

UNIT 4: HANDOUT A

EXERCISE 2

LIVING IN PREJUDICIA

The Scenario

It is the year 2020. The economic situation in Scotland has deteriorated drastically over the past few years. There is large scale unemployment and very little sign of an economic upturn. You and your family have emigrated to the country of Prejudicia, and your children have begun to attend local schools.

Your first impressions of Prejudicia are:

- Scotland is portrayed as a poor, backward country, in need of aid. There are regular collections for 'poor white babies' at your children's schools.
- Although you are a qualified and experienced teacher, your qualifications and experiences are not recognised. You are unable to work as a teacher or a teaching assistant. The closest you can get to the education system is to work as a dinner lady in your local school
- No mention is made of Scotland's major contributions to art, literature, science or sport. Scottish schooling and academics are seen as second rate and corrupt. On the other hand, Prejudicial culture and achievements in these fields are seen as the only desired norm.
- Children are actively discouraged from speaking English at school, although there are other English-speaking children there. So while they have to get extra help with Prejudiciac, other children are progressing in other subjects.
- Similarly, if you or your family speak to each other in English while in public you get disapproving stares and general resentment.
- You were recently in hospital for a minor operation. Whilst there you were offered mince and tatties for your lunch because you were Scottish. Nobody spoke English and you have only learned basic Prejudiciac so you had difficulty explaining that you were vegetarian. You were also treated as a pest because of your different needs.
- All references to Scotland in books, newspapers or television have pictures of men in kilts, living in overcrowded, deprived estates, eating fish and chips and getting drunk. There is a general belief that it is a very violent and unsafe place.



UNIT 4: HANDOUT A (CONT)

LIVING IN PREJUDICIA

- The Prejudicial people continue to treat you as outsiders – even those Scottish people who came here years ago and whose children were born in Prejudicia. All your concerns are trivialised and treated with contempt. If you persist you are accused of being fundamentalist and having a chip on your shoulder.
- There have been several instances reported in your area of Scottish children being attacked. When the children have mentioned this to their teachers they have been told not to over-react, and not be so sensitive. The attacks were probably nothing to do with them being Scottish. They live in a poor area and these things just happen.

One of your children comes home from school one day saying she is not very happy because:

- Other children will not play with her
- She doesn't understand the teacher or the lessons being taught
- The Prejudicial children call her rude names and make fun of her accent, behaviour and colour



UNIT 4: HANDOUT B

EXERCISE 3

NO ONE HEARS

By: Zoë Charlotte Mason

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Looking back I guess one could say that it's always been there, brimming under the surface. Or rather, she's always been there, my Nervosa.

Ever since I hit the teens I have felt agitation, disgust and despair for myself, my actions and my appearance. I repulsed myself both, inside and out. However, when I finally found the motivation to start running regularly, outside and in public, things began to change. I finally felt like I had a hold over my stresses, and I could control how my body formed. Don't get me wrong, I've never been overweight. I have always received compliments for my 'slim yet hour glass frame'. But it's so easy to pass comment; everything is relative.

The more stress that hit me, the more I ran, and the more I re-formed myself from the outside in. My outlook became so much more positive. I became closer to being the girl I had always wanted to be, calm, caring, spontaneous and lovable. Until this point, I felt the oppressing factors in my life had prevented this from happening and had effectively shaped me into being everything I didn't want to be. My home life had not been great. Yes, I had married parents and we had lovely houses. Yes, I'd had a desirable upbringing (financially speaking) but what worth is money when family bonds are broken and you feel like there is no love? I grew up feeling like there was something fundamentally wrong with me, that I, (the pretty little blonde girl) was the source of all negativity. I had never heard the words "I love you".

I spent the whole of my teenage years suffering in the depths of depression, despising myself and my very existence. I craved answers. I felt like my mother begrudged me and that I was her verbal punch bag. Why? I couldn't understand it. So I ran, I ate less and I ran. I cut myself off emotionally a little more every day and was finally beginning to feel emancipated from my repulsion. I was floating into a blissful daze; it was beautiful, enticing and surreal. I loved it.

Then everything got dark.

My Nana passed away with cancer, my Daddy couldn't cope, and my mother couldn't comfort him. My sister had her own ordeals, as did my flatmates who were dealing with their own issues. I became the pillar that held everyone up. I felt all alone and that I was fighting with a withering soul. By this point, I felt like the Nervosa was all that I could turn to and that not a single person in my world had the energy to care. So I held my head and I ran. I ran through rain, sleet and snow. Ran screaming, tears streaming down my face and anger oozing from my feet into the pavement. And it was during the month of March that the devil took hold. The day I baked that flipping Tarte Tatin. Nervosa got me to do things I promised myself I would NEVER do. She got me to vomit.



