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THE SOCIOLOGY OF DISABILITY

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Abstract:

Handicap is a sensation that is socially characterized, has pervasive social outcomes for people, and has huge effect on social orders (Barnartt 2005). The social reality of inability is described by "significant variety in the knowledge of disability by expansive quantities of individuals who regardless impart basic states of prohibition, underestimation, and disservice" (Williams 2001:141). In the meantime, regardless of rejection, minimization, and burden, the typical significance characteristic in incapacity may be communicated in a solid and positive feeling of personality. Handicap can likewise be seen as a political benefit, in the feeling of convey authorization to be absolved from the work-based framework, military administration, obligation, and criminal risk (Stone 1984).

Key words: socially characterized , physical or mental weakness , Sociology of Disability.

INTRODUCTION

In the medicinal writing, handicap is thought to be "a physical or mental weakness that significantly constrains one or a greater amount of the significant life exercises" (Fried et al. 2004). In this connection, inability is seen as a restorative element. Analysis of handicap is focused around either (an) a self-reported trouble or requirement for help in completing exercises and/or performing ordinary parts or (b) execution based tests of working. While disability is a precondition for handicap as a medicinal element, incapacity does not so much need to come about because of a physical or mental impedance.

The demography and the study of disease transmission of inability shift relying upon how persons with handicap are characterized (Verbrugge 1990; Laplante 1991, 1993; Ing and Tewey 1994; Kaye et al. 1996; La Plante and Carlson 1996). The Social Security Administration characterizes persons with handicaps as the individuals who have a physical or mental condition that keeps them from participating in paid vocation. Different meanings of incapacity incorporate having a characterized condition thought to be impairing (e.g., deafness); utilizing assistive gadgets; recognizing toward oneself as an individual with an inability; and being viewed by others as having a handicap. Irving Zola (1993) shrewdly contended that the origination, estimation, and tallying of handicap vary truly relying upon the reason for which this data is required. Likewise, incapacity is a status that might possibly be appropriate at diverse times in a singular's life. Zola kept up, accordingly, that incapacity is best imagined as liquid and persistent instead of as altered or dichotomous. The significance of the last point is accepting expanding criticalness in the setting of populace maturing.

II. How did the Topic of Disability Become a Matter of Interest?

After World War II, social researchers working in social prescription, social arrangement, and recovery started to concentrate on social parts of constant sickness and inability identifying with damage. The vast majority of this work concentrated on the commonness of handicap however needed concurrence on definitions or methodologies to estimation. Weights for estimation illumination rose up out of distinctive sources, thusly speaking to diverse investments. An early British report, trying to record the quantities of persons with impedances, demonstrated that terms, for example, disability, incapacity, and impediment were not plainly characterized. The World Health Organization (WHO) attempted the undertaking of creating an acceptable set of definitions, which built up and finally finished in distribution of the International Classification of Impairments, Disabilities, and Handicaps (WHO 1980). In light of a legitimate concern for advocating portion of Social Security advantages in the United States, Saad Nagi (1979) created comparative definitions as he endeavored to accommodate disagreements between meanings of "therapeutic debilitation" and "capacity to work."

Despite the fact that Nagi and partners helped the social science of inability as right on time as 1965, there was little catch up on their ideas until reports were issued in the 1990s by the Institute of Medicine (IOM) and the National Academy of Sciences (Pope and Tarlov 1991; Brandt and Pope 1997). Wording initially tagged by Nagi (1965) gave a premise to the IOM's separation among pathology, impedance, useful impediment, a possibly impairing condition, and an inability. The IOM reports unequivocally embraced utilization of a conceptualization of incapacity that fuses natural elements as essential donors to the production of handicap and prescribed moving the center from the individual and the disability to the communication between the debilitation and the nature's turf. Imperatively, in this view, the social classification of "handicapped" is socially, instead of therapeutically, built (Higgins 1992), to some extent by social definitions and partially by the requests and obligations of social and physical situations. This conceptualization challenges the therapeutic model of handicap, in which the center is on a weakness related impediment in need of remediation.

