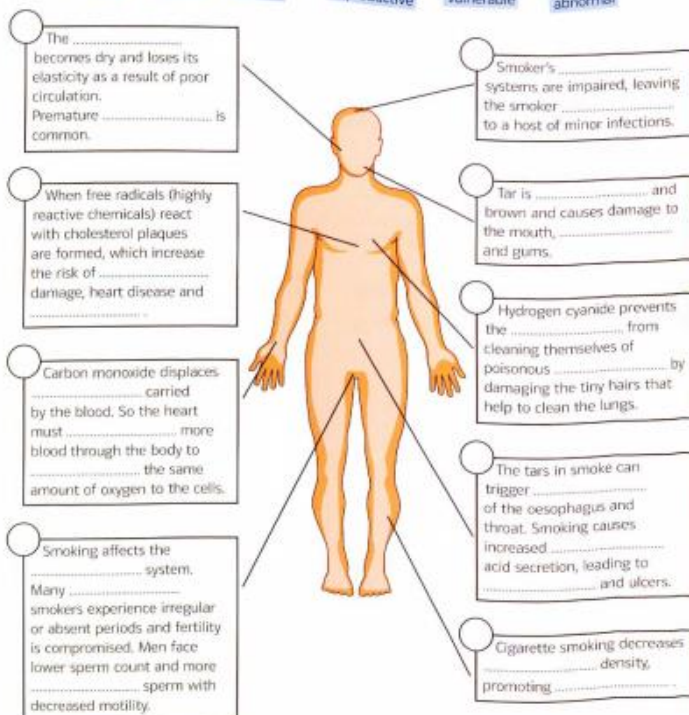
Extract 41. PT 7 (2011), page 28

1 How smoking harms our bodies

The harmful substances contained in smoke affect our bodies in many ways.

a) Complete the descriptions with suitable words.

cancer osteoporosis stroke chemicals teeth immune heartburn lungs
skin stomach female transfer sticky wrinkling pump
bone arterial oxygen reproductive vulnerable abnormal



b) Prepare a short speech for 14-year-olds highlighting the harmful effects of smoking. As you cannot use all the information, select three aspects and present them in a graphic way by adding examples young people can relate to.

Extract 42. PT 7 (2011), page 27

3 Speaking: No smoking

A friend of yours and you have decided to organise a big birthday party to celebrate both your birthdays. In the course of planning the party you are now discussing the question whether or not smoking should be allowed. With a partner, choose one of the role cards each, prepare the conversation and act it out.

Role card A: Smoking allowed

You suggest to have the party at your house. It's a cool location and your parents don't mind if guests smoke there. Try to persuade your partner by giving convincing arguments on the following points:

- atmosphere
- friends who smoke
- health issues

Role card B: Smoking not allowed

You suggest to have the party at your house. It's a cool location, but you and your parents are strict non-smokers. Try to persuade your partner by giving convincing arguments on the following points:

- atmosphere
- friends who don't smoke
- health issues

Extract 43. PT 7 (2011), page 29

5 Writing: Smoking ban in restaurants

You have come across an article about Mr Jusufi's private club in the newspaper (see page 28). You have a strong opinion about his idea and decide to write a **letter to the editor**. Depending on whether you adopt a smoker's or a non-smoker's point of view, you either complain about or welcome his courage to break the law. In your letter, you should:

- describe the atmosphere in smoking and non-smoking restaurants
- discuss the costs caused by smoking
- identify health problems related to smoking

Write about **250 words**.

Ad Eating & Body Dysmorphic Disorders

Extract 44. PT 6 (2011), pages 128, 129, 134, 137



p.134

p.134

p.128

p.137



p.129

p.129

5 Discussion: Plastic surgery

a) Study the fact file and make sure you know what these terms mean.

b) Use the information to discuss the following aspects of plastic surgery:

- Comment on the figures and their development as shown in the fact file.
- Is there a difference for you between reconstructive and cosmetic plastic surgery?
- Would you consider resorting to plastic surgery? If yes, under which circumstances?

FACT FILE

- Since 1997, there has been a 447% increase in the total number of cosmetic procedures in the U.S. Surgical procedures increased by 74%, and nonsurgical procedures increased tenfold.
- Men had nearly 800,000 cosmetic procedures, 9% of the total.
- The top five nonsurgical cosmetic procedures in 2011 were: Botox injection, hyaluronic acid, laser hair removal, microdermabrasion and laser skin resurfacing.
- The top five surgical cosmetic procedures in 2011 were: liposuction, breast augmentation, abdominoplasty, eyelid surgery and breast lift.

(Figures based on ASAPS 2011 Statistics on Cosmetic Surgery)

Extract 45. EIC 5 (2013), page 4

Look at the image of Arnold Schwarzenegger when he was still just a young bodybuilder from Thal. Is this an ideal that many boys and young men aspire to nowadays? Why (not)?

4 Writing: formal email

You have just seen a TV interview with your favourite American actor or musician. You expected to see a proper interview but in fact it was little more than an advertisement for his/her new diet book and diet drinks which promise to help teenagers to 'lose weight fast'. You are disappointed and angry.

Write a polite email of complaint to the person's fan website. Mention the following information:

- why you are a fan of this person
- what you saw and when
- the problem of eating disorders among teenagers
- the importance of healthy eating and exercise
- how you think the person should behave on TV in future

Write about 150 words.

SP

39 Writing a Formal Letter or Email
(p. 56)

b) Work together with a partner. Imagine that one of you works for a phone helpline where teenagers can discuss what they are worried about. The other one calls the helpline because they are worried that a friend of theirs is suffering from an eating disorder. In your discussion, cover the following points:

- the difference between a diet and a healthy diet
- symptoms of an eating disorder
- the role of the media
- what the caller should do to help their friend

WORD BANK

Eating disorders

abnormal • anorexia nervosa •
binge eating • bulimia nervosa •
cause • eating habits • excessive •
food intake • idealised body types •
influence • insufficient • peer
pressure • psychological issues •
self-help • social situation • therapy
group • to affect • treatment centre

Check-out

NOW YOU CAN

- Discuss healthy choices in your nutrition.
- Talk about your eating habits.
- Explain health risks associated with smoking.
- Speak about people with special needs.
- Complain about discriminating behaviour.
- Form words with suffixes.

1 Writing: Healthy food

As the Agony Aunt/Uncle of a teen magazine you have received a letter from Mike who has problems with his physical appearance. You respond with an **e-mail**. In your e-mail, you should:

- comment on his situation
- help building up some self-confidence
- make suggestions for a healthier lifestyle

Write about **250 words**.

Re: Healthy food

Reply Reply to All Forward

I've been really unhappy recently. I'm 14, rather short and fat, and was bullied quite harshly in primary school. I started making some friends in my first years at high school but my "friends" are gradually drifting away from me. There's a group of nine of us including me but over the last few months we see each other in school but don't interact much even when I try my hardest. All these issues around me make me overeat even more and it just becomes a vicious cycle. I've thought about making some new friends but no one at all around school wants anything to do with me. I just sit on my computer playing games these days because my only actual friends are the ones that I chat to online in gaming forums. I just needed to get all that off my chest and get some guidance for the future. Please help me.

