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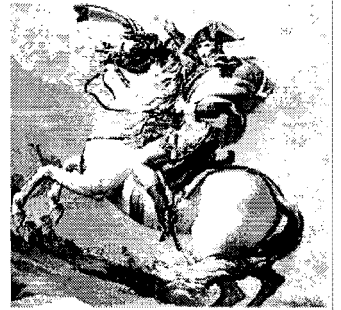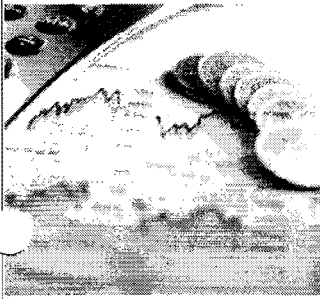
European Journal of Social Sciences is an international peer-reviewed academic research journal, which has a particular interest in policy-relevant questions and interdisciplinary approaches. The journal serves as a forum for review, reflection and discussion informed by the results of recent and ongoing research. It adopts a broad-ranging view of social studies, charting new questions and new research, and mapping the transformation of socia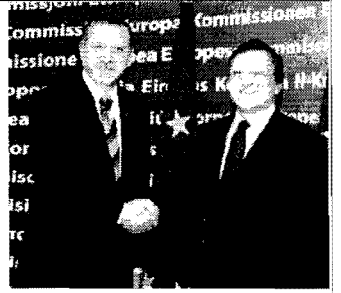l studies in the years to come. The principal purpose of European Journal of Social Sciences is to publish scholarly work in the social sciences defined in the classical sense, that is in the social sciences, the humanities, and the natural sciences. The research that is published may take a theoretical or speculative model as well as statistical and mathematical. Contributions are welcome from all fields which have relevant and insightful comments to make about the social sciences.

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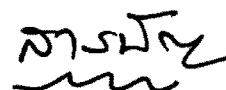
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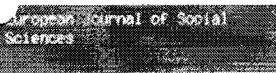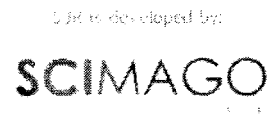
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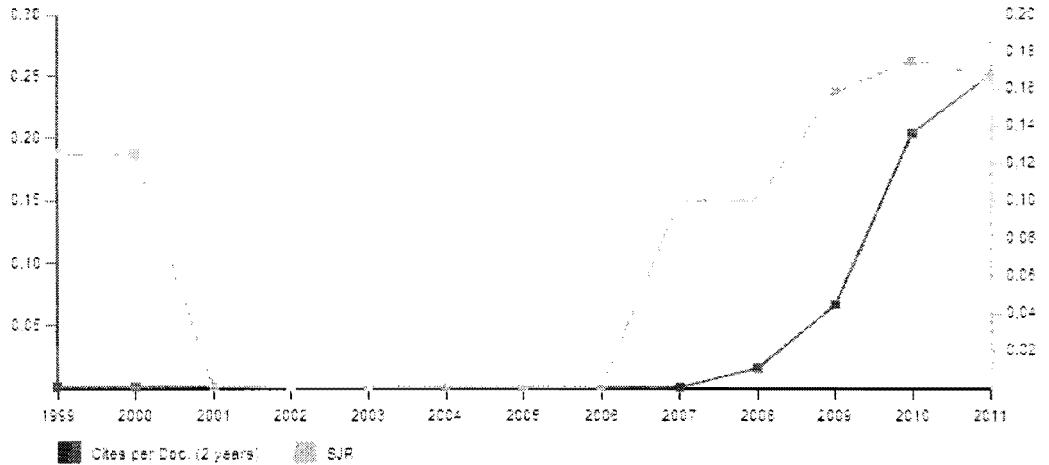
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Citation vs. Self-Citation

Physically Disabled Women and Social Acceptance in Non-Disabled Community: Evidence from Rural Thailand

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Abstract
This article, which is drawn from face-to-face interviews, explores the causes hampering physically disabled women's social involvement in community. Findings from in-depth interviews with 20 physically disabled women in northeastern Thailand indicated that their social acceptance was hampered by over worries from family, false impression of women with disabilities from non-disabled people. Despite demonstrating their ability to cope with daily life, physically disabled women are still socially excluded from wider community because non-disabled community still considers physically them completely disabled and family dependent. The author concludes that to ensure high level of social involvement, physically disabled women must be given complete access to community activities. Without social acceptance, social-economic inclusion effectiveness and disabled women's empowerment cannot be realized in practice.