UNIT 4: HANDOUT B (CONT)

At first the purging was just minimal, the odd time here and there. It was nothing to worry about, or so I convinced myself. Did you know that vomiting is addictive? The more I vomited the more I craved it and it soon became paramount to my daily routine. Nervosa was in control, she was in full force. Though what I hadn't anticipated was the debilitated life that it would lead me to. I wasn't living. I merely existed and could barely function. I could no longer run, but boy did I try. My joints were weak, my legs were frail, my teeth ached and my chest burned. I felt permanently shattered.

One day in May, following a moment of clarity, I begged a good friend to drag me to the doctors for blood tests. I went reluctantly, kicking and screaming, but I went. And I believe this was the day my recovery began.

I finished my University year and I packed up and went home to my parent's house. I enlisted at the NHS Eating Disorder unit in Aberdeen and began my therapy. The support from the psychiatrist, dietician and health doctor was invaluable; I really could not have pulled through the first stages without them.

And of course the ride hasn't been easy. I most certainly did NOT enjoy being jabbed with needles on a weekly basis, being told that I risked a heart attack and that only 40% of sufferers make a full recovery. Similarly, attending hospital tests and being surrounded by OAPS was heartbreaking; as was being told that I risked developing Osteomalacia and/or Osteoporosis later in life, and that I could risk losing my teeth and causing a brain haemorrhage through excessive vomiting. But I kept going, I kept pushing for recovery. I was so weak and I felt like life was no longer beautiful, enticing and surreal as it had once been.

For the most part all I did was talk. After so long suffering in silence, feeling isolated and alone, this was all I needed. I love my family and friends dearly, but boy were they clueless. I felt like they kept brushing it off and hiding heads in sand. They avoided me, 'forgot' to invite me to events, hid food from my sight and often screamed at me to stop being so selfish. Needless to say, this was not helpful, if anything it made me retreat to the comfort of the Nervosa.

This was when I realised where the real issue lay and it wasn't me at all, most people simply do not understand eating disorders. So I set out to change this, to raise awareness and help break the stigma. I set up a Facebook group called 'Behind the Haze' and for the first time I spoke openly about my condition. Here I relay facts and information about Anorexia and Bulimia, share my thoughts and experiences; I have my poems (one of which is included at the end of this story) and pictures posted from my darkest hours. I also have pictures from a recent photo shoot that I did with photographer Amber Joy (two of which are included here). We collaborated in an attempt to depict the graphic reality of eating disorders and break down misconceptions and stigma by creating provocative imagery. Although it was an emotional experience, this too was a significant time in my recovery process.



UNIT 4: HANDOUT B (CONT)

By creating this group and sharing my experience, my hope has been to raise awareness of the experience of eating disorders, as well as offer hope that recovery is possible.

The response has been so very warming (and somewhat overwhelming at times); it provides me with hope that one day people will be able to speak freely of their experiences and will receive the care they need from their loved ones and from society. Since setting up the group, I too have found hope with regards to my own condition. In raising awareness I have rid myself of the fear of talking about my condition. And in writing this piece, I have really had to delve into the depths of what went on. Of course, it's still so painful and raw to reminisce over but talking/writing about it helps alleviate that pain little by little.

Whilst I acknowledge that I am recovering from Anorexia Nervosa and Bulimia, I am by no means fully recovered...yet! Right now I still have days where I can't get out of bed and days when I can't keep food down at all. Though having been to hospital and learnt the facts, I know what I am doing to my body and I know that with support I can get through. It's a sad truth but relapse does happen, but the difference now is that I'm stronger and I know that I can break free once more. Communication is so very important and I urge others to talk openly too and to express their feelings, however painful it may be. To anyone that has suffered or is suffering in silence please know that I have been there and be assured that you will be able to find peace through perseverance.

Now consider the following questions:-

- Outwardly affluent, what was missing in Zoë's family life?
- How common is Zoë's experience of not being understood by friends and relatives?
- How has sharing her experience helped Zoë?
- What role has communicating her experiences had in Zoë's recovery journey?