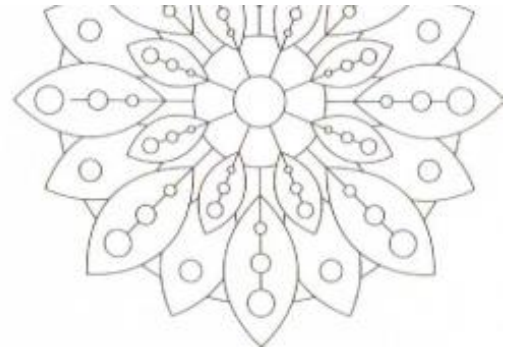
Can write letters [...] highlighting the personal significance of events and experiences and commenting on the correspondent's [...] views. (B2)

Ad Mental Health Disorders

Extract 49. W2G 8 (2020), page 11-12

WRITING 12

You are a student at an international school. Your school wants to hold a 'Mental Health Day'. Write an email to parents explaining why you think this is a good idea. Include some tips for parents on how they can help their children improve their mental well-being. Write around 250 words. Make sure you include some of the expressions from the previous pages.



SPEAKING 13

Get together in small groups. Plan a 'Mental Health Day' for your class and write a programme describing the different events and workshops your class could give. Here are some things you could offer:

- visualisation techniques
- positive thinking classes
- breathing exercises
- your own ideas

Present your programme to the others.



Extract 50. W2G 8 (2020), page 11

SPEAKING 10

Sometimes even young people need professional help for their mental health. Both Austria and the UK have a tax-funded healthcare system intended to look after the medical needs of people of all ages. Talk about the following questions in pairs, then share your ideas in class.

- 1 Should mental health problems also be covered by the public healthcare system? Why?/Why not?
- 2 Do you think young people have more or fewer mental health problems today than in the past? What might be the reasons for that?
- 3 Why do you think do mental health issues still have a social stigma attached to them?

READING 14

Read the text about mental healthcare for young people in the UK, then choose the correct answer (A, B, C or D) for questions 1–7. Put a cross (x) in the correct box. The first one (0) has been done for you.

Four in 10 GPs suggest seeking private care for mentally ill children

In a survey, 43% of UK family doctors said they told parents whose children were struggling with anxiety, depression, self-harm or eating disorders to seek treatment privately if they could afford it because NHS² care is heavily limited and involves delays of up to 18 months. The fact that so many families are being directed to private treatment highlights the inability of NHS child and adolescent mental health services (CAMHS) to cope with the growing demand for care from under-18s who have mental ill health.

Many GPs who took part in the research, undertaken by the mental health charity Stem4, criticised CAMHS for not being available to see children and young people they referred for care. Some described CAMHS as “dire”, “non-existent” and “totally inadequate”. According to one GP, “Seeing a psychiatrist is more difficult than seeing the Pope.”

Dr Nihara Krause, a consultant clinical psychologist and founder of Stem4, said: “Parents want support for their children and young people as soon as possible and so will often stretch themselves financially to pay for treatment. Parental anxiety about the mental health needs of young people is high and recent statistics on, for example, suicide being the primary cause of death in young people adds very real fear.

“Parents whose child has cancer or a serious physical health condition would never have to pay for private care, so why should it be OK for those whose children have mental health problems to be told to do that? This again shows that equality between physical and mental health services is still a far-off goal.”



GPs’ advice to go private has prompted concern that it results in a two-tier system in which children from poorer families are denied any care and leaves parents who can pay the fees involved confused as to which private mental health professional is best placed to help. “These findings are a cause for serious concern. Timely access to mental health support is essential. Asking parents to pay for their children to get help will make inequalities that are already very stark even worse,” said Andy Bell, the deputy chief executive of the Centre for Mental Health think tank.

Krause said: “From a GP’s perspective it makes sense that they are offering parents something to help with a potential problem. However, it concerns me that so many parents of children and young people are being advised to pay for private care. Some parents are concerned about making the right choice of private specialist since it is confusing to check who is suitably qualified. At the same time, some are also frustrated with the long wait, potential rejection and the level of care they receive from CAMHS.”

The private sector cannot always provide the specialist assessment and care that under-18s with complex mental health conditions need, she added.

Four in five (83%) GPs say there has been a rise in the number of young people seeking help because of anxiety while 79% have seen more coming with depression, 64% with self-harm and 35% with eating disorders. Experts believe the increase in mental ill health in under-18s is linked to exam stress,

bullying on social media, poverty, pressure to look good and be popular, and dysfunctional backgrounds.

An NHS England spokesperson pointed out: “Actually, record numbers of children and young people are being treated for mental health conditions, waiting times are improving significantly and the NHS is ahead of its target to treat 70,000 more children every year, as part of the NHS long-term plan.”

Ad Terminal Illness

Extract 52. ETWO 2 (1985), page 103

DEVONSHIRE STREET W. 1

The heavy mahogany door with its wrought iron screen
Shuts. And the sound is rich, sympathetic, discreet.
The sun still shines on the 18th century scene
With Edwardian faience adornments—Devonshire Street.

No hope. And the X-ray photographs under his arm
Confirm the message. His wife stands timidly by.
The opposite brick-built house looks lofty and calm,
Its chimneys steady against a mackerel sky.

No hope. And the iron knob of this palisade,
So cold in the touch, is luckier now than he.
“Oh merciless, hurrying Londoners! Why was I made
For the long and the painful deathbed coming to me?”

She puts her fingers in his as, loving and silly,
At long-past Kensington dances she used to do.
“It’s cheaper to take the tube to Piccadilly,
And then we catch a nineteen or a twenty-two.”

John Betjeman

Extract 53. GB 1 (1985), page 68

Doctors and hospitals

When you travel to England, one thing that you do not have to worry about is being ill, because the National Health Service is able to look after you quickly, efficiently and, most important, — *free of charge*.

Of course it is not often that visitors are so ill that they have to be taken to hospital to be examined by a specialist. This only happens if the doctor thinks it is necessary. Usually, if you are ill, you can see the doctor at his *surgery*. The doctor will tell you to *strip to the waist*, after which he examines you by testing your heart and chest with a stethoscope, sometimes takes your blood pressure and makes a diagnosis. He then prescribes a medicine or a *treatment*. Many patients are not actually ill, they are suffering from colds, influenza or minor complaints.

Perhaps if you really have something more serious, the doctor will visit you at home. However, unless you are very ill or unless you have a broken bone, you need not go to hospital. Hospitals in Britain are neither frightening nor upsetting though.

If you have to stay in hospital, a nurse will look after you. You can even have breakfast in bed, that is to say, after the nurse has weighed you, taken your temperature and given you your medicine. It is only if an operation or an X-ray is needed that you probably will not be given breakfast before being brought into the operating theatre or to the X-ray department.

Even if an ambulance takes you to hospital, you needn't worry, usually only serious illnesses need operations. The doctors and nurses will try to help you and you can have visitors during visiting hours who will tell you all the news or will walk around with you. You can also talk to other patients in your *ward* or in one of the others, unless you are unlucky and find yourself in a children's ward.

The in-patients in the wards will be suffering from diseases. There are people who have had their *appendices* removed, others with *diabetes*, who have to be given injections of insulin, or some who have had heart attacks.