Keywords: Disabled Women, Social Acceptance, Social Sector, SE Asia

1. Introduction
Women with disabilities are one of the most marginalized groups in the development process at every level. A country needs to include everyone in each development process from community to national level, i.e. political development, social development and economic development. Unjust discrimination against a person on the ground of disability shall not be permitted. However, in the developing and least-developed countries, non-disabled community ignores a person with disabilities as a contributing factor. This article, therefore, attempts to investigate the causes hampering physically disabled women's social space negotiation in rural Thailand.

The ultimate goal of social involvement is to improve their social status and bring them back to development. The key factors governing the development process are the people in the country. From mainstream development perspectives, people with disabilities have, therefore, been in the spotlight recently because disability severely hampers the process of economic development. However, most societies in developing and least-developed countries consider people with impairments burdensome because they believe that those people are economically non-productive. People with disabilities are reported to be three times more likely to be socially excluded and remain in unemployment much longer than non-disabled people (Barnes, 1991).

Disabled people have become widely spotlighted since the inception of The United Nations Decade of Disabled Persons from 1983 to 1992. The key explanation of disability throughout the centuries has revealed that disabled people are socially excluded, alienated and disadvantaged. Ash and Fine (1988) summarize a set of common assumptions about disability, pointing out that disability is

located solely in biology; when disabled people face problems, it is because of their impairments; they are always social victims; they need social help. It can be argued that disabled people become disabled because of social attitudes and definitions.

As authorized to define disability, the World Health Organization (WHO) defines that Disability, in the context of health experience, refers to any restriction or lack of ability to perform activity within the normal life of a human being (WHO, 1980). According to the WHO definition, disability was established by WHO speaking on behalf of disabled people. The focal point of the WHO definition considers the health contexts. Many WHO member countries including Thailand have adopted this definition and promulgated health laws to rehabilitate people with disabilities. Legal provision legitimately puts disabled people into medication.

Under the explanation offered by the medical approach, disability is linked to sickness. The sickness role of disability, as perceived by non-disabled people, is synonymous with impairments. The sickness role is ascribed to those whose health conditions are unlikely to change or difficult to ameliorate, but which are liable to cause dependency.

Sickness-framed conceptions have socially stigmatized disabled people. The medical context of disability is a signpost to unequal power relationships because it has resulted in disabled people being subject to the dictates of physicians and medical staff. A stigma is associated with the negative definition of disability and bodily dysfunction, and as such, has always been identified with a wide range of social biases, stereotypes, inferiority, and dependency. It can be argued that medical explanations can lead to false impressions of disability.

Finkelstein (1980), Oliver (1990), Whyte and Instad (1995) contend that studies of disability require a paradigm shift away from the clinical approach towards social approach. They assert that a disability study must be seen in the context of ordinary social interaction. Their arguments illustrate that people with disabilities require social contexts within their lives. Letcher and Perlow (2009) suggest that the involvement experienced through comprehensive community participation can promote better health among disabled persons. Social involvement confirms that disabled people who receive meaningful social acceptance live longer, become sick less often, and recover more quickly (Oliver, 1990; Barnes, 1991; Ralph & Usher, 1995; Tilley, 1998; Edmonds, 2000; Ville, Crost, Ravaud & Group, 2003; Sheldon, 2004).

With sufficient support from a non-disabled community, disabled women can perform their everyday communal activities more independently because, according to Zakus and Lysack (1998), they will be capable enough to: (a) assess their own health needs and problems, (b) implement the necessary solutions by themselves, and (c) be a contributing factor in a community.

High level of social acceptance opens up opportunities for disabled people to fully involve themselves in community activities. From the view point of the individual, social acceptance is applied to lessen feelings of alienation toward mainstream society. Such involvement will encourage people to express their concerns and make them feel socially associated and affiliated. Furthermore, it establishes trust (Berkman & Kawachi, 2009). It infers that only medical rehabilitation is barely enough to fulfill self-esteem of women with physical disabilities. Without social acceptance, these women are less worthy of attention. As such, this article attempts to investigate the main reasons why physically disabled women are considered too frail to participate in community activities. This article also aims to be a contributory cause in promoting the representation of women with physical disabilities in community.