UNIT 4: HANDOUT C

EXERCISE 3

RURAL HEALTH NEEDS

Understanding rural health needs demands that we challenge our existing understanding of rural Scotland in order to come to terms with new realities of rural life, and even challenge existing community representations of their health needs. The dominant discourse of rurality which emphasises the advantages of rural life, and presents positive images of rural community has created a powerful rural myth which masks increasing economic divisions in rural communities. In addition, social changes and the impact of counter-stream migration have led to the formation of new interest groups in rural Scotland which often have conflicting agendas. During the research, a significant number of affluent migrants who had retired to rural communities expressed the view that distant and/or inadequate health services should be viewed, and accepted, as part of a 'rural way of life'. These economically powerful migrants had the time and energy to participate in community organisations, notably in community councils and with the exception of campaigning on behalf of the elderly, were reluctant to address issues of social exclusion within their communities. In addition, it was notable that in all areas individuals in most need, such as lone mothers, families reliant on welfare benefits and itinerant workers, were frequently identified as 'the wrong sort' or 'problem households', and many respondents intimated that they should be excluded from public housing in rural areas. The persuasive representation of all-inclusive 'close knit' rural communities with easily accessible help and support networks is false, but perceptions of policy makers and many rural services deliverers has failed to keep up with the changing reality.

Other Health Issues -

In all research areas, respondents expressed concern about the effects of what they perceive to be the budgetary cuts in the National Health Service. Many respondents attested that rural people were in 'double jeopardy', facing high costs to both access and charges for health services, for example dentists, and opticians. The difficulty of accessing chemists for non-prescription medicine and goods, ranging from children's cough medicine to condoms, was raised as a problem in all case study areas

In relation to wider issues of health and well-being, respondents in Harris and Wester Ross linked their demands for leisure facilities to the apparently high levels of heart disease in the Western Isles and the West Coast, and felt that their general health would be improved by more exercise activity. Conversely, many respondents also identified social pressures which labelled taking exercise, notably jogging, as a strange activity. Respondents also raised concerns about diet and water quality in rural areas. Many respondents felt that rural people had a lower quality of diet than people in urban areas, due to the high cost and poor selection of fresh vegetables and other staples, for example, wholemeal bread, in rural shops. European Union regulations on water supplies had led to what many respondents viewed as excessive chemical additives in rural water supplies in all research areas.



UNIT 4: HANDOUT C (CONT)

It was notable that throughout the rural disadvantage research, despite the rhetoric of community, rural men and women's first loyalties were identified as being to their families and public discussion of 'private' health problems, notably relating to alcohol and sexual health, was labelled as a betrayal of family loyalties, with often serious social and familial consequences.

As discussed above, rural communities are reluctant to raise socially divisive issues, and development agencies prefer to dwell on the virtues of a diverse economy reflected by 'occupational pluralism', rather than health implications of households relying on low and insecure incomes generated by a series of seasonal part-time jobs. Tourist Boards trade on clean 'healthy' images of rural Scotland, and resource limitations will inevitably restrict Health Boards' rural funding allocations.

[Source: Clark, G. (1997). 'Health and Poverty in Rural Scotland' in Health Bulletin – September 1997]

Questions

1. According to affluent migrants in rural areas how should distant and/or inadequate health services be viewed?
2. In rural areas who are the individuals most in need and how were they viewed by other respondents?
3. What is the 'double jeopardy' that rural people face in relation to health services?
4. What were some of the wider issues of health and well-being that were identified by respondents in Harris and Wester Ross?
5. What implications arise from rural people's first loyalty being to their families?



UNIT 4: HANDOUT D

EXERCISE 3

THE IMPACT OF DOMESTIC VIOLENCE ON HEALTH

The impact which domestic violence has will vary from person to person, but it has a major impact on health which extends well beyond physical injury alone. There is growing evidence to confirm that domestic violence does have serious and long lasting consequences for the well-being of women and children. There has been no research to date which comprehensively addresses both the short and long term (lifetime) costs which domestic violence has for women and children, although there are now recent studies in the UK which have considered the health consequences, the costs to services and the impact upon the welfare of children.

The two most important health consequences of domestic violence are the physical injury (including sexual abuse) and the psychological effects.

Physical Injury -

A qualitative study of 56 women's experiences of domestic violence in Northern Ireland found 39% of the women interviewed (recruited through women's refuges) had, at least once, suffered violence which required hospital treatment. Eleven percent (53) of the 484 surveyed in the Surrey research reported having been beaten up and 5% (20) had been attacked with a weapon.