Social researchers' aggregate commitments to a "sociomedical model of incapacitating disease" (Bury 1997:138) served to fortify better approaches for taking a gander at handicap. For instance, the work of Goffman (1963) on disgrace impacted perspectives of the way of mental and physical ailment and authenticity of applied and examination approaches. Economists concentrated on national issues connected with incapacity advantages and work, a large number of which were sociological and also monetary in nature, for instance, the structure and capacity of handicap projects, expenses connected with professional recovery (VR) and with specific sorts of inability, for example, mental hindrance, investigations of open projects, for example, Social Security, and impacts of incapacity on the work supply. In 1956, establishment of Social Security Disability Insurance formalized an arrangement association between restorative guess and business potential, making an assurance of profits for persons esteemed at hazard, that is, powerless, because of their wellbeing. The approach was gone for lessening these persons' monetary danger, however the enactment successfully given a setting to talk of rights among persons with incapacities. Government officials proposed the ideas of focused on help and individual independence as plan B to all inclusive qualification, reflecting worry about the capacity of the welfare state to accept administer to persons with incapacities delineating differentiating perspectives that have surrounded a proceeding with level headed discussion about suitable societal reactions to the needs of incapacitated persons.

In the late 1960s and early 1970s, the consolidated driving force gave by the social liberties development, an expanding number of persons with inabilities going to school, and talented administration among persons with handicaps helped the start of the autonomous living development (Scotch 1989). This development was introduced on a sociopolitical model of incapacity, that is, handicap emerging from association of an individual with a specific environment, instead of a therapeutic model in which inability is connected with physical or mental debilitation. In the sociopolitical model, inability is seen as a result of individual environment communication as opposed to as an individual quality. This perspective, thus, intimates that the handicap comparison can be adjusted by changing an individual's capacity through recovery or ecological change. The social model of incapacity created by British scholars basically reduced individual practical impediments and concentrated rather on the impacts of an "abusive" environment and social structure.

III. Humanism and the Study of Disability

Sociological research on unending sickness, weakness, and incapacity started in a push to comprehend the relationship between encounters of indications or hindrance, the social circumstances inside which individuals live, and the consolidated impact these have on individuals' lives. Real topics that have been produced incorporate acclimating to incapacity through socialization methodologies and supposition of a debilitated part, understanding handicap as a type of abnormality, the minority gathering model of inability, rise of incapacity developments, and administration of disease and incapacity in individuals' ordinary lives.

A. Acclimating to Disability

For a significant part of the twentieth century, inability was principally characterized by a biomedical schema and saw as a property characteristic in people who were "not quite the same as typical." The restorative model to a great extent likened handicap with reliance, intimating people's requirement for welfare and different manifestations of social protection. Along these lines, much early sociological and social brain research examination concentrated on people's change in accordance with a ward status. Handicap onset was seen as obliging a redefinition of one's circumstance and a remaking of parts and social communication designs (Albrecht 1976). Researchers concentrated on change in accordance with, and adapting to, weakness (Cohn 1961; Kelman, Miller, and Lowenthal 1964; Ludwig and Collette 1970; Safilios-Rothschild 1970; Ben-Sira 1981, 1983), confidence and inspiration in recovery settings (Litman 1966; Starkey 1968; Brown and Rawlinson 1976), and the essentialness of social backing from family and group (New et al. 1968; Tolsdorf 1976; Petersen 1979; Smith 1979, 1981).

In her investigation of the intricacy of people's associations with the authoritative arrangement of welfare, Blaxter (1976) kept up that inability is best seen inside the skeleton of a profession, in which the last result is constantly later on. Patients' meanings of self and needs are constantly being created and arranged, thus forming their help-looking for conduct. Blaxter, in the same way as Roth (1963) and Scheff (1965), watched that the way that people present themselves is molded by the offices with whom they connect, setting in movement a constant procedure of conformity. Julius Roth (1963) saw timetables created by the medicinal calling as organizing the quiet's profession in routes harmonious with the plan of the restorative association. Scheff (1965, 1966) recommended that associations use generalizations of the "correct customer" as a gadget for taking care of vulnerability. The more minimal the customers, the less exact and legitimate the generalizations will be. Safilios-Rothschild (1976) outstanding that there was striking likeness in mentality at the impaired and ladies, both of whom have a comprehended need to acknowledge and conform to a stereotyped part to get endorsement.