2. Body Interpretation and Community

Moser (1989) suggests that low involvement in community-based activities impoverishes rural women generally and rural women with physical disabilities particularly. Several studies of physically disabled women found that their bodily impairment had negatively influenced their participation in their communities (Thomas, 1999; Anderson & Kitchin, 2000; Orme, 2001; Mays, 2006; Crooks, Chouinard

& Wilton, 2008; Bualar, 2009; Nixon, 2009). Body and society are inextricably interwoven because people pay attention to physical appearance and facial expressions in daily life. Goffman (1979) reveals two aspects of the body: first, the relationship between physical appearance and personal communication in society and second, the relationship between physical appearance and daily life.

The body is socially involved with society's structures, norms, folklore, and attitudes (Butler, 1993). As such, bodily definitions and value are not judged solely by the owner of that body, but also by other people in the community (Turner, 1996). The human body is best regarded as a potentiality in everyday life and social activities. Following this argument, the perceived body, as a set of social practices, is derived from the perspective of symbolic interactionism. The body plays an active role in social contexts and it can be best argued that an individual's body is trained, constructed, and socialized by the culture of its given society (Nosek, Young & Rintala, 1995; Sobsey & Doe, 1991; Thomas, 1999; Hughes, 2009; Naemiratch & Manderson, 2009).

Mainstream communities expect beauty and bodily completeness from women. Non-disabled people have stereotyped disability and continue to have a strong sense of denial toward persons who present deviant signs and symbols. Shakespeare (1994) argued that the non-disabled community has branded disability as negative and this has resulted in social prejudice against disabled people. In terms of women with physical disabilities, non-disabled people often take pity on their bodily deformities because they are accustomed to bodily completeness.

Physically disabled women are categorized as social deviants and they will be judged by the notion of culturally imposed normalcy (Morris, 2004; DePoy & Gilson, 2004; Mays, 2006; Hughes, 2007). Thus, it becomes evident that mainstream society has influenced the level of social acceptance of women living with disabilities.

Many scholars and academics have conducted research on people with disabilities; however, very few have been interested in the relationship between disability and social acceptance. Additionally, it should be strongly emphasized that the greater part of professional literature concerning disabled women has failed to address the situation of women living with physical disabilities in rural areas of developing countries.

3. Local Disability Context in Thailand

Although included among those with sensory impairments and learning disorders, mental dysfunction, or intellectual impairments, women with physical disabilities are more marginalized even though they are capable of participating in community activities and, subsequently, are usually excluded from the non-disabled community (Asch & Fine, 1988). In terms of bodily movement, women living with sensory impairments are able to move more independently than physically disabled women. Interestingly, when it comes to community participation, persons with learning disorders, i.e., mental dysfunction and intellectual impairments have usually focused themselves inwardly and pay less attention to non-disabled community activities. This article therefore casts light on women with physical disabilities.

According to the National Survey of people with disabilities in 2009, the total number of registered disabled people was 864,437 out of 62,871,000 non-disabled people (Office of Disability Empowerment, 2009). Out of 864,437, there were 357,309 women having physical disabilities, the highest classification of disability among disabled women population. In Thailand, disability rights are enshrined in the 2007 Constitution. For example, Section 54 states that:

> "Disabled or handicapped people shall have the right to receive access to public
> amenities and other aids from the state provided by the law.

Furthermore, there are a lot of other laws and regulations ensuring disabled people's rights such as The Rehabilitation and Empowerment of Disabled Persons Act, 2007, ministerial regulations on employment opportunities for disabled people, public accessibility for people with disabilities, and vocational training schemes. The government also provides the disability provident fund. Each

disabled recipient would receive 500THB per month (17 USD, approximately). The above-mentioned sections in the 2007 Constitution and Laws and Regulations are quintessential examples of Disabled Persons' Rights Protection. But the laws shed light on health protection rather than social protection. The government programs delivered to disabled people have become a medical model which obviously refers to sickness and needs medical intervention.

Apart from the medical model, the context of disability in Thailand is also inextricably linked to religious beliefs. A large majority of Thai people believe in Buddhism. The influences of Buddhism on disability in Thailand are profound because religious beliefs affect the everyday actions of people. According to Buddhism, disability and impairments result from 'negative karma' (negative actions from past behavior). Physical disabilities are good examples of negative karma. Buddhists strongly believe that a perfect body comes from 'positive actions'. A perfect body, therefore, suggests physical health and a sense of completeness. In contrast, disability suggests negative alternatives. These religious beliefs are deeply embedded in people's mindsets. In north-eastern Thailand, rural people strongly believe that negative karma is the actual cause of disability (Sethabuppha & Kane, 2005).

