

**Geo F. Mason: THE HEPHAESTUS PHENOMENON**  
**(An essay on the psychology of rehabilitation)<sup>1</sup>**

There are two symbols which can be said to embody nearly the whole of psychology of disability: one is the figure of Hephaestus and the other leprosy. Each emphasizes a different aspect of the question at issue. Let us begin with the latter.

LEPROSY AS A SYMBOL

In a documentary novel on rehabilitation (*Take my Hands, The Remarkable Story of Dr. Mary Verghese*) set in India in the sixties, in which Dorothy C. Wilson tells the story of the struggles of a female surgeon paralysed from the waist down in a serious bus accident, one of the figures is a leper who has to live excluded from society until the disease is no longer active. Then Dr. *Verghese* carries out an operation on a tendon in the leper's hand, which had been damaged by the disease, thus restoring its use by means of a special procedure. Hope for full recovery and reintegration into society are quite high. However, the leper remains an outcast for life. The patient, fully recovered after the successful operation returns to his doctor in the hospital and says in bitterness and desperation: "You have done a bad job, Doctor, because I *still* can't use my hand for work, but can *no longer* use it to beg." Although people knew that he had recovered, it was to no avail since he still bore the indelible traces of the dreaded disease on his body (he had no eyebrows, etc.). This case too shows that medical rehabilitation in and of its own is worth nothing without the rest: social and occupational rehabilitation - cf. anti-discrimination legislation.

The leper is the symbol of rejected persons, entirely alone with their problems. This is why they have become the focus of the attention of Michel Foucault, one of the most outstanding social scientists of the 20th century. In one of his seminal works, cited earlier, he expressed the problem in the following terms: "... the values and images attached to the

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<sup>1</sup> The author is indebted to Mr. Rob Dawson for his stylistic recommendations.

person of the leper continue to exist and persist in an age when the leprosy hospitals have been empty for years; and the exclusion has remained, and the stubborn and fearful symbol, which can only be kept away by drawing a sanctified circle around it, has not lost its importance in the society.”

Other authors refer to the long road traveled by our science and everyday practice from Taigetos up to the present day and the modern attitude and practice of rehabilitation. However, there is no place for complacency: the practice of Taigetos has not ended and has certainly not disappeared without a trace. Whether in faint traces or quite manifestly, the much condemned Greek tradition has continued to haunt human history over the centuries. Moreover, since the 17th century it has been present in European culture in clearly visible, institutional forms - embodied in the closed institutions. (We must be perfectly clear about this. What was wonderful and revolutionary in its novelty in the time of Guggenbühl, despite its methods and installations since developed to perfection has now become irrevocably harmful and retrograde.) Yet, even this is not enough. Would there be a need to emphasise the special attitude of modern rehabilitation, for a movement aimed at achieving an independent life for persons with physical disabilities, or even simply for investigations in this direction if exclusion, confinement, rejection, segregation, in short, seriously unfavourable discrimination and stigmatisation were not an integral part of everyday life in modern societies? Taigetos has not ended. It lives on in the reactions of the parents of children born with disabilities, in the conflicts of these children, in the mockery they all suffer, in the failure to accept their otherness, in the prejudices and the stigma with which they are branded.

Umberto Eco discusses the phenomenon in a striking way in *The Name of the Rose*: “The lepers are a sign of exclusion in general... We were talking of those excluded from the flock of sheep. For centuries, as pope and emperor tore each other apart in their quarrels over power, the excluded went on living on the fringe, like lepers, of whom true lepers are only the illustration ordained by God to make us understand this wondrous parable, so that in saying ‘lepers’ we would understand

‘outcast, poor, simple, excluded, uprooted from the countryside, humiliated in the cities.’ But we did not understand; the mystery of leprosy has continued to haunt us because we have not recognized the nature of the sign.”

#### HEPHAESTUS AND MR. DAVIS: PAST AND PRESENT

Although the symbol of the leper could be analysed in much greater detail, let us return to the hero we have already encountered in our wandering through history: the Greek smith! The lame Greek smith-god, Hephaestus, began life rejected by his mother who even cast him down from Olympus, desiring his death. He almost lost his life (*Iliad* XVIII, 395-398). The first major event in his young life was pre-determined by his disability. His mother’s reaction is a well-known phenomenon and unvarnished in its sincerity. A child born into a family with a disability often also leads to averting and compensating reactions. For example: denying the child’s disability, self-deceit; endowing the child with non-existent capabilities, a self-punishing, self-destructive lifestyle. Lord Byron, the poet, comes to mind - himself born with a physical disability - who recalled: “My poor mother raved every day, and goaded me too into fury, especially at times when she forgot herself and reproached me for my deformity.” The child’s counter-response, counter-rejection, his search for a scapegoat arising from his pain is logical and understandable.