How meanings of handicap are socially made (Higgins 1992; Goode 1994) or managed through connection (Gerschick 1998), and through demeanor of others to persons with incapacities (Yuker, Block, and Campbell 1960; Siller and Chipman 1964; Yuker, Block, and Younng 1966; Richardson and Royce 1968; Shears and Jensema 1969; Richardson 1970, 1971; Schroedel 1978; Altman 1981), has been a topic in the work of numerous sociologists. Comer and Piliavin (1972) suggested that the healthy show less variability in verbal yield, less grinning conduct, less eye contact, and more prominent engine restraint with the handicapped. This, thus, cutoff points sorts of social collaboration for crippled persons and gives them with less chances to going for parts and conduct. Davis (1964) kept up that the all the more obviously characterized and noticeable the incapacity, the more prominent the straightforwardness with which the crippled individual and the gathering conform to one another. Vagueness encompassing level of hindrance, alternately, has an adverse effect on interpersonal connections (Zahn 1973), ensuing in befuddled desires, objectives that are vague, and parts that are opposing. Subsequently, as per Gove (1976), social orders, for example, the United States, which have created formal procedures for managing the handicapped, have a tendency to be more tolerant of inability than those that have no such methodologies.

The opportunity for authentic exclusions from typical part commitments, reliable with Parsons' (1951) idea of the wiped out part, was viewed by a few sociologists as just about synonymous with incapacity. Case in point, Gordon (1966) utilized the thought of a "debilitated part" to depict the avoidance of impaired persons from social exercises and obligations. David Mechanic (1959) concentrated on handicap as a natural issue, expressing that "difficulty seeing, paraplegia, deafness, or some other condition . . . renders [the] capacity to possess typical social parts either constrained, dubious, or incomprehensible" (p. 38). Workman (1968) later recognized the discriminating part of the nature's turf, nonetheless: "the working rule of . . . restoration endeavors is to change the abilities and environment of an individual with the goal that his condition brings about the slightest conceivable handicap and interruption of life examples" (p. 410). Hahn (1994) notes that this proposal could have put medicinal humanism at the core of the rising field of psychosocial recovery. Repairman's concentrate on individual working and on the as far as anyone knows inalienable impacts of an impedance seemed to originate from the medicinal model of incapacity, in spite of the fact that his later affirmation of the essentialness of the fit between people's qualities and the situations in which they worked (Mechanic and Aiken 1991) delineated a shift far from the ramifications of the debilitated part idea.

IV. Handicap Movements

In the 1970s, hard of hearing persons dissented outside phone organizations around the nation due to outrage at needing to pay for unique supplies and use more to make long-separation phone calls. This show was deciphered as a passionate reaction to the smashed trust that years of volunteer push to accomplish information transfers access would be fruitful. Rejection, delineated by the prohibition experienced by hard of hearing persons from phone access, came to assume a constructive part in the development of an "incapacity group," serving as an impetus for a feeling of imparted personality and recognizing a focus for aggregate activity (Scotch 2001). In a comparative manner, dark force, women's activist, and other social developments of the 1960s focused on a positive mental self portrait established in the aggregate personality of a prohibited gathering requesting more noteworthy support.

Scotch (2001) contends that various elements served to support a social development of incapacitated persons:

- Medical innovations, including prosthetics, meds, and surgical procedures, empowered longer life, survival of wounds, and more full cooperation in regular life exercises.
- The promotion of a philosophy of deinstitutionalization and standardization, particularly in the mental wellbeing field, energized the development of noninstitutional emotionally supportive networks and more prominent interest in group life.
- With the changing age structure of the bigger society, an expanding number of elderly persons had physical handicaps and imparted administration needs.
- The Vietnam War delivered an extensive number of handicapped veterans who were activists, and the war itself produced across the board dissents that served to genuine social activism.