Medical science has progressed rapidly. *Plastic surgery* or organ transplantation is nothing extraordinary any more. But nevertheless doctors still have a lot to learn, especially about such things as *cancer*, which even after years of *research work* is still one of the biggest *scourges* of mankind.

But it is unlikely that you have to go into an English hospital for one of these more or less serious diseases. Normally the worst that can happen to you is that you have to be examined by a doctor and to go to the chemist afterwards to buy medicine like tablets, pills or *fluid mixture*, depending on the doctor's prescription.

Extract 54. EiC 7 & 8 (2018), page 211

1 Analysing a diagram

a First, match the terms (1–10) on the left with the definitions (A–J) on the right.

1 gene	A part of a living cell that contains genes
2 genome	B organic chemical in which genetic information is encoded
3 chromosome	C technique for making genetically identical copies of an organism
4 uterus	D done outside the body, i.e. in a laboratory
5 in vitro	E the smallest unit of hereditary information
6 cloning	F the complete set of genes belonging to an organism
7 DNA	G cell that is capable of developing into one of several types
8 nucleus	H organ in a woman's body in which an embryo develops
9 genetic engineering	I thread-like structure that carries genes
10 stem cell	J technique of artificially manipulating the genetic structure of an organism

hereditary given to a child by its parents before it is born



Language Help

- after removal from ...
- through artificial insemination in vitro
- under the microscope
- embryos free of genetic defects
- the selected embryo

- b Use the diagram to explain PGD to a partner. Discuss any points that are unclear to you.
- c **EXTRA** Write a paragraph explaining how PGD can be used to prevent children being born with specific genetic defects.

SP 37 Writing a Paragraph (p. 54)

Extract 55. EiC 7&8 (2018), page 214

6 Group discussion

Work in groups of four. Each choose one of the following roles and discuss Anna's decision not to allow her kidney to be used to save her sister Kate.

Partner A	Partner B	Partner C	Partner D
You are one of Anna and Kate's parents. You love both your children equally but you can't understand why Anna does not want to help her sister. You want to keep the decision in the family and don't want outsiders to interfere.	You are the lawyer that Anna has hired. Even though she is a minor, she has the right to decide what she wants or doesn't want to do with her body. You won't allow her parents to make her do anything against her will.	You are Kate's doctor. You know that she needs the kidney transplant urgently, otherwise she won't survive. The transplant is a routine operation today and donors can survive easily with one kidney.	You are a child psychologist familiar with the case. You are concerned about the effect the choice is having on Anna. She thinks that she was only conceived for the purpose of providing spare parts for Kate.

7 EXTRA Discussing ethical issues

In the video in Part A, exercise 2, Dr. Offit mentions the possibility that PGD could be used to eliminate embryos with other unwanted hereditary characteristics, such as obesity. Alternatively, it could be used to select embryos with desirable traits, e.g. 'saviour siblings' chosen to donate bone marrow to an older brother or sister, or 'designer babies' created to their parents' wishes. Discuss the moral issues surrounding these measures in class.

2 Read through the following text from the *American Journal of Nursing*. Then answer the questions below.

I am a student nurse. I am dying. I write this to you who are, and will become, nurses in the hope that by sharing my feelings, you may someday be better able to help those who share my experience.

I'm out of the hospital now – perhaps for a month, for six months, perhaps for a year – but no one likes to talk about such things. In fact, no one likes to talk about much at all. Nursing must be advancing, but I wish it would hurry. We're taught not to be overly cheery now, to omit the 'Everything's fine' routine, and we have done pretty well. But now one is left in a lonely silent void. With the protective 'fine, fine' gone, the staff is left with only their vulnerability and fear. The dying patient is not yet seen as a person and thus

void: emptiness

cannot be communicated with as such. He is a symbol of what every human fears and what we each know, at least academically, that we too must someday face.

But for me, fear is today and dying is now. You slip in and out of my room, give me medications and check my blood pressure. Is it because I am a student nurse, myself, or just a human being, that I sense your fright? And your fears enhance mine. Why are you afraid? I am the one who is dying!

I know you feel insecure, don't know what to say, don't know what to do. But please believe me, if you care, you can't go wrong. Just admit that you care. That is really what we search for. We may ask for why's and wherefore's, but we don't really expect answers.

Don't run away – wait – all I want to know is that there will be someone to hold my hand when I need it. I am afraid. Death may get to be a routine to you, but it is new to me. You may not see me as unique, but I've never died before. To me, once is pretty unique!

You whisper about my youth, but when one is dying, is one really so young any more? I have lots I wish we could talk about. It really would not take much more of your time because you are in here quite a bit anyway.

If only we could be honest, both admit of our fears, touch one another. If you really care, would you lose so much of your valuable professionalism if you even cried with me? Just person to person? Then, it might not be so hard to die – in a hospital – with friends close by.

2 When a famous person dies it is usual for newspapers to print an obituary – that is, a text in tribute to their life.

Read the obituary for Elisabeth Kübler-Ross and choose the correct option to complete the sentences.

- 1 Elisabeth first became concerned for the dying
 - a when she became involved in the Second World War.
 - b through visits to a concentration camp.
 - c when her mother died.
- 2 She used the symbol of the butterfly for death
 - a in tribute to those who had died in the concentration camps.
 - b because the butterfly is a symbol of peace.
 - c because she saw it as a symbol of change.
- 3 Her early lectures were based on
 - a her war experiences.
 - b the differences she found between the US and Switzerland.
 - c her experience of working in several American hospitals.
- 4 She felt that many of her colleagues
 - a weren't really interested in the feelings of terminal patients.
 - b had more important things to do than care for the dying.
 - c didn't really know much about the dying process.
- 5 Her book "On Death and Dying"
 - a is not as well respected today as it was.
 - b brought her the recognition of the medical world.
 - c was written in 1969.
- 6 Her "five psychological stages of dying"
 - a were dismissed by many doctors at the time.
 - b were first introduced to the world in a speech during the 1970s.
 - c are accepted throughout the modern medical world.
- 7 When she retired, she
 - a bought a farm.
 - b met several famous people.
 - c still continued to give speeches.



Elisabeth Kübler-Ross in front of her house in Scottsdale, Arizona (1998)

Dr Elisabeth Kübler-Ross, perhaps the world's leading expert on death and dying, has herself died at the age of 78.

The Swiss doctor, who devoted her life to the terminally ill, died on August 24th 2004 in Scottsdale, Arizona. She was surrounded by family and close friends.

Born in Zurich, Switzerland, in 1926, Elisabeth was one of triplet sisters. Her interest in death was a result of the time she spent in the International Voluntary Service for Peace, an organisation which helped communities suffering from the devastation of the Second World War. In Maidanek, a concentration camp, she found pictures of butterflies sketched onto the walls – a symbol that she would use for the beautiful transformation that she believed took place at the time of death.

She graduated in medicine from the University of Zurich, where she also met her husband-to-be, Emanuel "Manny" Robert Ross and in 1958 she went to America to work in hospitals in New York, Colorado and Chicago. She was particularly concerned by the way dying patients were treated – ignored, as if no-one wanted to get involved. She made a point of sitting with them and listening to what they wanted to talk about. She began giving lectures based on her experiences and featuring terminally ill patients who talked about their dying experiences.

"My goal was to break through the layer of professional denial that prohibited patients

from airing their innermost concerns," she wrote.