Is it any wonder that a child born this way is able to accept himself only through serious conflicts and does not always succeed? The trap is open later too: when the renowned smith’s wife deceives him with Ares, the god of war, he feels - not at all surprisingly - that it is done to mock him. But all this is not enough, he even adds to his mocking by chaining together the lovers caught *in flagranti*, with an invisible, gossamer-fine but unbreakable mesh and calls witnesses to see his grievance. Although he could have explained the adultery either by Aphrodite’s coquetry or Ares’ seducing wiles, he blames his own disability. (But if Aphrodite is the goddess of love, is it surprising that she should deceive her husband?) It is worth noting his words:

*“Father Zeus and you other happy gods who live for ever, come here and see a comic and cruel thing. Zeus’ Daughter Aphrodite has always despised me for my lameness, and now she has given her heart to this butcher, Ares, just because he is good-looking and sound of limb, while I was born a cripple. And whom have I to blame for that, if not my father and my mother? I wish they had never begotten me!”*

Life and self-acceptance of people who are not born this way but become disabled later in life is similarly fraught with conflict. The confidence of the persons with disabilities can be broken. They might lose their self-confidence, their security is jeopardised, they might feel as if they are both a burden and defenseless. They have phantom sensations and in some cases an unjustified fear of death. For an extended period and sometimes even to the end of their lives their everyday life is marked by mourning: they mourn their former self and the capabilities they have perhaps lost for ever. The most widely varied abnormal psychological reactions can arise or be strengthened: over-sensitivity, hypochondria, products of an overactive imagination, over evaluation of the competence and possibilities of specialists providing assistance, an expectation of miracles and aggression.

The *self-image* also undergoes change frequently. What will be the self-evaluation and definition of persons who yesterday were still themselves and for their environment were healthy, strong, attractive, capable of persistent and hard work, independent and active, yet are now no longer any of these? The situation is further aggravated in a society such as modern society where physical beauty and health are very highly valued properties, persons with disabilities can easily think that they are less valuable than the others. This is why, although each level of rehabilitation has its own specific psychological problems, we consequently come up against inadequacies of personal self-evaluation. If someone has been carrying out a particular function or playing a role more or less effectively, in the great majority of cases this situation will change following injury. Even if the person has never before asked themselves “What am I good for?” or “Am I a valuable person?” they almost certainly will now. They will generally find themselves wanting.

Our example also gives a cross-section of emotional rehabilitation. “Who am I? One thing is certain: I have changed. I have become different from what I was. I will never again be able to do what I would like. I have become unproductive and useless, a burden on others, and I will stay that way. I was perhaps never attractive, but now I am definitely ugly. I repel people, no one loves me, how could they? Nothing will ever again be what it has been up to now. My family and friends have become different too, they will leave me. The world has changed too. I have lost all hope. What am I worth like this, a cripple? The whole thing is terrible, unbearable. I sometimes think it would be better if I were to die.”

This train of thought is familiar and it is not easy to find a chink in it. However, this is nevertheless the duty of rehabilitation. This needs the *conviction of defiance*. As it is difficult to refute the bitter words: the conclusions drawn from them appear to be logically unassailable. Nevertheless, since in reality there are very few truly hopeless situations, it *is* possible to help in most cases. Not with lies and by painting a rosy picture of the future, but with a positive assessment and precise evaluation of the situation. The primary aim of the therapy is to change the negative self-definition into a positive one. This starting point can be followed by the development of capabilities and different forms of activity. The great possibilities inherent in celebration and play must be emphasised here.

The task is thus to bring the person to think differently: “It is true that I have become different from what I was. But as far as the essence is concerned, I am still what I was. The world may appear to be all mixed up now, but it hasn’t changed after all, I only feel that it has. But I didn’t see that earlier and I behaved childishly. So I have to face it and myself. That is the way it should be: I have to accept myself for what I am. I still have my friends, although there are some things we are no longer able to do the way we used to. My family still loves me the same way. That gives me a reason to face the big questions such as what I will do in the future, how I will live, whether I will be able to work and, if so, what.”