4. Methodology

Based on field research, this article examines the relationship between women with physical disabilities and their non-disabled communities. Semi-structured, in-depth interviews were conducted from November, 2008 to January, 2009 in northeastern Thailand. Since disability research in rural northeastern Thailand is unexplored territory, data and information concerning physically disabled women are scarce and rarely recorded. Therefore, the first phase of data collection was a reconnaissance survey of physically disabled women to obtain fundamental information about them, their families, and their local communities. Interview checklists were pre-tested by ten disabled women. In addition, disability experts in Thailand were asked to review the checklists. After pre-testing, minor changes were made to correspond with the test results. The complete checklist was designed to examine physically disabled women's feelings toward their families and investigate the stereotypical ideas of non-disabled people in their communities.

In order to prevent bias from women with physical disabilities, I used triangulation method by gathering information from different sources to compare information from disabled. I also introduced the key informant interview method to collect data and gather results to compare with those from physically disabled participants. Key informants from the non-disabled community were purposively selected for focus group interviews aiming to investigate their perceptions toward women with physical disabilities in their communities. They are government agents who are authorized to provide advice to local people. They know well the situation of those in their areas and their livelihoods. These people have real power to facilitate public participation. The key informants included two local politicians, two local government officials from each Sub-district Administrative Organization, two Village Headmen from each sub-district, and disabled family caregivers.

4.1. The Selection of Physically Disabled Participants

The disability phenomenon in poverty-stricken rural areas is significantly interwoven with poverty. However, very few researchers have shed light on the problem. Hence, this study focused on the poorest areas. The research was conducted in northeastern Thailand–the poorest area of the country. The poorest sub-districts of the provinces of Nakonratchasima and Kon Kaen were purposively selected.

Criteria for the selection of disabled participants included those (1) between the ages of 18 and 60, (2) women with physical disabilities which affected normal life activities, (3) not having any intellectual impairment or mental disorder, and (4) able to communicate verbally. The reason why 18 to 60 year-old interviewees were chosen is that they are legally allowed to answer questions, give comments, and participate in any social activity without parental guidance.

The names of physically disabled women were provided by the Office of Social Development and Human Security from Nakonratchasima and Kon Kaen. According to the criteria, forty women with physical disabilities were recruited. Then, the Human Security Official and I contacted the women and explained the objectives of the research to them. Eventually, only twenty physically disabled women agreed to participate.

4.2. Data and Information Collection

The selected participants in this study speak a northeastern Thai dialect. In order to avoid miscommunication, I employed four local field assistants. We used a semi-structured checklist with face-to-face interviews to collect data and information. In order to protect the privacy of the participants, they were given fictitious names and their bio-data remained anonymous. After the interviews, I grouped the responses by statement. All quotations were taken from these interviews. The interviews took place at the subjects' homes and lasted for approximately two hours. Each interview was tape-recorded and then transcribed verbatim.

4.3. The Participants

Of the 20 participants, three women were 20 to 30 years old, ten were between 31 and 40 years of age, five were between 41 and 50 years old, and two were between 51 and 60 years of age.

Common disability types included loss of limbs (10 persons), followed by post-polio conditions (6), and half-paralysis and joint defects (2 each). Twelve had become physically disabled as a result of accidents. Four were born disabled, and another four were disabled because of illness. More than half of the participants had had their physical disabilities from five to 10 years (14), four for 11 to 20 years, and two for more than 20 years. Most of participants were single (16), while the rest were married or widowed (2 each). Only four of the individuals had children.

No participants were highly educated, though more than half had received a primary education certificate (18 persons), and while two had achieved a secondary education certificate. In terms of dependence, three were dependent on their parents, fifteen on their relatives, and two on their husbands, sons, or daughters. Their employment opportunities were very limited. Most of them were unemployed (15). Three raised poultry, while two did knitting and sewing.

5. Results

After grouping the responses, I began with the over worries by the family, followed by the thoughts of the non-disabled community about women with physical disabilities.

5.1. Over Worries by the Family

It is clear that these women rarely feel good when they are left behind. Findings indicate that family members usually keep them at home during the day. Their family members use *'womanhood'* and *'impairment'* as their excuses for not allowing the women to participate in the wider community. Over-protective family members deter disabled women from participating in community life because they hypothesize that the women are vulnerable to health complications and exploitation if they are away from their families. Family members, however, have no time to pay attention to them because they must be out at work from dawn to dusk. During the daytime, disabled women stay at home feeling lonely. For instance, Jennifer, a 30-year-old woman, said:

> *'My younger sister, who takes care of me, says that community-based activities are not worthwhile because such activities are for non-disabled people and the activities can cause more health complications. She says that home is best.'*