She gained international fame with her classic book "On Death and Dying" published in 1969 – a book that is still standard reading on most nursing and psychological courses.

Her influence continued to grow throughout the seventies as she continued to give speeches and work in hospitals. The "five psychological stages of dying" (denial, anger, bargaining, depression and finally acceptance) introduced in her book soon became accepted as common knowledge throughout the world.

She was also interested in mysticism, the after-life, and other less commonly accepted forms of therapy, and in 1980 she bought a 300 acre farm in Virginia which she called "Healing Waters" and used as a healing workshop centre.

She was never scared of controversy and was one of the first to turn her attention to babies suffering from AIDS when most other people weren't interested.

She retired in 1995 after a series of strokes left her debilitated. However, even in retirement she continued to receive visitors from all over the world. Among the celebrities who dropped in were Mohammed Ali, Susan Sarandon and Lady Sarah Ferguson. In 1999 she was named as one of Time magazine's 100 greatest scientists and thinkers of the century.

(based on information from
<http://www.elisabethkublerross.com/index.html>)

3 Read through these quotations from Elisabeth Kübler-Ross.

Choose the two that you like best and rewrite them in your own words. Work in small groups. Explain which quotes you have chosen and why.

"The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity and an understanding of life that fills them with compassions, gentleness, and a deep loving concern. Beautiful people do not just happen."

"We run after values that, at death, become zero. At the end of your life, nobody asks you how many degrees you have, or how many mansions you built, or how many Rolls Royces you could afford. That's what dying patients teach you."

"Dying is nothing to fear. It can be the most wonderful experience of your life. It all depends on how you have lived."

"There is no joy without hardship. If not for death, would we appreciate life? If not for hate, would we know the ultimate goal is love? ... At these moments you can either hold on to negativity and look for blame, or you can choose to heal and keep on loving."

"We make progress in society only if we stop cursing and complaining about its shortcomings and have the courage to do something about them."

"It's only when we truly know and understand that we have a limited time on earth and that we have no way of knowing when our time is up, we will then begin to live each day to the fullest, as if it was the only one we had."

"Guilt is perhaps the most painful companion of death."

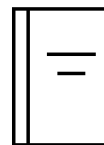
"We need to teach the next generation of children from day one that they are responsible for their lives. Mankind's greatest gift, also its greatest curse, is that we have free choice. We can make our choices built from love or from fear."

"There is no need to go to India or anywhere else to find peace. You will find that deep place of silence right in your room, your garden or even your bathtub."

(From: <http://www.elisabethkublerross.com/pages/contact.html>)

Appendix C. Created ELT Materials

Unit description – Taboo Issues: Down Syndrome, Stigmatisation and Advocacy



- **Key words**

Down Syndrome, stigmatisation, critical health literacy, social advocacy skills, person-first language, identity- first language, debunking myths, human rights, social justice

- **Topic relevance**

Though much focus is open put on developing functional health literacy in ELT, the critical, stigma-sensitive variant should also be emphasized more, especially with regards to taking action on social justice issues through health advocacy. This draws on students' previously existing interrelated (health) literacies and helps them to use their knowledge for greater social purposes, while also critically identifying situations of stigmatisation. The unit tackles such a perspective, linking the concepts of social determinants of health and stigmatisation-awareness with cases of discrimination of Down Syndrome, a group that is commonly marginalised and stigmatised.

- **Target group**

intermediate/advanced learners of English in Austria (B1-B2)

- **Setting**

mid-end upper secondary school (or at another level, depending on students' language proficiency and the language learning context)

- **Topic context**

to be placed into a newly developed coursebook (or used in a workshop/ project)

- **Estimated duration**

1-2 weeks (depending on number of classes available)

- **Skill focus**

developing practical social advocacy skills (e.g., action letter, campaign planning), identifying cases of social injustice & discrimination, distinguishing processes of linguistic (non-)stigmatisation

Aims & Objectives

- Students can categorize concepts related to (de-)stigmatisation of disability.
- Students can summarize textual information and link it with processes of stigmatisation and related topics.
- Students can critically form and justify their opinion about a given text about a taboo topic.
- Students can identify adequate informational sources within their chosen field of research and practically implement them in their chosen social (health) advocacy projects.

CEFR descriptors

Writing

Can synthesise information and arguments from a number of sources. (CEFR B2: Reports and essays, p. 62)

Listening / Audio-visual reception

Can understand standard spoken language, live or broadcast, on both familiar and unfamiliar topics normally encountered in personal, social, academic or vocational life. (CEFR B2: Overall listening comprehension, p. 66)

Can follow extended speech and complex lines of argument provided the topic is reasonably familiar, and the direction of the talk is sign-posted by explicit markers. (CEFR B2: Overall listening comprehension, p. 66)

Reading

Can recognise the line of argument in the treatment of the issue presented, though not necessarily in detail. (CEFR B1: Reading for information and argument, p.70)

Can read with a large degree of independence, adapting style and speed of reading to different texts and purposes, and using appropriate reference sources selectively. (CEFR B2: Overall reading comprehension, p. 69)

Can understand articles and reports concerned with contemporary problems in which the writers adopt particular stances or viewpoints. (CEFR B2: Reading for information and argument, p. 70)

Speaking

Can exchange, check and confirm information, deal with less routine situations and explain why something is a problem. (CEFR B1: Overall spoken interaction, p. 74)

Can make his/her opinions and reactions understood as regards possible solutions or the question of what to do next, giving brief reasons and explanations. (CEFR B1: Goal-oriented co-operation, p. 79)

Can account for and sustain his/her opinions in discussion by providing relevant explanations, arguments and comments. (CEFR B2: Informal discussion, p. 77)

Taboo Issues: Down Syndrome, Stigmatisation and Advocacy



In this unit you will ...

- learn about Down Syndrome & disability allyship and related taboo issues
- consider cases of (disability) stigmatisation & social determinants of health
- try out practical advocacy skills related to critical health literacy (= 'kritische Gesundheitskompetenz') and become a changemaker for stigmatised groups

Why?

The disabilities community accounts for approximately 16% of the global population and is incredibly diverse with regards to socioeconomic status, gender and religion etc. Yet they are one of the largest groups worldwide to be discriminated against. This also includes Down Syndrome, which is still frequently stigmatised in many sectors of society. However, disability allies, including you, can work together with member of the community to advance processes of de-stigmatisation with the help of critical health literacy engagement.

Section 1: Stigmatisation & Down Syndrome

Task 1: Consider the concepts in the first word map with the question mark. What do they mean and how are they related? What are the 3 cognitive, affective, and behavioural dimensions of stigma? Discuss your ideas with your neighbour.

Task 2: Now try to organize the words from the second word map about Down Syndrome into two categories, namely stigma-sensitive and stigmatising language and enter them into the table below. Have you yourself used such language before? Have you consciously thought about it in English/German or another language?



stigmatising language	non-stigmatising language *	
=	=	
	person-first language	identity-first language

--	--

*note: Though both person- and identity first language do not intend to perpetuate stigma, it is important to note that their usage often is context-dependent, e.g., different people from the disabilities community may have various preferences. Thus, ideally one needs to check in with the person, which language use is adequate for them.