Psychological Effects -

As well as physical injury, domestic violence can also have psychological effects including depression, anxiety, post traumatic stress disorder and suicide. Women may also feel anxious, helpless, afraid, demoralised, ashamed and angry and may experience panic attacks. Battered Women Syndrome (BWS) is a psychological condition that is characterised by psychological, emotional and behavioural deficits arising from chronic and persistent violence. The central features of BWS include 'learned helplessness', passivity and paralysis. Understanding BWS can be a useful frame of reference in terms of understanding the victims' reaction to domestic violence.

In the longer term, and after separation, women most frequently stress the impact which living through domestic violence has had upon their mental health, their self esteem, feelings of self worth and security. There is a tendency to stress the psychological effects as being the most profound, even when there has been life threatening or disabling physical violence from the perpetrator.

'I'm still very anxious that I don't meet him, it's almost been two years now but I'm still sort of, if I hear a motorbike pull up outside or something, I'm almost reaching for the telephone to phone the police. If I'm in the street and I hear a motorbike, I'm still trying to dive for cover.

'You just never knew what was going to happen and when and afterward, if somebody brushes past you in the street, it gives you a fright . . . if somebody reaches out to touch you, you draw back. You just don't want to be touched by anybody'.



UNIT 4: HANDOUT D (CONT)

The Impact Upon Children -

Domestic violence to the mother is very likely to have some effect upon the welfare of children. In households where there are children, most domestic violence incidents (75 to 90%) are witnessed by children, although adults may not always be aware that the children have been present or have heard what has happened from an adjacent room. Witnessing domestic violence can cause considerable harm to children in both the short and long term. In the short term, both boys and girls who have witnessed domestic violence may show a range of disturbed behaviour, including withdrawal, depression, increased aggression, fear and anxiety. Boys are more likely to show increased aggression in the longer term.

[Source: British Medical Association. (1998). 'Domestic Violence: a health care issue?'. BMA.]

Questions

1. According to the authors what are the two most important health consequences of domestic violence?
2. In the Northern Ireland study what percentage of women interviewed had suffered violence which required hospital treatment?
3. What are some of the psychological effects of domestic violence?
4. What percentage of domestic violence incidents are witnessed by children?
5. In the short term what kinds of behaviour do children who have witnessed domestic violence exhibit?



UNIT 4: HANDOUT E

EXERCISE 3

MAY I BE MOTHER?

Disabled women are often assumed to be unfit or unable to be parents. Veronica Marris examines the various obstacles put in the way of women with illnesses and other disabilities who want to have children.

Alison John, a woman with cerebral palsy, author and mother of two, was at a local council meeting with her children when a woman said to her, 'Isn't it lovely that you and your husband can adopt children?' Alison replied, 'Excuse me, actually we bonked for them!' leaving the woman in a state of complete shock at the idea of an obviously disabled woman having sex and getting pregnant. Alison told this story at the 1992 Maternity Alliance conference on Disabled People, Pregnancy and Early Parenthood, at which many women came together for this first time to talk about the difficulties they had faced in becoming parents.

A woman I know with multiple sclerosis was once told by someone visiting to discuss adaptations to her home, 'No one in their right mind would leave you alone with the children', not knowing that she was at the time fostering two children.

Women who have been disabled from birth or early childhood are themselves often seen by family and professionals as perpetual children, in need of care from others, rather than as adults who could care for someone else. Girls may therefore grow up with the message that the adult world of boyfriends, marriage and children is one from which they will always be excluded.

Sex is something which healthy, attractive people do and society finds the idea of sex rather disgusting when it involves people who are old or fat or ill, or who in any way fail to meet standards of physical normality. Disabled women are expected to give up the right to ordinary desires for love, physical closeness and sex which others take for granted. If our partners are 'normal' men then people wonder why they are with us, and if our partners are also disabled we inspire deep fears about disabled people breeding more disabled people and destroying the health of the nation. As for those of us whose partners are women, much of society has not got as far as thinking about the possibility of disabled lesbians existing, let alone being parents.

If disabled women do have children they will have a much harder job than other women to prove that they are coping with motherhood. They will be at risk of having their children taken into care if they are thought not to be managing and it may be impossible to get appropriate help when it is needed. Positively Women, the support organisation for HIV positive women, told me of one London borough where women with AIDS can get 24-hour cover so that they can stay home with their children rather than go to hospital and their children go into care. There are so many women living with so many different illnesses and conditions who with their children would benefit from this sort of help, but mostly it doesn't exist.