Quite often modification of the self-image is caused by a change in the *body-image*, especially in the case of persons who lose a part of

their body or an organ as a result of an accident or operation. It can even happen that fear of a change in the body-image and self-image sets a limit to an operation preceding successful rehabilitation, making the whole process impossible. Our example promised earlier is the case of Mr. Davis. He was a black man aged 55, the father of three children who were around twenty. He had a good relationship with his wife, but one day he was found to have cancer of the testes. His doctor recommended various therapies, but especially drew his attention to the surgical removal of the testes, which in his experience offered the best hopes of survival and in this case would probably bring complete recovery. But he also told his patient that he would become impotent as a consequence of the operation. However, his sexual relations with his wife were very important to Mr. Davis. His manhood was an integral part of his body-image and his self-image. The doctor insisted on the need for the operation in vain. "I'm not going to let any surgeon cut out my balls!" exclaimed Mr. Davis, and left the hospital. Without treatment he died six months later. (Example given by Earl E. Shelp)

When discussing the case of Mr. Davis, whom I never met personally, it would be difficult not to mention the legendary figure in the battle against cancer in Hungary, the psychiatrist *Enikő Papp*. She was a Transylvanian, a member of the profession, whose own cancer was diagnosed in the early eighties when she was still living at the foot of the Carpathians. She turned simultaneously against her own cancer and towards others suffering from the same disease. Due to the conditions in Romania at the time, she did not receive appropriate treatment for a long period either. When she moved to Hungary with her family and joined the Social Anti-Cancer Foundation for Man, for the Future as a volunteer, she only had a few months left. Before her death she published *The Nest of the Phoenix*, the analysis by a great European mind, then already very ill, of life and death, suffering, sickness and hope. It was a fitting farewell by a true intellectual.

Numerous other elements in the prevailing social values raise further difficulties. It is not only the aesthetic values that have influence, but also such categories as status which is determined by income, financial independence, the possibility and capability of creation, the

prestige of the occupation. All these factors strongly influence the individual's self-esteem and self-acceptance.

One of the fundamental aims of rehabilitation is to bring the person in need of rehabilitation - the client - to recognise and help him to build fundamental life values supporting a balanced and certainly not a destructive self-image. Recent literature on rehabilitation regards development of the inner life and internal resources as being particularly important, and stresses the exceptional significance of the attitude and life philosophy that makes the person capable of answering the most difficult questions and leads him to live what must be lived.

The success of rehabilitation depends to a great extent on the attitude of a person with a disability towards rehabilitation efforts. People react to the situation in many different ways: some people would like to adapt to their disability, accept it and try to live with it. They are full of hope. The behaviour of others is determined by their old lives and old experiences: they are incapable of adapting to their changed situation. They are constantly frustrated by their limited capabilities and narrower horizons, they regard their new situation as their own personal misfortune and are incapable of coming to terms with it; many people lose hope. In these cases, a strong self-centeredness and selfishness may also be typical and personality disorders can often be observed as well.

It is no wonder that this is so. Serious disability often places people in a seemingly impossible predicament. Not everyone, not all family members or relatives have answers, for example, when close relatives begin to talk about our now permanent invalidity the feeling of being entirely superfluous and that "death would be better!" If someone has closed their mind, has become apathetic and has no *motivation*, if they no longer expect anything of life or are no longer capable of fighting for it, then no matter how developed and expert rehabilitation may be, it stands no chance of succeeding. Marriages fall apart in an instant when trouble strikes. Couples often feel there were already abundant reason for separating, but they had been putting it off, perhaps out of habit. Now they just cannot carry on any longer. ("At least you could have broken your neck *properly* when you fell off that cart dead drunk! How will I be

able to nurse you and look after you, if you are as helpless as a baby?" - says the wife and has already brought another man into the house.)

How important continuous motivation is: a helping environment, constant enquiry, calling to account! The still recuperating, recently persons with disabilities need to feel that those around them expect them to make every effort to improve their condition. Family and friends can help by giving meaning to a disrupted life. There is also a danger: the limiting environment, the mother raising a young person with a disability, but becoming too sheltering, impeding and restricting the child, the repressive father or paternal, authoritarian specialists.