Task 3: Down Syndrome Myths

Over time various myths about Down Syndrome were created, and some of them have persisted despite increasing medical knowledge on the condition. The Global Down Syndrome Foundation has created a list of some of the most common myths, which have contributed to stigmatisation of Down Syndrome. Have you heard of them before? After reading them, do some research and explain why they are myths.

People who have Down Syndrome ...

myth	reality
#1 ... cannot walk or play sport.	
#2 ... die young.	
#3 ... are always happy.	
#4 ... have no memory.	
#5 ... feel no pain.	
#6 ... cannot go to regular public schools.	
#7 ... are only born to older mothers over 35.	
#8 ... are a result of incest.	
#9 ... negatively impact their siblings.	
#10 ... cannot live independently or get jobs.	

Source: <https://www.globaldownsyndrome.org/about-down-syndrome/misconceptions-vs-reality/>

These myths also may also show themselves in stigmatisation on an institutional level, limiting access to education, health care and employment. This is closely related to the “social determinants of health”, a concept will help you to in your development of critical health literacy.

Section 2: Critical Health Literacy and Social Determinants of Health

What is critical health literacy?

It is the third and most complex part of 'health literacy', which encompasses also functional and interactive components. Critical health literacy builds on the other two types and can generally be defined as *"the ability to reflect upon health determining factors and processes and to apply the results of the reflection into individual or collective actions for health in any given context"* (Abel, Benkert 2022: 1). It is closely related to the social determinants of health.

Task 1: Do some research on definitions of both concepts and try to describe them in your own words.

Task 2: Here is a brief video that further explain social determinants of health (as seen from a US-American perspective). Watch it and compare it with your thoughts on the topic from the previous task.

<https://www.youtube.com/watch?v=17jeXGbKITQ> ("Social Determinants of Health" by PsychHub (Oct. 5th, 2020))

Task 3: Now watch the video on affordable housing for disabled people in the USA and social determinants of health. How could this be related to (discrimination against) people with Down Syndrome? Take notes.

Also think about Kimberly Munro's life. Which questions would you like to ask her? How would she react to your questions? Create three questions for her, think about how the conversation could go and discuss your thoughts with your partner.

Think about it briefly and discuss it with your neighbour. Also think of 3 questions you would like to ask her.

<https://www.youtube.com/watch?v=rInMonUdiZs> ("Social Determinants of Health- Affordable Housing- Disability Assistance" by Samaritas (May 31st, 2017))

Section 3: Disability Advocacy & Allyship

The following text is concerned with a recent case of Down Syndrome discrimination and government media censorship in France. However, in order to protect diversity and fundamental human rights, legal action was taken by Alliance Defending Freedom International (ADF), a global human rights legal organisation. This fight against social injustice shows an interesting perspective of disability advocacy and allyship, which may inspire all of us to contribute to change.

Task 1: Before you read the text, watch the video, which was censored from state television, and note down your thoughts about potential reasons for censoring it:

<https://www.youtube.com/watch?v=Ju-q4OnBtNU&t=1s> ("Dear Future Mom"- March 21- World Down Syndrome Day (Mar 13th, 2014 by CoorDown)

Task 2: Read the text and answer the questions on the next page.

***Text 1: WORLD DOWN SYNDROME DAY - France Taken To Europe's Top Court
After Censoring People With Down Syndrome***

Disability rights organisation faced discrimination after video speaking about life with Down Syndrome was censored on state television channel

Case could set a precedent for protecting freedom of expression, and against the stigmatization of persons with Down Syndrome across Europe

STRASBOURG (18 March 2022) – The French government is facing legal action at the European Court of Human Rights after censoring of eighteen people with Down Syndrome.

The group had created a short infomercial about the joys and challenges of life with their condition, in order to tackle societal stigma. Fondation Jérôme Lejeune, the organisation which has, for years, set the standard in research and care for people with Down Syndrome, supported the initiative and broadcast the message on several platforms in France. Yet, after a French public authority deemed the video to not be a “message of general interest”, the foundation were prevented from sharing their message on state television.

“ADF International is proud to support Fondation Jérôme Lejeune in calling out discrimination against people with Down Syndrome. Freedom of speech is the foundation of a democratic society, protected by international human rights law. Why censor somebody for speaking out about their life with a disability? We hope that the court will recognise that these voices are of immensely high value and make a stand for the rights of persons with disabilities across Europe,” said Jean-Paul Van De Walle, legal counsel for ADF International, who are representing the disability group before the court.

Sharing about life with Down Syndrome “not a message of general interest”, says French government

The video, titled “Dear Future Mum”, begins by quoting an email from a pregnant mother, seeking advice. Her message read, “I’m expecting a baby. I’ve discovered he’ll have Down Syndrome. I’m scared: what kind of life will my child have?”. In response, people with Down Syndrome share their stories, their joys and their challenges to reassure the worried mother that life with Down Syndrome can be fulfilling and enriching.

“No matter who the child is, their mother can be happy! I urge everyone to accept people like me because we are no different from you,” said Robin Sevette, Actor with Down Syndrome, featured in the infomercial ‘Dear Future Mum’.

For some time, Fondation Jérôme Lejeune shared this encouraging footage across various French media platforms as a “message of general interest”.

That was until the French government issued an opinion to say that it was not in fact such a message. It claimed the video would cause offense to women who had chosen to abort their children with disabilities. In France, 96 percent of pre-born children with a Down syndrome diagnosis are aborted.

Suddenly, the state television channel refused to broadcast the video anymore.

Advocates across Europe call for end to discrimination against Down Syndrome

In 2019, some 104 000 children were born with congenital disorders in the EU, representing 2.5% of all births in that year. Data from 2015 estimates the population of persons with Down Syndrome in Europe to be at 417,000. Yet, widespread discrimination and stigmatization remain.

Last week, the World Health Organisation was forced to apologise for incorrectly implying that Down Syndrome is a “birth defect” which is “preventable” through antenatal and newborn care. Parents of children with Down syndrome were particularly vocal in calling out the “ignorant” use of language which according to experts, can play a critical role in perpetuating stigma and discrimination. Down Syndrome is a genetic disorder, not a birth defect.

Meanwhile in the UK, a 26-year-old woman with Down Syndrome is taking legal action against the government for upholding a law which allows for children with the condition to be aborted up until birth; compared to the 24-week gestation limit for other children.

Source: <https://adfinternational.org/france-in-court/>

Task 3: Questions

1. Which form(s) of stigmatisation is/are taking place here? Find examples and justify them.
2. What could be the underlying cause of such stigmatisation and discrimination against people with Down Syndrome? (in any country)
3. What could a de-stigmatising (or stigma-sensitive) response by the French government have looked like? What can individuals with Down Syndrome, their friends, family, colleagues, and YOU do against such injustice/ censorship on the media? (Consider fundamental human rights.)
4. Can you think of other similar situations of stigmatisation against people with Down Syndrome (or other health-stigmatised groups)?
5. Critically discuss your personal opinion on the following statement (with regards to stigmatisation and birth- and abortion-rates mentioned in the text). Also, consider various standpoints (mother-to-be, father-to-be, medical staff, family, friends). In how far can they (dis-)agree with Robin?
“No matter who the child is, their mother can be happy! I urge everyone to accept people like me because we are no different from you,” said Robin Sevette, Actor with Down Syndrome, featured in the infomercial ‘Dear Future Mum’.
6. Briefly discuss the case of the 26-year-old woman with Down Syndrome, Heidi Carter, fighting against the UK government’s law which permits abortion of babies with Down Syndrome until birth. (As a member of the national Down Syndrome policy group, she gained media attention for her lawsuit in 2021 and also for her campaigning for the groundbreaking #DownSyndromeBill designed to provide better social care for people with Down Syndrome in 2022) (cf. [bbc.com](https://www.bbc.com)).
 - Is her behaviour justified (or not)? Should she get more support from her community, disability allies, friends, family? Would you personally support her effort?
 - Do you regard UK’s different possible abortion limits for babies with (=until birth) and without Down Syndrome (=24-week) as health-stigmatisation/ discrimination? Why (not)? (Also consider ethical implications different methods of abortion at this stage.)