It is likewise essential that amid the 1960s and early 1970s various real projects were instituted that advanced more finish interest by persons with incapacities: the Architectural Barriers Act of 1968, extended financing for professional and autonomous living administrations under the VR project starting in 1968, the Developmental Disabilities Services and Facilities Construction Act of 1970, the Education for All Handicapped Children Act in 1974, and Project Head Start in 1974. These projects spoke to an intelligent expansion of an example of extending qualifications and administrations gave by the central government focused around extensively held social and political qualities, an example alluded to by Daniel Bell as an "upset of climbing privileges" (Scotch 2001). This example, more than vocal support by handicapped persons, is thought to have encouraged the reception of Section 504 of the 1973 Rehabilitation Act. Shopper bunches did, on the other hand, along these lines dissent the deferred usage of Section 504 at work places of the Department of Health, Education, and Welfare, which helped incapacity gatherings getting to be enabled to partake all the more effectively in the political stadium.

The issues confronted by persons with diverse sorts of disabilities, and the proposed answers for these issues, may be truly distinctive, making the improvement of an imparted awareness dangerous (Scotch 1989). Barnartt and Scotch (2002) examined "antagonistic political activities" inside debilitated groups from 1970 to 1999. They inferred that requests for craved changes and activities were frequently impedance particular. "Cross-incapacity" challenges, including requests that conceivably apply to individuals with numerous types of disabilities, were found to happen just 28 percent of the time. This examination by Barnartt and Scotch recommended that, in light of the fact that persons with diverse disabilities might not have an imparted aggregate cognizance, deliberate backing by expansive quantities of persons with handicaps is liable to be rare.

V. Dealing with the Experience of Chronic Illness/Disability

Investigations that endeavor to see how individuals oversee ailment in their ordinary lives speak to a push to enlighten an "insider's" point of view: What is the subjective knowledge of sickness? The knowledge of inability is one concentrate inside the subjective knowledge of ailment as examined by Conrad (1987). Interestingly, Conrad characteristics a rising enthusiasm toward the ailment involvement to a limited extent to the handicap development that had its inceptions in the 1970s: "These self improvement and support bunches considered experiential information important, since they were it might be said "masters" in it, and cultivated another social consciousness of the issues of living with incapacity" (pp. 3–4).

A social science of disease experience is concerned with how individuals live with and despite sickness. It is focused around methodicallly gathered and broke down information from a number and mixture of persons with a specific ailment, as in Schneider and Conrad's (1983) investigation of living with epilepsy and O'brien's (1983) investigation of living with incessant hemodialysis. The center is on the importance of sickness to the individual, the social association of the singular's reality, and the techniques the individual uses in adjustment.

This point of view is subjectively not quite the same as the thought of conforming to an incapacity status characterized by others (an "outsider's" as opposed to an "insider's" view). It perceives that people imaginatively deal with their disease in their ordinary lives, characterizing and reclassifying who they are and how they identify with others. Corbin and Strauss (1985) contended that ailment experience can be significantly conceptualized as far as work that must be fulfilled. Since work is an idea vital to the lives of people who don't have incessant sickness, this conceptualization demonstrates imparted experience for individuals who are sick and individuals who are well—an alternate understanding from the debilitated part conceptualization. Conrad (1987) alerts against overconceptualizing the sickness encounter as sorts of work, then again, keeping up that overseeing different parts of disease has different implications also.

The idea of vocation, utilized by Blaxter (1976) in her investigation of debilitated people's collaborations with social offices, is important to comprehension the disease experience. Conrad notes that the idea of ailment trajectory (Corbin and Strauss 1985) may be significantly more fitting to studies in the knowledge of sickness on the grounds that it envelops process and change and does not expect linearity or organization in disease movement. Other central concerns from exploration on the knowledge of sickness incorporate the need to oversee vulnerability and disgrace (see, e.g., Schneider and Conrad 1983) and the requirement for historical work and reconstitution of self (see, e.g., Corbin and Strauss 1985; Charmaz 1987)

REFERENCES:

1. Albrecht, Gary L. 1976. “Socialization and the Disability Process.” Pp. 3–38 in The Sociology of Physical Disability and Rehabilitation, edited by G. L. Albrecht. Pittsburgh, PA: University of Pittsburgh Press.
2. Albrecht, Gary L. 1992. The Disability Business. Newbury Park, CA: Sage.
3. Altman, Barbara M. 1981. “Studies of Attitudes toward the Handicapped: The Need for a New Direction.” Social Problems 28: 321–37.
4. Altman, Barbara M. 2001. “Disability Definitions, Models, Classification Schemes, and Applications.” Pp. 97–123 in The Handbook of Disability Studies, edited by G. L. Albrecht, K. D. Seelman, and M. Bury. Thousand Oaks, CA: Sage.
5. Anspach, Rene R. 1979. “From Stigma to Identity Politics: Political Activism among the Physically Disabled and Former Mental Patients.” Social Science and Medicine 13A:765–73.
6. Asch, Adrienne. 2001. “Disability, Bioethics, and Human Rights.” Pp. 297–326 in The Handbook of Disability Studies, edited by G. L. Albrecht, K. D. Seelman, and M. Bury. Thousand Oaks, CA: Sage.
7. Barnartt, Sharon. 2005. “Report of the ASA Committee on the Status of Persons with Disabilities (PWD).” Retrieved August 23, 2014 (http://www.asanet.org/images/asa/docs/pdf/Disabilities%20Status%20Committee%20Report%202005.pdf).

8. Barnartt, Sharon and Richard Scotch. 2002. Disability Protests: Contentious Politics, 1970–1999. Washington, DC: Gallaudet University Press.
9. Becker, Howard. 1963. Outsiders: Studies in the Sociology of Deviance. New York: Free Press.
10. Ben-Sira, Zeev. 1981. “The Structure of Readjustment of the Disabled: An Additional Perspective on Rehabilitation.” Social Science and Medicine 15A:565–81.
11. Ben-Sira, Zeev. 1983. “Loss, Stress and Readjustment: The Structure of Coping and Bereavement and Disability.” Social Science and Medicine 17:1619–32.
12. Blaxter, Mildred. 1976. The Meaning of Disability: A Sociological Study of Impairment. New York: Neale Watson Academic.
13. Bogdan, Robert and Steven J. Taylor. 1987. “Toward a Sociology of Acceptance: The Other Side of the Study of Deviance.” Social Policy 18:34–39.
14. Bogdan, Robert and Steven J. Taylor. 1989. “Relationships with Severely Disabled People: The Social Construction of Humanness.” Social Problems 36:135–48.
15. Brandt, Edward N., Jr. and Andrew M. Pope, eds. 1997. Enabling America. Washington, DC: National Academy Press.
16. Brown, Julia and May Rawlinson. 1976. “The Morale of Patients Following Open-Heart Surgery.” Journal of Health and Social Behavior 17:134–44.
17. Bury, Michael. 1997. Health and Illness in a Changing Society. London, England: Routledge & Kegan Paul.
18. Charmaz, Kathy. 1987. “Struggling for a Self: Identity Levels of the Chronically Ill.” Pp. 283–321 in Research in the Sociology of Health Care, vol. 6, edited by J. A. Roth and P. Conrad. Greenwich, CT: JAI Press.
19. Christiansen, John B. and Sharon N. Barnartt. 1987. “The Silent Minority: The Socioeconomic Status of Deaf People.” Pp. 171–96 in Understanding Deafness Socially, edited by P. C. Higgins and J. E. Nash. Springfield, IL: Charles C. Thomas.
20. Cohn, Nancy. 1961. “Understanding the Process of Adjustment to Disability.” Journal of Rehabilitation 27:16–18.
21. Comer, Ronald J. and Jane A. Piliavin. 1972. “The Effects of Physical Deviance upon Face-to-Face Interaction.” Journal of Personality and Social Psychology 23:33–39.
22. Conrad, Peter. 1987. “The Experience of Illness: Recent and New Directions.” Pp. 1–31 in Research in the Sociology of Health Care, vol. 6, edited by J. A. Roth and P. Conrad. Greenwich, CT: JAI Press.
23. Conrad, Peter and Joseph W. Schneider. 1992. Deviance and Medicalization: From Badness to Sickness. Philadelphia, PA: Temple University Press.
24. Corbin, Juliet and Anselm L. Strauss. 1985. “Managing Chronic Illness at Home.” Qualitative Sociology 8:224–47.
25. Davis, Fred. 1964. “Deviance Disavowal: The Management of Strained Identity by the Visibly Handicapped.” Pp. 119–37 in The Other Side, edited by H. S. Becker. New York: Free Press.
26. DeJong, Gerben. 1979. “Independent Living: from Social Movement to Analytic Paradigm.” Archives of Physical Medicine and Rehabilitation 60:435–40.
27. Erikson, Kai T. 1964. “Notes on the Sociology of Deviance.” Pp. 9–21 in The Other Side, edited by H. S. Becker. New York: Free Press.
28. Fox, Ellen. 1997. “Predominance of the Curative Model of Medical Care: A Residual Problem.” Journal of the American Medical Association 278:761–63.
29. Freidson, Eliot. 1965. “Disability as Social Deviance.” Pp. 71–99 in Sociology and Rehabilitation, edited by M. B. Sussman. Washington, DC: American Sociological Association.
30. Fried, Linda P., Luigi Ferrucci, Jonathan Darer, Jeff D. Williamson, and Gerard Anderson. 2004. “Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improved Targeting and Care.” Journal of Gerontology: Medical Sciences 59:255–63.
31. Garland-Thomson, Rosemarie. 2004. “The New Disability Studies: From Oedipus to the Human Genome.” Pp. 5–11 in Disability Studies in the University, Emory across Academe, No. 4, edited by R. Garland-Thomson. Atlanta, GA: Academic Exchange.