The change that frequently occurs in the attitude towards work is also a well-known phenomenon. If occupational rehabilitation is considered to be a valuable thing for restoring the individual's self-esteem, for productivity and earning an income, it may seem surprising upon first glance, when one encounters the fact reported in the international literature and also experienced by a small co-operative in Hungary employing workers with disabilities: after spending a certain period of time without work individuals with disabilities lose their affinity for work and it is then only with great difficulty that it can once again be made a part of their life. Nevertheless, all persons with disabilities, just like "normal" ones, feel the need to belong somewhere, for self-fulfillment, to do creative work, for a secure and stable life, to be appreciated. Self-acceptance often arises from the feeling that "I can do it myself" and the security this gives: "I don't need the help of others, I am capable of doing it alone".

## MECHANISMS OF EXCLUSION: STIGMA AND PREJUDICE

### *The stigma*

The situation of Hephaestus is perfect from the viewpoint of occupational rehabilitation: he makes incomparable creations that are used by the gods and people come from far and wide to admire them. Despite this, he is different from his fellows. Reading the stories about him, we cannot fail to notice that he is very different from the other gods, not only in his external appearance but also in his inner qualities.

His disability is stamped on him: he is stigmatised. Ever since the time of the ancient Greeks, the word *stigma* has been used in various senses - sign, mark, stamp, distinguishing sign (a Catholic may even speak of "receiving the stigmata"). In 1963 Erving Goffmann introduced a definition which serves very effectively as an explanation for the theory of rehabilitation and is highly instructive: it characterises a human life situation which is for the most part undesirable and which is often definitely discrediting in the eyes of others. There are three different types of stigma: physical disabilities; distortions and shortcomings of character; and racial, national and religious identity. It is worth paying close attention here to the characteristics of the first type, although it is of considerable interest to point out the parallels that can be drawn with the other two and especially with the third type. This is because stigma and prejudice (see later) often go together. Prejudices against the stigmatised person develop and are reproduced relatively simply. It is characteristic that "normal" people generally do not regard the stigmatised person as being equal in value to themselves. They use terms in connection with him, without being aware of their meaning or origin - "sightless", "cripple", "idiot" - and in addition, in many cases the stigma is used as a name to identify a person with a disability.

Without hesitation, other forms of mental, sensory or other disability that also lead to the serious or even total disability already mentioned can be added to those physical disabilities mentioned by Goffmann. It is not only the clearly visible disabilities that can lead to a person becoming stigmatised. The second type clearly indicates this. Even if the situation of a person with cancer differs the average in that it is not clearly visible, the individual living with a disability becomes stigmatised for himself and others, assuming, of course, that the disability has been recognised. And since man lives in society, his reputation precedes him, the members of the community discuss him among themselves and whisper behind his back: "Look, here comes that ...". Thus, the essence of the stigma is not that it is visible, but that it is indelible: the individual wears it not reluctantly, like old clothes, but like his skin - he is unable to cast it off. The blind person can throw away one stigma, the white cane, but this will place their life in danger. The slave

or draught animal marked, branded bears the sign burnt into their skin till the end of life, just like the prisoners freed from the *scandal of humanity*, the immeasurable sufferings of Auschwitz, Mauthausen and Dachau.

Hephaestus says that his beautiful wife deceived him with the god of war *because* his rival is handsome, while he - in his own words - is a cripple. Stigmatised persons often draw advantage from their stigma, using it to justify their lack of success and failures. As Goffman put it, the stigma is a “hook” on which the bearer can “hang” their shortcomings, failures and dissatisfactions and so escape from them.

Strangers often consider that the stigmatised person with a disability can be approached at their will, that they can take liberties provided they show sympathy for the stigmatised and others in a similar situation: “My mother has the same prosthesis too, so I think I know all about your difficulties”; “Tell me, how can you go to bed with your prosthesis?”

It is of fundamental importance from the viewpoint of management psychology, management science and the psychology of work that a person with a stigma be accepted, received and integrated into the workplace community. It is worth considering the social psychology syndromes of vocational rehabilitation and community syndromes, drawing on the basic study of Nathanson and Lambert.