Task 4: Research task

As the overall topic of pregnancy termination was recently widely discussed internationally since the Roe v. Wade abortion bill (which granted the right to this procedure in the US., was overturned on 25.6.2022 by the Supreme Court), it is necessary to consider the Austrian situation with regards to

‘eugenic indication’ (=grounds to allow pregnancy termination (up until birth) if severe disability of the child is suspected or diagnosed).

Do we have a similar situation regarding ‘eugenic indication’ as the UK (mentioned in the article)? What about numerical facts? Go online and fill out key facts down below, which will be your informational basis for the next writing task.

- abortion limits (with and without ‘eugenic indication’) (in weeks)
- legal considerations (both variants): (il)legal status?, doctors’ conscientious objection?
- estimated number of abortions (both variants)
- information on procedure (in case of eugenic indication)
- options parents have (i.e., alternatives, counselling, medical advice, government services, etc.)

Task 5: Writing task – Taking action

Write an email of response (similar to an “action letter”) to a French government representative or (directly to the EU parliament) regarding the case of the censored Down Syndrome video in France outlined in the article. In your email you should

- describe your reaction to the video and article
- discuss your opinion on the Down Syndrome censorship and the ongoing court case
- outline the Austrian situation on eugenic indication and Down Syndrome discrimination (and inclusion)
- suggest strategies to tackle the issue of discrimination, marginalization and stigmatisation of people with Down Syndrome and other chromosomal conditions in the EU

Write about 250 words (+/- 10%).

Additional information

If you are interested in more personalized and expert information with regards to this taboo topic in Austria, then consider watching the Austrian-produced documentary *Let Us Talk (Lass Uns Reden)* (2022). It contains various standpoints to discuss the issue from a neutral perspective and is an “invitation to engage in this discourse, break the silence on taboo subjects of our society and draw our own conclusions”. The producers also acknowledge that “[i]t takes a lot of courage to talk about such real issues of life, as there are an estimated 35,000 abortions per year in Austria. It needs good advice and adequate time to reach such important decisions” (cf. lassunsreden.film).

Text 2: Ethics, Difficult Decisions and Disability

The following academic reading task is about a ‘taboo issue’ that is still very much present in our society, and it often occurs in context with Down Syndrome and similar chromosomal conditions, such as Trisomy 13 or 18. It is about two diagnostic methods developed a few decades ago to detect ‘abnormalities’ in early stages of pre-born human life. Ethically it is a very complicated matter,

causing debate in medical expert circles, with some disability advocates and medical professionals even arguing that these methods of selection constitute ways to further discriminate against (or even eradicate) people with disabilities before they have a chance to live. Certainly, such difficult decisions offer up a lot to consider from various perspectives....

Task 6: Before you start reading discuss these questions:

What do you know about pre-natal (=before birth) diagnostics? How do they work? What could be the general advantages and disadvantages in terms of opportunities and risks?

Truly Taboo- A Brief History of Down Syndrome Stigmatisation In- and Outside of The Womb in the West

Among many taboo topics discussed today, it appears that few are as taboo as that of Down Syndrome stigmatisation in- and outside the womb. Medical treatments and technology have advanced rapidly throughout the last century, leading to the creation of pre-natal diagnostics (PND) and pre-implantation genetic diagnosis (PGD) intended for use in the field of obstetrics and gynaecology. Yet while both practices have been deemed useful for their screening purposes, they are not uncontroversial from an ethical viewpoint, albeit in slightly different ways.

Pre-Natal Diagnostics

Ever since the 1970s, PND's global sphere of influence has increased, enabling physicians to diagnose chromosomal conditions. Though the accuracy of such screening procedures is not 100%, this has, over the years, led to a significant increase in Down Syndrome diagnosis-related abortions, most sources alternate between 90% (cf. Lindeman 2008: 1088) and 99% (cf. Lou et al. 2018: 1228) in most Western countries, across all stages of pregnancy. By some disability and Down Syndrome advocates, this development has been criticized and deemed a practice of 'selection' (cf. Birnbacher 2006: 317), due to its pushing life and death decisions of a child with Down Syndrome (or other conditions) back to even before its birth excluding its chances to live (cf. Rehmann-Sutter 2022: 10). Proponents of this practice have, however, often drawn on the "Good Samaritan" argument, which prevents children with Down Syndrome from living a lesser quality of life by terminating its life during pregnancy (cf. Friberg-Fernros 2017: 196) or in some cases of failed late-term abortions, after birth by not providing life-support in the neonatal intensive care unit (NICU). Though abortion policies are different across the world, the fact that against-the-odds surviving babies of failed late-term abortions are often failed to be provided with medical support due to their stigmatised chromosomal condition, such as Down Syndrome, or others, such as surgically repairable cleft palate/ lip (cf. UN HRC 2014: 3), and instead are left to die (cf. 3), needs to be addressed health-stigmatisation

discussions. This is because arguably this still is a highly discriminatory, morally, and ethically questionable practice in the health care setting. The Human Rights Council of the UN's General Assembly, for example, argues in its report, "The Human Rights of Babies Surviving Late Abortion", that more research is needed into this subject, stating that "hospitals and governments are often unwilling to disclose them. Even statistics on late abortion are often concealed or minimized" (UN HRC 2014: 3). Their report also highlights the ambiguity of doctors' decisions regarding the matter, using the UK's National Health Service (NHS) as an example:

"Once a child slated for death by abortion is born alive, no medical help is offered to him. On the contrary, "Guidance from the Royal College of Obstetricians and Gynaecologists recommends babies over 22 weeks which survive abortion should have their hearts stopped by lethal injection". In other words, doctors are recommended to kill newborns, while they are trying to save premature babies in the same gestational age. [...] Early in the pregnancy, the foetus will die within a few minutes, but after 21 weeks, some can breathe unaided for a long while. [...] Most of the time, these babies are left to die without any care, not even a blanket, left alone in a room or a closet. Sometimes they are killed, either by lethal injection, asphyxiation or even by breaking their spine." (UN HRC 2014: 2)

Several cases in different countries of children with genetic or chromosomal conditions, who suffered such a fate among the rising numbers of (late-term abortions) (cf. UN HRC 2014: 3), are also pointed out in the report: One of them is a "little girl with Down Syndrome, born alive after a botched abortion at 21 weeks", who continued to breathe for three hours after birth (UN HRC 2014: 3). Her parents, who already have a child with a disability, claim to have been "coerced by staff" (3) and much to their dismay "were later told that their baby had not "really" been alive, even though she was clearly breathing" (3). This girl can be counted among the 66 left-to-die newborn babies (of a total of 2235 newborn deaths) affected by legal abortion "predominantly on account of congenital abnormalities" (CEMACH 2007: 28), listed in the Confidential Enquiry into Maternal and Child Health (CEMACH) Perinatal Mortality 2005 report (2007), drawing upon NHS hospital data in England and Wales from the year 2005. Additionally, "[p]aediatricians were less likely to request a post mortem in congenital anomaly cases" (CEMACH 2007: 32, indicating that these babies were of less relevance to be considered medically. However, consecutive reports have not published such information anymore (UN HRC 2014: 3), "excluding notified terminations of pregnancy, babies with lethal congenital abnormalities, babies born less than 22 weeks' gestation" (CEMACH 2009: 3). This disregard for abortion survivor mortality rates in conjunction with disability impedes data access to this issue, which needs further stigma-sensitive discussion in contemporary times.