However, when I did an in-depth interview with one of the family members of these women, the person explained that the intention was not to make these women feel lonely. More income must be

earned to pay for medical bills for their disabled daughters, if necessary. One mother who takes care of her 25-year-old disabled daughter reported that:

> *'My husband and I do our best to support her emotionally and personally. We are not rich enough to cover her medical bills, so we work harder on our farm. In the morning, I prepare her three meals and everything she needs. When we come back at dusk, she likes to talk with us before her bed time.'*

This indicates that family members are trying to over-protect their disabled relatives and keep them at home. After listening to their disabled daughter during in-depth interview, I heard a different answer. Their daughter said:

> *'I understand that my parents have got to work harder. I feel ashamed of this since I have become a poor amputee. While they are working in the field, I am doing nothing in the house. I do not want to be in the house alone every day. The house is deadly quiet during the daytime. I want to go out with them, but they always refuse my request.'*

The answers from her parents and herself indicate that she is unintentionally over-protected by her parents. Her parents intend to keep her in a safe place like home. However, good intentions sometimes do not yield good results because, in this case, their daughter feels lonely.

Community-based activities held far away from home usually cost money. Family members who take these women to community-based activities lose their chance to earn a wage that day. Even if some women with physical disabilities are mobile enough to take part in community-based activities alone, their family members would have to cover the cost of participation, such as travelling costs, the possibility of health complications, or any another unwanted situation.

5.2. Women with Physical Disabilities and False Impression from non-Disabled Community

The more people with disabilities confine themselves to home, the more they are excluded from the community. If non-disabled people in a community rarely see physically disabled women, they will fail to include them in mainstream society (Priestley, 2004; Pescosolido, 2001).

Apart from health, women with physical disabilities have encountered inaccessible buildings. Most community-based activities usually take place in either temples or government buildings. However, the structures of these buildings are not designed to allow easy entry to people with disabilities. The main hall of the temple where people have meetings is elevated and the staircases are steep. Government buildings are not designed to welcome disabled people, either. Climbing steps requires strength from women with physical disabilities. Furthermore, there are no disabled-friendly toilets, no ramps for wheelchairs, and no facilities to promote their participation. Hilda, 41 years old, gave her response to this problem.

> *'If any meeting takes place at the temple, I have no way to join them. The steps are high and climbing them requires strength. More importantly, toilets are downstairs and I have to negotiate steps up and down if I need them.'*

Her response shows that non-disabled people do not understand disability. One of the misunderstandings results in disabled-unfriendly physical settings which can discourage women with physical disabilities from joining the wider community. Indeed, some physically disabled women are capable enough for some participation, but false impressions from non-disabled people in their community make them feel anxious and upset (Swain, French & Cameron, 2003). Apart from non-disabled people in the community, local politicians, local government officials, and village headmen do not understand women with physical disabilities, either. After asking key informants, I discovered that they had stereotyped physically disabled women.

Local politicians who provide an allowance to disabled people in their jurisdiction said that these women looked frail and impaired. One local politician said to me:

> *'I do not feel comfortable when she comes to my office. I feel more comfortable talking to her non-disabled family members.'*

This response from a local politician indicates that physically disabled women are seen in a negative light. Their negative perceptions have a major impact on social involvement among disabled women.

6. Discussion

Findings reveal that false impressions of disability, stereotypical views of physically disabled women, and an unfriendly environment are the major factors discouraging the women from joining community activities. These three factors have also influenced the perception of non-disabled people toward women with physical disabilities. Non-disabled people always assume that these women are the family's responsibility and they need special care at home.

Many parents, family members, and non-disabled people do not understand why wider community involvement is significant for physically disabled women (Bualar 2009). The women, themselves, may know only about disability allowances and medical rehabilitation, but may not be aware that there are other activities involving their communities. False impressions of disability influenced by medical explanations, cultural context, and religious beliefs go a long way toward explaining why women with physical disabilities are not included in public activities in their wider communities. However, the main reason why women with physical disabilities are excluded from their communities is because of non-disabled people viewing them with excessive pity (Huges, 2007; Naemiratch & Manderson, 2009; Nixon, 2009).

These findings are strongly supported by theories of erroneous impressions of women with physical disabilities as noted, for example, in the descriptions from Oliver (1990), Morris (1991), Barton (1996), and Shakespeare (1996). Social expectations of physically disabled women have influenced the attitudes of family members toward these women. Family ignorance is the most deleterious situation because physically disabled women need affection from their families.