*“You are marked!” (The practice of labeling.)* Labeling people with disabilities and using said label to refer to them is widespread in business and enterprise communities. Workers using wheelchairs are referred to simply as “the man in the wheelchair”, while those with other physical disabilities are called “invalids” or “cripples”. Others are called simply “the dumb man”, “the deaf man”, “the blind man”, and so on.

*“I feel sorry for you!”* Pity is perhaps the most frequently expressed feeling towards individuals with disabilities. The person with a disability is made to appear the hopeless victim of a tragic misfortune. This is dangerous because it represses possible helping reactions and masks the problems of a colleague with a disability. (It is the person who feels pity who becomes important, not the other.) “A tragedy! How

terrible, I can't imagine how you can live like this, my dear! In your place I wouldn't be able to bear it!"

*"Don't be afraid, I'll protect you!"* This is typical bad help. The wings spread out by the "big friend" paternally (or "maternally" - think of the archetype, power-obsessed Big Nurse in *One Flew Over The Cuckoo's Nest*) have the effect of reducing self-confidence and increasing dependency. Helen Keller supplements this kind of attitude with experience taken from her own life: "Nor do I like those who try to descend with their speech to my ability to understand. They are like those people who try to take shorter steps when out walking to adapt to you: the hypocrisy is outrageous in both cases." But the example she mentions does not quite cover the essence: authoritarian behaviour manifested towards a person with a disability. This can be observed on the part of both family and experts.

*"You cause us too many problems!"* Rejection based on this argument generally occurs if there is nothing to protect an individual with a disability applying for a job. Its basis is generally that all decisions affecting him too "fully take into account the interests" of a person with a disability. But nevertheless behind it lies the admitted or unspoken fear of the employer that workers with disabilities will "impose themselves" on the firm and will demand too much help and the satisfaction of special personal needs. Such a situation is most often the consequence of ignorance or misinformation, as a result of which the workplace community greatly overestimates the costs of employing the worker with a disability and tends to leave the benefits out of account.

*"If I'm lucky, we won't meet again!"* Disdain and contempt are often found behind this kind of reception: "I can't work together with him. I simply can't stand the sight of his misfortune! He's a very nice and a good worker, but it depresses me to see him. I would prefer to see him transferred somewhere else."

*"Oh, if only you knew how your strength of mind impresses me!"* This is the expression of exaggerated recognition. Also: "It's amazing! What obstacles you overcome! You're simply fantastic!"

“Well, who’s more concerned, you or me?” A frequent type of relationship to a person with a disability is marked by exaggerated caution and infinite concern.

*...and prejudiced behaviour*

Our examples also suggest that *the community attitude to disability is one of the central problems of rehabilitation*. For example, the unfounded fears arising from prejudice, concerning persons with psychosocial disabilities (Will they attack? Are they really dangerous? Can they be trusted?) differ from the fears associated with other disabilities. In themselves, these observations indicate that the existence of a hierarchical scale of preferences regarding groups of individuals with disabilities is not out of the question. The Social Distance Scale devised by E.S. Bogardus in the twenties was often used in examining attitudes. For example, the prejudices of white and black students toward each other and other ethnic groups were measured at two universities in Georgia 50 years ago by Allport. In 1966 Yuker, Block and Young used the Bogardus scale to develop techniques and instruments for the study of community attitudes toward disability. The first step in the investigation was to devise the Attitude Toward Disabled Persons scale (ATDP). The scale used for the investigation ranged between the two extreme values of 1 (“I would marry him/her”) to 9 (“I would have him/her destroyed”). The initial value given for the scale was undoubtedly an ideal choice since it is marriages between individuals with disabilities and non-disabled that give the most characteristic upper indexes of integration. Between the two extreme values, there were others such as: “I would accept him/her as my neighbour” (3), or “He/she would make a good colleague” (5). The criteria at the end of the list were also well chosen: “I would shut them up in an institute” (7); “I would exclude them from my country” (8). It is precisely such typical reactions we have observed in our exploration of the historical sources of prejudice! The subjects were then asked to match these categories with 21 groups of disability, such as alcoholics, amputees, asthmatics, epileptics, cancer sufferers, the blind, etc.