Pre-Implantation Genetic Diagnosis

PGD came into being in 1980, ten years after PND and changed the way pre-natal diagnosis was handled, as the selective focus now was put onto the earliest developmental moment, namely that of fertilization, an issue which is not unproblematic in a stigma-sensitive discussion. “[O]riginally developed [...] as an alternative [...] for couples wishing to produce a genetically related child free of an undesired, heritable, genetic condition where at least one of the prospective parents is a known carrier” (Krahn 2011: 157), pre-implantation genetic diagnosis is practised with in-vitro fertilization (IVF) or intracytoplasm sperm injection (ICSI) (cf. Zhang et al. 2007: 515). The thereby generated generated embryos are then analysed for genetic defects, using methods, such as “fluorescence in site hybridization” (FISH), which aim to “detec[t] the chromosome status in single cells [...], using fluoro-chrome-labelled DNA probes that are complementary to DNA sequences specific to individual chromosomes” (515). Though a variety of conditions, such as “Tay-Sachs disease, cystic fibrosis, sickle cell, Huntington’s chorea, and Cooley’s anaemia” (Krahn n.d.: 46) can be detected with this method, it is increasingly used for Down Syndrome (Zhang et al. 2007: 515), as abortion in this case “is not acceptable for some couples” (517) and “potential complications of invasive procedures, such as [...] hemorrhage and uterus infection” (517) can be avoided. This practice, however, is questioned as the ‘seriousness’ of the condition is often undefined, making for an arbitrary decision for procedure (cf Krahn 2011: 163).

Ultimately, it is clear that both diagnostic methods, their implementation and ethical implications for both child and parent are very difficult topics, which many future parents need to consider carefully. But also, other members of society should reflect on them in relation with deeper issues of human diversity, tolerance, and inclusivity.

Section 4: Practical Examples of Down Syndrome Advocacy Writing

Task 1:

Since you too can contribute to change in society, here are some examples of different forms of health advocacy in the context of disability.

Have you done something similar before? Which other forms of health advocacy can you think of?

Share them with the class.

Example 1: Action statements by Down Syndrome International

COVID-19 vaccination prioritisation (2021)

The COVID-19 pandemic constitutes a serious challenge in implementing the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) and the realisation of the Sustainable Development Goals in respect of people with Down syndrome.

People with Down syndrome are being left behind in the COVID-19 response around the world. COVID-19 has exposed inequalities, deepening existing discrimination and marginalisation.

This must not happen in the rollout of COVID-19 vaccinations, particularly in light of the current limitations of vaccine supply.

Furthermore, despite growing evidence that they are at greater risk of death from infection and severe outcomes from specific issues associated with the syndrome, not all countries have policies in place to vaccinate people with Down syndrome against COVID-19 as a priority.

We call on national governments and UN agencies to:

- recognise people with Down syndrome as a priority Group;
- make COVID-19 information campaigns and vaccination sites inclusive and accessible to people with Down Syndrome;
- ensure that organisations of persons with disabilities (OPDs) are actively involved in the development of COVID-19 related planning and policy-making and that vaccinations must only happen with free and informed consent and
- collate data on the vaccination of people with Down syndrome, disaggregated by age and sex and shared this in accessible formats.

Adapted from <https://www.ds-int.org/covid-19-vaccination-prioritisation> and <https://workdrive.zohoexternal.com/external/444aae0a5d4bcef00816d60bc0deb5fed8cdf707ac59832062074bee5220dde>

Task 2:

Following these statements, the organisation Down Syndrome International put out a “toolkit” for advocacy in different areas of society, called “DSi Toolkit COVID-19 (2021)”.

Read the examples given and answer the following questions. Which type would you choose and why? What skills do you have that are suited to this type?

Example A

Lobbying	
This involves direct contact with decision-makers aimed at influencing them to bring about changes in laws, policies and practices. Often successful lobbying involves building relationships with decision-makers across multiple meetings and interactions. Lobbying is often aimed at the primary target for advocacy (for example the Minister for Health), although can also be aimed at secondary targets who may be able to influence the primary target (for example a member of parliament with a link to the Minister for Health). Here are some activities that can be used to lobby decision makers:	
• Writing a letter • Producing a statement or position paper (see DSI statement in Supporting Materials section for an example) • Making a phone call	• Meetings and visits • Arranging for decision-makers to visit your community

Example B

Mobilising People	
Mobilising people involves organising and supporting people to take action to put pressure on decision makers. It is generally aimed at secondary targets for advocacy and is open to anyone who wants to support the campaign. The people that are mobilised may include people that are directly affected by the issue (for example self-advocates with Down syndrome and their families) or people that are not directly affected but care about the issue. Here are some activities that can be used to mobilise people to support a campaign:	
• Public meetings and discussions • Demonstrations, marches, or protests • Group meetings with decision-makers • Stunts or flash mobs	• Petitions (see example petitions here) • Letters to decision makers • Sharing internet campaigns and messages

Example C

Media Campaigns	
Using media for advocacy campaigns is a powerful way to mobilise people and put pressure on decision makers. Media campaigns can take place in many formats including radio, TV, newspapers, emails, blogs and social media. Here are some activities that can be used for media campaigns:	
• Press releases, articles and letters to the editor (see template press release in Supporting Materials section) • Blogs • Factsheets, fliers or posters	• Radio and TV interviews • Video campaigns • Social media campaigns (see example social media here)

Example 2: Action letter – Letter to the author (2019) by Down Syndrome Australia

In 2019, a new edition of *Up the Duff* the “go-to-book for pregnant women in Australia and New Zealand” (linkedin.com) was published, containing content which stigmatises the Down Syndrome community, much to their dismay. Shortly thereafter, Ellen Skladzien, the CEO of the Down Syndrome Australia organisation, decides to act, advocating for their de-stigmatisation...

Task 3: Read through the text and briefly analyse it with regards to structure and argumentation style. How is the call-to-action formulated?

Open letter to the author of ‘Up the Duff’

RE: Portrayal of Down syndrome in “Up the Duff”

Dear Kaz Cooke,

I am writing to you as CEO of Down Syndrome Australia on behalf of the Down syndrome community. I was incredibly disappointed and alarmed by the portrayal of Down syndrome in the recently released 2020 edition of *Up the Duff*. It is my hope that we can work together to address the concerns raised below.