32. Gerschick, Thomas J. 1998. “Sisyphus in a Wheelchair: Men with Physical Disabilities Confront Gender Domination.” Pp. 189–213 in Everyday Inequalities: Critical Inquiries, edited by J. O’Brien and J. A. Howard. Malden, MA: Blackwell.
33. Gill, Carol. 2001. “Divided Understandings: The Social Experience of Disability.” Pp. 351–72 in The Handbook of Disability Studies, edited by G. L. Albrecht, K. D. Seelman, and M. Bury. Thousand Oaks, CA: Sage.
34. Gilman, Sander L. 2004. “Defining Disability: The Case of Obesity.” Pp.49–55 in Disability Studies in the University, Emory across Academe, No. 4, edited by R. Garland- Thomson. Atlanta, GA: Academic Exchange.
35. Gliedman, John and William Roth. 1980. The Unexpected Minority. New York: Harcourt Brace Jovanovich.
36. Goffman, Erving. 1963. Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Prentice Hall. Goode, David. 1994. A World without Words: The Social Construction of Children Born Deaf and Blind. Philadelphia, PA: Temple University Press.
37. Gordon, Gerald. 1966. Role Theory and Illness. New Haven, CT: College & University Press.
38. Gove,Walter R. 1976. “Societal Reaction Theory and Disability.” Pp. 57–71 in The Sociology of Physical Disability and Rehabilitation, edited by G. L. Albrecht. Pittsburgh, PA: University of Pittsburgh Press.
39. Gove,Walter R. and Patrick Howell. 1974. “Individual Resources and Mental Hospitalization: A Comparison and Evaluation of the Societal Reaction and Psychiatric Perspectives.” American Sociological Review 39:86–100.
40. Hahn, Harlan. 1982. “Disability and Rehabilitation Policy: Is Paternalistic Neglect Really Benign?” Public Administration Review 42:385–389.
41. Hahn, Harlan. 1983. “Paternalism and Public Policy.” Society 20:36–46.
42. Hahn, Harlan. 1984. “Reconceptualizing Disability: A Political Science Perspective.” Rehabilitation Literature 48:362–65.
43. Hahn, Harlan. 1985a. “Toward a Politics of Disability: Definition, Disciplines and Politics.” The Social Science Journal 22:87–105.
44. Hahn, Harlan. 1985b. “Disability Policy and the Problem of Discrimination.” American Behavioral Scientist 28:293–318.
45. Hahn, Harlan. 1986. “Disability and the Urban Environment: A Perspective on Los Angeles.” Society and Space 4:273–88.
46. Hahn, Harlan. 1993a. “The Political Implications of Disability Definitions and Data.” Journal of Disability Policy Studies 4:41–52.
47. Hahn, Harlan. 1993b. “The Potential Impact of Disability Studies on Political Science (as Well as Vice-Versa).” Policy Studies Journal 21:740–51.
48. Hahn, Harlan. 1994. “The Minority Group Model of Disability: Implications for Medical Sociology.” Pp. 3–24 in Research in the Sociology of Health Care, vol. 11, edited by R. Weitz and J. J. Kronenfeld. Greenwich CT: JAI Press.
49. Hahn, Harlan. 2000. “Accommodations and the ADA: Biased Reasoning or Unreasonable Bias?” Berkeley Journal of Employment and Labor Law 21:166–92.
50. Hahn, Harlan and Todd L. Belt. 2004. “Disability Identity and Attitudes toward Cure in a Sample of Disabled Activists.” Journal of Health and Social Behavior 45:453–64.
51. Hanks, Michael and Dennis E. Poplin. 1981. “The Sociology of Physical Disability: A Review of Literature and Some Conceptual Perspectives.” Deviant Behavior 2:309–328.
52. Higgins, Paul C. 1992. Making Disability: Exploring the Social Transformations of Human Variation. Springfield, IL: Charles C Thomas.
53. Hunt, Paul, ed. 1966. Stigma: the Experience of Disability. London, England: Chapman.
54. Ing, Christine D. and Betsy P. Tewey. 1994. Summary of Data on Children and Youth with Disabilities.Washington, DC: U.S. Department of Education, National Institute on Disability and Rehabilitation Research.