Riewpaiboon, Riewpaiboon, Ponsoongnern and Van den Berg (2009) conducted research on disability care given in northeastern Thailand. They found that disabled persons received home-based care and that the caregivers were their non-disabled family members. Findings showed that family members had been held accountable for medical bills. Family members did not feel comfortable when dealing with the costs of medication of disabled members. Permission to socialize away from the family is seldom granted because family caregivers fear that their disabled relatives may accidentally suffer injuries which could result in expensive medical bills.

Permission to let the women be away from their families is, therefore, seldom granted. Women with physical disabilities have to rely on family financial support. The families of these women, however, have limitations–for example, they have to be very careful with the household income and cut back on household expenditures. Therefore, physically disabled women tend to reduce their involvement in the community if such activities consume financial resources (McFarlane, 1994; Morris, 2004; Pagan, 2009; Taub, Mclorg & Bartnick, 2009). Perceiving that women with physical disabilities are economically burdensome, families refuse to let them join community-based activities regularly as this could result in heavy financial outlays (DePoy & Gilson, 2004).

In terms of facilities, local government officials do not provide a great deal of support for women with physical disabilities during meetings. Lack of staff and lack of budget are their excuses for the paucity of facilities for these disabled women. Local government officials fail to draw the attention of physically disabled women to persuade them to join community-based activities. In addition, local government officials tend to greatly assist these women. Doing so much for women with physical disabilities may yield negative effects because non-disabled officials will misinterpret their needs. The best thing, from the perspective of local government officials, may not be viewed equally as good in the mindset of a disabled woman. Because of poor facilities, women with physical disabilities may ignore wider community participation (Mackelprang, 1993; Gleeson, 1999; Reinders, 2000; Davis, 2002; Krieger, 2003;).

The medical context, too, has conditioned them to be obedient. Physically disabled women fall into the trap of the sickness-frame explanation. The strong influence of the medical model has obscured the disabled woman's image in the public space and formed a doctor-patient relationship rather than a social relationship (Begum, 1992; Lloyd, 1992; Charles, 2000; Parker, 2003). The social space of these women has become narrower as they have become objects of home care. The findings confirm the conclusions of other researchers pointing out that women with physical disabilities have to combat social stress. Although social involvement is designed to promote social inclusion for everyone in community, the participation of physically disabled women is construed as lacking and impaired. The atypical appearance of these women maps out the places where they belong and where they do not. As these women have received no recognition of sameness in their community, their involvement in community activities is diminished (Shakespeare, 1996).

In order to step outside a false impression, a stereotypical idea, and an unfriendly environment, raising disability awareness is essential. Promoting physically disabled women's representation in their communities can create a more inclusive society. Comprehensive cooperation between non-disabled people and women with physical disabilities is required. When the non-disabled community fully understands disability and the individual capacities of these women, disability awareness will increase dramatically. Increased comprehensive cooperation will create a more inclusive society, enabling a better environment and truer social acceptance.

7. Conclusion

The findings in this article demonstrate that the non-disabled community strongly believes that women with physical disabilities need the special protection provided by family members. This set of beliefs influences the social acceptance of physically disabled women as family members and non-disabled people will deter these women from exposure to the wider community because they unintentionally impose overprotection on them.

Protections are necessary for physically disabled women, but over worries have not empowered them as dignified persons in the community. Perceiving that they are beneficiaries of social assistance, women with physical disabilities feel inferior to non-disabled community members and will subsequently internalize anxiety, fear, and low self-esteem when in public.

The non-disabled community does not understand why community involvement is very important to women with physical disabilities. The one notion they do understand concerning disabled people is that they are the responsibility of the family, not of society; therefore, the family is the primary unit to accommodate these disabled women. Because of poverty, family members do not have the time to take care of them and they do not have enough money for possible medical bills. In practice, therefore, physically disabled women are left at home.

Family members, local politicians, local government officials, village headmen, local staff, and the non-disabled community as a whole unknowingly govern women with physical disabilities in an unfair way and prevent them from having opportunities to enjoy participatory community-based activities. Rules and regulations governing community participation are prioritized and finalized by non-disabled people, not physically disabled women, and make them feel alienated, causing a sense of *otherness* to develop in the public sphere.

To ensure their high levels of involvement in the community, women with physical disabilities must be given complete access to community participation, beginning at the decision-making stage. Without high levels of involvement in the community by these women, positive outcomes, such as social inclusion effectiveness and physically disabled women's empowerment cannot be realized in practice.