One interesting conclusion reached by the various investigations conducted on the basis of the scale among students and teachers at Connecticut University in the late sixties and early seventies was that they showed which groups are most dispreferred in public opinion. In order these were - largely the same for men and women – people with psychosocial difficulties, alcoholics, and persons with a prison record. It was also found that women are slightly more accepting of individuals with disabilities than men. It was also confirmed that this kind of prejudice and social distance declines as the level of schooling rises. J.E. Jordan and colleagues published a study on prejudices against individuals with physical disabilities in 11 countries. Another survey conducted in the United States in 1971 showed that in the case of people belonging to a group where a good appearance is less important from the occupational viewpoint (e.g. typists), and among stewardesses for whom it is of outstanding importance, there is a significant difference in the intensity of prejudices toward people with a physical disability. The former were considerably less prejudiced than the latter.

Similar investigations were made in Hungary in the eighties to explore the adjustment problems of children with disabilities. One of the most recent studies was directed at adults and aimed to reconstruct the disability image held by non-disabled persons and their attitude toward individuals with disabilities.

Certain jokes illustrate the stigmatising reactions. American researchers analysed 7000 jokes and found that slightly more than 40% were based on mockery of physical deformities.

In the great majority of cases the negative discrimination against people in need of rehabilitation has a negative effect on the psychological state of a person with a disability and also unfavourably influences the process of rehabilitation. Such discrimination is equally harmful, whether it is the result of negative, rejecting behaviour on the part of the community, the employers or the non-disabled colleagues. Foreign experiences - for example in Sweden - show that even the handicap arising from a serious injury can be overcome if a person with a disability has a good motivation for work. The friendly and helpful co-operation of colleagues is an essential contributing factor in this case. Nevertheless, it

very frequently happens that even the most highly motivated persons with disabilities are unable to break through the *wall of prejudices*. We might easily think that such prejudices do not exist in reality on a wide scale, but only in the minds of isolated individuals who have lost their mental balance. In fact, in the case of epileptics, for example, it is precisely the prejudiced social attitude that is the most difficult obstacle in the path of successful rehabilitation.

The American, Nick Palermo, in exercising his profession lived for many years among children with disabilities. He summed up his experiences as follows: "In our society and culture physically handicapped children find themselves faced with an impenetrable wall, built by the ignorance and misconceptions of healthy children. Although what physically handicapped children need is to be able to experience human contact with their healthy fellows." We know from our everyday experience that these words apply just as well to European and Hungarian culture as they do to America.

The very apt example of *Irving Lee* (cited by Allport) also comes from America: "I once knew a blind man who had lost his sight in both eyes. They called him "Blind". They could just as well have called him an excellent typist, a diligent worker, a good student or unemployed. For he was unable to get a job in the customer service of a department store where the employees typed the orders received by phone. The personnel officer could hardly wait for the employment interview to end. "Look, you're blind," he kept saying and the man couldn't rid himself of the impression that the personnel officer thought if someone was injured from a certain point of view he could be regarded as unfit from all other points of view as well. In reality it was the personnel officer who was blind because, trusting in his label "blind" he was incapable of seeing the person behind it."

It can be seen that in the experience of many different countries there is not only racial discrimination on the manpower market but also discrimination that is independent of skin colour, arising from visible and invisible disabilities and is generally not at all justified as regards holding the given job. This was the case e.g., in the 80-ies in the Federal Republic of Germany and in France as well. An indication of the

situation in France in the recent past can be found in the report of the president of the national Cancer League; when his serious disease was discovered ten years ago he was unable to find a job for a long while.

A few typical cases that have occurred in Hungary can be cited to give an idea of the seriousness of the situation. Here too, an attitude of rejection is frequently found on the part of employers. In one case a firm refused to hire a person with a physical disability to work in an office in the Inner City with a large street-level window on the grounds of: "How would that person in the wheelchair look there in the window!" A pale young man with a heart disease who applied for a job as a telephone exchange operator was not hired either, perhaps because they feared that he would be absent from work a lot. In another case an individual with a disability was refused employment on the pretext that the workplace community would not accept him anyway. Elsewhere, also in Hungary in the recent past, an employee refused point blank to work together with a colleague with a disability who had just been hired. A young girl with a physical disability, with a university degree recounts how, after graduating from secondary school it was only through connections that she managed to get a job as a semi-skilled labourer and has since been unemployed a number of times.