UNIT 4: HANDOUT E (CONT)

So even if women overcome the barrier of others' prejudice and find the confidence to think of having children, there is much for them to fear. Women who have managed as adults to live independently and to free themselves from professional interference have to contemplate a new army of professionals, this time concerned for the welfare of their children and the prospect of losing children to the state is terrifying.

Last but not least women may have fears about the effect on their own health of pregnancy and looking after small children. These fears are sensible and well-founded, but it is hard for us to voice them in case we are dissuaded from having much wanted children or are seen as neurotic and cowardly.

Thousands of women with illnesses succeed in having children and staying healthy; many more need information to help them do so.

Information about pregnancy and childbirth for those of us living with illness is scarce and often contradictory. Professionals seem at times unconcerned and blandly reassuring, but at others terrify us with threats of what will happen to our babies if we get pregnant or fail to follow their instructions when we are pregnant. In a survey published by Positively Women several women mention the negative attitudes of doctors towards them becoming pregnant: 'The doctor said I would die of AIDS and so would the baby.'

Women with conditions such as lupus, sickle cell anaemia, diabetes and many others receive conflicting advice and information about the risks of pregnancy to themselves or to the baby. One friend with thyroid disease and another with diabetes have both had several miscarriages and badly want to know if those are connected to their medical condition or if there is any way they can be helped not to miscarry again, but the information they want is not available. In a survey done by Maternity Alliance a woman with rheumatoid arthritis mentions putting off having a family for 11 years because of inaccurate advice about the likelihood of passing on the disease to her child. Disabled women and women with illnesses are often left out of literature and discussions about pregnancy, childbirth and reproductive rights. Women's Health and other organisations could do much to lessen women's isolation by developing appropriate information.

Veronica Marris is the author of 'Lives Worth Living: women's experience of chronic illness,' published by Pandora Press in 1996, and has been involved in a support network for women with diabetes.

Source: Women's Health Newsletter, 27 November, 1995.



UNIT 4: HANDOUT E (CONT)

QUESTIONS

1. In the article, what 'shocking idea' did Alison John leave the woman at the meeting with?
2. How does the author suggest that women who have been disabled from birth are treated?
3. What does the author suggest is a common attitude towards disabled women, sex and sexuality?
4. Name three obstacles, outlined in the article, faced by disabled women if they decide to have children.



UNIT 4: HANDOUT F

EXERCISE 4

THE MEANING OF 'EQUITY' IN HEALTH

The term 'equity' implies a moral and ethical judgment.

If we say that things are inequitable, we refer to differences which are unnecessary and avoidable, rather than just ordinary differences amongst people. We also mean that this is the result of unfairness or injustice.

Inequity means that things are;

- Unnecessary and Avoidable
- Unfair and Unjust

If things are unnecessary and avoidable, we can begin to work to change them.



UNIT 4: HANDOUT G

EXERCISE 5

SOCIAL JUSTICE

Social justice 'can be defined in terms of a hierarchy of four ideas. First, that the foundation of a free society is the equal worth of all citizens, expressed most basically in political and civil liberties, equal rights before the law and so on. Second, the argument that everyone is entitled, as a right of citizenship, to be able to meet their basic needs for income, shelter and other necessities . . . Third, self-respect and equal citizenship demand more than the meeting of basic needs: they demand opportunity and life chances. Finally. . . we must recognise that although not all inequalities are unjust . . . unjust inequalities should be reduced and where possible eliminated' (Commission on Social Justice, 1994, pp. 17-18).

'Our vision for delivering social justice in Scotland:

A Scotland in which every child matters, where every child, regardless of their family background, has the best possible start in life;

A Scotland in which every young person has the opportunities, skills and support to make a successful transition to working life and active citizenship;

A Scotland in which every family is able to support itself – with work for those who can and security for those who can't;

A Scotland in which every person beyond working age has a decent quality of life;

A Scotland in which every person both contributes to and benefits from the community in which they live'

(Social Justice . . . a Scotland where everyone matters, Scottish Executive, 1999).

'I reiterate the Executive's commitment to Social Justice . . . The attack on poverty is our first priority.'

(Donald Dewar MSP, First Minister for Scotland, 14 August 2000).

' . . . the first thing I want to do is to continue the programme of social justice: tackling poverty and disadvantage.'

(Henry McLeish MSP, First Minister for Scotland, 26 October 2000).

[Source: Robina Goodlad's paper for Working Together Learning Together]