I assume that different disability types and different age groups of disabled women may provide different responses. I would therefore suggest that researchers should broaden their focus on inclusive education, employment, universal design in community and society when dealing with disabilities and

wider community participation. In order to make disability research findings more comprehensive, disability research objectives should really incorporate both qualitative and quantitative methodologies.

References

[1] Anderson, P. & Kitchin, R. (2000). Disability, space and sexuality: access to family planning services. *Social Science & Medicine* 51(8): 1163-1173.

[2] Asch, A. & Fine, M. (1988). Disability beyond Stigma: Social Interaction, Discrimination and Activism. *Journal of Social Issues*, 44(1): 3-21.

[3] Barnes, C. (1991). *Disabled People in Britain: A case for anti-discrimination legislation for disabled people*. London: Hurst/BCODP.

[4] Barton, L. (1996). *Disability and Society: Emerging Issues and Insights*. London: Addison Wesley.

[5] Begum, N. (1992). Disabled Women and Feminist Agenda. *Feminist Review*, 44(2): 70-84.

[6] Berkman, L. & Kawachi, I. (2009). Social cohesion, social capital, and health. In *Social Epidemiology*, edited by Lisa Berman, and, Ichiro Kawachi, pp. 174 – 190, New York: Oxford University Press.

[7] Bualar, T. & Ahmad M. (2009). Why does Community-Based Rehabilitation fail physically disabled women in northern Thailand? *Development in Practice* 19(1): 28-38.

[8] Butler, J. (1993). *Bodies that matter: On the discursive limits of sex*. London: Routlege.

[9] Charles, N. (2000). *Feminism, the state and social policy*. Basingstoke: Macmillan.

[10] Crooks, V., Chouinard, V. & Wilton, R. (2008). Understanding, embracing, rejecting: Women's negotiations of disability constructions and categorizations after becoming chronically ill. *Social Science & Medicine* 67(11): 1837-1846.

[11] Davis, L. (2002). *Bending over backwards: Disability, Dismodernism & other difficult positions*. NY: New York University Press.

[12] DePoy, E. & Gilson, S. (2004). *Rethinking Disability: Principles for professionals and social change*. CA: Thompson Brooks Co.

[13] Edmonds, L. (2000). *Disabled People and Development*. Manila: ADB.

[14] Finkelstein, V. (1980). *Attitudes and Disabled People: issues for discussion*. Geneva: WHO.

[15] Fiske, S. & Glick, P. (1995). Ambivalence and Stereotypes Cause Sexual Harassment: A Theory with Implication for Organizational Change. *Journal of Social Issues* 51(1): 26-48.

[16] Gleeson, B. (1999). *Geographies of disability*. New York: Routledge.

[17] Goffman, E. (1979). *Gender Advertisement*. London: Macmillan.

[18] Hughes, B. (2007). Being disabled: towards a critical social ontology for disability studies. *Disability & Society* 22(7): 673-684.

[19] Hughes, B. (2009). Wounded/monstrous/abject: a critique of the disabled body in the sociological imaginary. *Disability & Society* 24(4): 399-410.

[20] Krieger, L. (2003). *Backlash against the ADA: Reinterpreting disability rights*. Ann Arbor: University of Michigan Press.

[21] Letcher, A. & Perlow, K. (2009). Community-Based Participatory Research Shows How a Community Initiative Creates Networks to Improve Well-being. *American Journal of Preventive Medicine* 37(6S1): 292 – 299.

[22] Lloyd, M. (1992). Does she boil eggs? Towards a feminist model of disability. *Disability, Handicap and Society* 7(3): 207-221.

[23] Mackelprang, R. (1993). A holistic social work approach to providing sexuality education and counseling for persons with severe disabilities. *Journal of Social work and Human Sexuality*, 8(2): 63-87.

[24] Mays, J. (2006). Feminist disability theory: Domestic violence against women with a disability. *Disability & Society* 21(2), 147-158.

[25] McFarlane, A. (1994). On becoming an older Disabled Women. *Disability and Society* 9(2): 255-256.

[26] Morris, J. (1991). *Pride against Prejudice: Transformation attitudes to Disability*. London: the Women's Press.

[27] Morris, J. (2004). Independent living and community care: a disempowering framework. *Disability & Society* 19(5): 427-442

[28] Moser, C. (1989). Gender Planning in the Third World: Meeting Practical and Strategies Gender Needs. *World Development, 17*(11): 1799-2825.