For decades it has been the practice once a person has been diagnosed as having cancer, in the great majority of cases to have them declared disabled and sent into retirement on a disability pension. This too has fostered the development of negative prejudices towards such people. A man with a physical disability applied by phone for a sedentary job advertised in the paper. His application was warmly welcomed and he was asked to come into the office as soon as possible. When he arrived and they saw that he was person living with a disability, he was not given the job.

Another example: an economic unit employing persons with disabilities for various reasons, most of them receiving disability allowances, found premises in the Inner City with very good access and a great location. However, a high-ranking official, the deputy chairman of the City Council at that time, allocated them a place at the edge of the city with very poor public transport. ("How would it look to have all

those disabled people in the centre of the city?” he asked the organisers in a tone of sincere surprise.) It is a fact that the limited transport and livelihood opportunities and the great mass of prejudices force many people with disabilities to leave the city and move to country towns or isolated settlements. This is understandable since all the examples cited are quite clearly negative prejudices. (Of course, numerous interpretations of prejudices can also be found. For example, according to Gadamer the notion of prejudice originally did not in itself have a negative emphasis. It did not mean “false judgement” but something that could be considered equally as positive or negative. Beyond that, prejudices are the conditions of understanding. From this point of view, it is of significance to make a distinction between true prejudices helping understanding and false prejudices that lead to misunderstanding.)

In his deservedly famous work, Gordon W. Allport shows prejudiced behaviour through the examples of two main types of prejudice, the ethnic, for example against whites or blacks, and the religious, concerning Christians, Jews and Mormons. In places he presents other examples too, such as those of a political nature, for instance, prejudices against the “Reds”. But his findings can also be put to good use to interpret prejudice against individuals with disabilities. At the same time, ethnic prejudice usually has a negative emotional colouring. There is a difference between prejudice based on a simple mistake, and real prejudice because information brought to light is incapable of changing the latter. In this way the real prejudice existing against persons with disabilities “may remain at the level of emotions, but it may also be expressed in behaviour. It may be directed at the whole of a group or at a single individual, on the grounds that the person is a member of the group concerned.” This means that prejudice is not always translated into action, but even so, repressed prejudice is still prejudice. Any striking manifestation of prejudice against persons with disabilities or in the economy against persons with a work disability is discrimination. Discrimination might be classified into six types. Namely: psychological discouragement, when the employer is reluctant to receive the applicant with a work disability; statistical discrimination, when the employer refers to the empirical data of earlier statistical surveys in

refusing to employ them; excessive demands; plain discrimination (cf. point 3 below!); discrimination justified by social policy (“they have income from other sources, they are not in real need of a job”); and discrimination originating from employees, a type which is essentially equivalent to the type described by Nathanson and Lambert under the formula “If I’m lucky..” already mentioned here earlier.

Both everyday life and history provide examples of all the degrees of prejudiced attitudes toward individuals with disabilities.

1. *Verbal prejudice*: the form expressed in speech, mainly among acquaintances, is a relatively mild degree.

2. In the case of *avoidance*, the prejudiced person does not come into contact with the persons concerned, even if it causes him inconvenience.

3. *Negative discrimination*: this is an active, serious form if the persons affected by prejudice are excluded from employment, settlement or the exercise of political rights. It was largely against this kind of seriously prejudiced attitude that the “independent living” movements of individuals with disabilities and cancer sufferers and the anti-cancer leagues were launched.

4. *Use of physical violence* (pogroms).

5. *Destruction*.

The practice of labeling already mentioned in connection with stigmas and community syndromes is also a form of prejudice. There are mild and strong labels and others that are of overwhelming force. For example, the “blind” label already cited, or others referring to striking disabilities, such as “mentally handicapped” or “crippled”. It is an important feature of our thinking that if we hear several characteristic things about someone or something we retain the strongest and the others fade. Allport illustrates the labels of overwhelming force with the example of the humane, Chinese, sportsman, doctor. According to the author’s hypothesis, it is highly likely that of these traits only one will impress us with overwhelming force: “Chinese”. Other such labels, from the many, are “fascist”, “negro” and “blind”.

The approach used consistently in this book of always speaking of a person with a disability is backed by the observation of the famous

anthropologist, *Margaret Mead*. She pointed out that labels of overwhelming force are weakened if they are transformed from a noun into an adjective, from subject to descriptor. And if we were to use them this way in everyday life, we would ease the burdens of the modern Hephaestuses.