Down Syndrome Australia works hard to address the stigma and discrimination experienced by people with Down syndrome. It is incredibly disappointing that a resource such as *Up the Duff* which is so widely utilised and respected provides such a level of misinformation about Down syndrome.

Prospective parents in Australia are already struggling to get accurate information about Down syndrome and prenatal screening. In 2017 a survey was conducted by Down Syndrome Australia and it found that of those who responded, more than a third of women who had a pregnancy with a prenatal diagnosis of Down syndrome felt pressure from medical professionals to terminate the pregnancy.

Down Syndrome Australia respects the rights of women to make decisions about their pregnancies. Informed decision-making following an unexpected screening result is only possible if up-to-date, balanced and accurate information is available about all conditions being screened for including Down syndrome. What is presented to the reader within the current edition of *Up the Duff* fails to support informed decision-making. This is incredibly disappointing.

More broadly, the misinformation contained in this edition of *Up the Duff* about life with Down syndrome perpetuates out-dated stereotypes. These are hurtful towards people with Down syndrome and those who love them.

There are many reasons for concern after reading this publication which are outlined below:

The portrayal of Down syndrome throughout the book is inaccurate and propagates negative stereotypes. The suggestion that “a child with Down syndrome will have a serious mental disability” is at best a very outdated way of discussing an intellectual disability and at worst purely biased and inaccurate information. There is no discussion of the fact that most children with Down syndrome are included and valued in their communities or that the vast majority of people with Down syndrome report having a high quality of life.

The use of the term “risk” to describe likelihood of a diagnosis of Down syndrome, is inappropriate and outdated. In 2016, Tasmania’s Anti-Discrimination Commissioner found the use of negative language in a Down syndrome diagnosis could breach the Anti-Discrimination Act. It has prompted a

change in the national guidelines for prenatal testing. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists guidelines now point to more neutral terminology like “chance” or “probability”.

The discussion of termination does not provide balanced information. The statement that “the quality of life of a person with Down syndrome is hard to predict” is not a useful statement, the quality of any baby’s life before it is born is unpredictable. There is research evidence that suggests that most people with Down syndrome have a very high quality of life. This is omitted in your book.

You do not provide information about the supports and information that is available in Australia. The reference to Down Syndrome Australia and the support our federation provides is limited to a link to a website saying that we are “a lobby and support site for parents of children with Down syndrome”. This is not the most accurate description of the work that we do.

Down Syndrome Australia is the peak organisation for people with Down syndrome in Australia. We are part of the Down Syndrome Federation who support people with Down syndrome and their families. Our State and Territory organisations often meet with families who have received high chance results and provide balanced information and an opportunity to meet other families.

The description of Non-Invasive Prenatal Test (NIPT) does not provide essential information about the accuracy of this test. More specifically, your book does not include any explanation of the issues around positive predictive value. The Positive Predictive Value (PPV) of the test refers to how likely it is that individuals who test positive are to be affected by the condition. PPV depends not only on test performance but also on the prevalence of the condition in the population studied. For example, if a woman has a pre-test likelihood of Down syndrome of 1 in 2000, then the likelihood that a positive result from NIPT is a true positive is only around 55%. Information about PPV is often not shared with families, and inaccurate presumptions are made that a high chance result is likely to be a true result 99% of the time.

We are incredibly disappointed by the biased and inaccurate information available in this edition of Up the Duff. As it stands, this edition of Up the Duff contributes to a culture of misinformation, stereotypes and discrimination which negatively impacts the Down syndrome community while making it difficult for women to make informed decisions.

I have attached Down Syndrome Australia’s position on pre-natal screening for your information and I would welcome the opportunity to speak with you about our current work in the area of pre-natal screening as well as the concerns I have raised about the book.

Down Syndrome Australia would be open to partnering with you to ensure information about Down syndrome and pre-natal screening is updated in future editions.

I urge you to publicly apologise to the Down syndrome community and acknowledge the errors in this edition of Up the Duff. I ask that you commit to offering accurate, balanced and up-to-date information about Down syndrome in future editions.

Kind Regards,

Ellen Skladzien

CEO Down Syndrome Australia

Adapted from <https://www.downsyndrome.org.au/blog/2019/11/26/post-4/> and <https://www.linkedin.com/pulse/stigma-discrimination-down-syndrome-ellen-skladzien>

Example 3: Self advocacy at the UN in Geneva (2019)

The last example is from the 2019 UN conference in Geneva, which also had a side-conference for people with disabilities. Here many self-advocates could hold short speeches about their life with Down Syndrome, their wishes and dreams. Reflect on the following statement below before reading the conference summary.

"A self-advocate speaks up for themselves. I have learned to stand on my own two feet." - Senam, self-advocate, Turkey

Self-advocates say 'Leave No One Behind' at the UN in Geneva

Geneva- 18th April 2019 (by Nathan Rowe)

This was a side event to the 21st Session of the Committee on the Rights of Persons with Disabilities, held at the Palais des Nations (the home of the UN in Geneva)

The event was intended to celebrate World Down Syndrome Day and to give self-advocates with Down syndrome a chance to speak up about their rights to employment. [...]

Key message: People with Down syndrome want to work and make good employees

People with Down syndrome make excellent employees in a variety of roles and industries. Studies and employer testimonies show that they have low absenteeism rates, commit to roles for long periods of time, and are enthusiastic team members.

"I am a very good worker and I'm proud of myself." - Iria Giunta

"I would like to work in a restaurant one day." - Morgan Maze

A recurring message from self-advocates with Down syndrome was that they want to work. Those with jobs all enjoyed working and were successful in their jobs.

Key message: People with Down syndrome have a right to access meaningful employment

Self-advocates spoke strongly about their right to work and to have a decent job with fair working conditions.

Employment rates of people with Down syndrome are low and often people with Down syndrome are offered unpaid or low wage jobs. Once in work they often experience bad working conditions. [...]

"I just have an extra chromosome and I have a right to a good job." – Pearl Luthy

"I could get unpaid jobs, but it's not fair. Would you work for nothing." – Kate Grant

"It also allows everyone with and without disabilities to expand their own horizons." – Andreas Rubin

Adapted from <https://www.ds-int.org/Blog/leave-no-one-behind-geneva-21-march-2019#comments> and <https://www.ds-int.org/self-advocacy>

Final Task: Building your Personal Social Advocacy Skills in the Context of Health-Stigmatisation

You have seen some examples of what health advocacy against Down Syndrome discrimination and stigmatisation can be. Now, it's your turn:

Do you know of a case of health-stigmatisation that would need your advocacy? Or would you like to find out something about a particular health-stigmatised community (such as people with various disorders or illnesses)?

Steps to take

Do some research, find a case (or a set of cases) and design your social advocacy project (using one of the forms introduced in this section). Since it revolves around 'real', 'authentic' people, it would be very helpful if you could contact them directly and get their personal input, ideally you design the project together... As a last step, briefly outline your project, put it into practice and reflect on how it went.

Further resources



- Down Syndrome International's Self-advocacy guide:
<https://www.ds-int.org/self-advocacy>
<https://workdrive.zohoexternal.com/external/8CkAlci0dp7-Jxfap>
- UN Convention on Human Rights (Easyread):
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345108/easy-read-un-convention.pdf

References (see bibliography)