[29] Naemiratch, B. & Manderson, L. (2009). Pity and pragmatism: understandings of disability in northeast Thailand, *Disability & Society* 24(4): 475-488.

[30] Nixon, J. (2009). Exploring interaction between two distinct spheres of activism: Gender, disability and abuse. *Women's Studies International Forum* 32(2009): 142-149.

[31] Nosek, M., Young, M. & Rintala, D. (1995). Barriers to reproductive health maintenance among women with physical disabilities. *Journal of Women's Health* 4: 505-518.

[32] Office of Disability Empowerment (2009). *Annual Report of Disability Registration*. The Ministry of Social Development and Human Security, Royal Thai Government

[33] Oliver, M. (1990). *The Politics of Disablement*. London: McMillan.

[34] Orme, J. (2001). *Gender and community care: Social work and social care perspectives*. Basingstoke: Palgrave.

[35] Pagan, R. (2009). Self-employment among people with disabilities: evidence for Europe. *Disability & Society* 24(2): 217-229.

[36] Parker, J. (2003). *Social Theory: Basic tool kit*. London: Palgrave.

[37] Pescosolido, B. (2001). The Role of Social Networks in the Lives of Persons with Disabilities. In., *Handbook of Disability Studies*, edited by Cary L. Albrecht, pp.468-499, London: SAGE Publications.

[38] Priestley, M. (2004). Generating debates: why we need a life course approach to disability issues. In *Disabling Barriers – Enabling Environments*. 2nd Edition, edited by John Swain, pp.94-99, London: SAGE Publications,

[39] Ralph, A. & Usher, E. (1995). Social Interactions of Persons With Developmental Disabilities living independently in the Community. *Research in Developmental Disabilities* 16(3): 149 – 163.

[40] Reinders, H. (2000). *The future of the disabled in liberal society: An ethical analysis*. Notre Dame, IN: University of Notre Dame Press.

[41] Riewpaiboon, A., Riewpaiboon, W., Ponsoongnern, K. & Van den Berg, B. (2009). Economic valuation of informal care in Asia: A case study of care for disabled stroke survivors in Thailand. *Social Science & Medicine* 69(4): 648 – 653.

[42] Sethabouppha, H. & Kane, C. (2005). Caring for the Seriously Mentally Ill in Thailand: Buddhist Family Caregiving. *Archives of Psychiatric Nursing* 19(2): 44 – 57.

[43] Shakespeare, T. (1994). Cultural Representations of Disabled People: dustbin or disavowal. *Disability and Society*, 19(3): 283-300.

[44] Shakespeare, T. (1996). Power and Prejudice: Issues of gender, sexuality and disability. In. *Disability and Society: Emerging Issues and Insights*, edited by Len Barton, pp. 97-150, London: Addison-Wesley.

[45] Sheldon, A. (2004). Women and Disability. In. *Disabling Barriers – enabling Environments*, edited by John Swain, et.al. pp. 69 – 74. London: SAGE Publication.

[46] Sobsey, D. & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability* 9(3): 243-259.

[47] Swain, J., French, S. & Cameron, C. (2003). *Controversial Issues in a disabling society*. London: Open University Press.

[48]   Taub, D., McLorg, P., & Bartnick, A. (2009). Physical and social barriers to social relationships: voices of rural disabled women in the USA. *Disability & Society* 24(2): 201-215.

[49]   Thailand, Ministry of Social Development and Human Security. 2008. *Survey Report*, Department of Disability Empowerment.

[50]   Thomas, C. (1999). *Female forms: Experiencing and understanding disability*. Milton Keynes: Open University Press.

[51]   Tilley, C. (1998). Health Care for Women with Physical Disabilities: Literature Review and Theory. *Sexuality and Disability* 16(2): 87 – 102.

[52]   Turner, B. (1996) *The Body and Society*. 2nd edition. London: SAGE.

[53]   Ville, I., Crost M., Ravaud, Jean-Francois & Group, T. (2003). Disability and a sense of community belonging: A study among tetraplegic spinal-cord-injured persons in France. *Social Science & Medicine* 56: 321 – 332.

[54]   WHO. 1980. *International Classification of Impairment, Disabilities and Handicap (ICIDH)*. WHO: Geneva.

[55]   Whyte, S. & Instad, B. (1995). Disability and Culture: An Overview. In *Disability and Culture*, edited by Benedicte Instad., pp.65-86, Berkeley: University of California Press.

[56]   Zakus, D. & Lysack, C. (1998). Revisiting community participation. *Health Policy and Planning* 13(1): 1 – 12.