55. Kaye, Stephen, Mitchell P. LaPlante, Dawn Carlson, and Barbara L. Wenger. 1996. “Trends in Disability Rates in the United States, 1970–1994.” Disability StatisticsAbstract, No. 17. Washington, DC: National Institute of Disability and Rehabilitation Research.
56. Kelman, Howard R., Jonas N. Miller, and Milton Lowenthal. 1964. “Post Hospital Adaptation of a Chronically Ill and Disabled Rehabilitation Population.” Journal of Health and Social Behavior 5:108–14.
57. Kutner, Nancy G. 1987. “Social Worlds and Identity in End-Stage Renal Disease.” Pp. 33–71 in Research in the Sociology of Health Care, vol. 6, edited by J.A. Roth and P. Conrad. Greenwich, CT: JAI Press.
58. Kutner, Nancy G. 2003. “Paradigm Tension in Management of Chronic Disease.” Pp. 107–23 in Research in the Sociology of Health Care, vol. 21, edited by J. J. Kronenfeld. Amsterdam, The Netherlands: Elsevier.
59. LaPlante, Mitchell P. 1991. Disability in Basic Life Activities across the Life Span. Disability Statistics Report 1. Washington, DC: National Institute on Disability and Rehabilitation Research.
60. LaPlante, Mitchell P. 1993. State Estimates of Disability in America. Disability Statistics Report 3. Washington, DC: National Institute on Disability and Rehabilitation Research.
61. LaPlante, Mitchell P. and Dawn Carlson. 1996. Disability in the United States: Prevalence and Causes, 1992. Disability Statistics Report 7. Washington, DC: National Institute on Disability and Rehabilitation Research.
62. Litman, Theodor J. 1966. “The Family and Physical Rehabilitation.” Journal of Chronic Disability 19:211–20.
63. Ludwig, E. G. and John Collette. 1970. “Dependency, Social Isolation and Mental Health in a Disabled Population.” Social Psychiatry 5:92–95.
64. Mechanic, David. 1959. “Illness and Social Disability: Some Problems in Analysis.” Pacific Sociological Review 2:37–41.
65. Mechanic, David. 1968. Medical Sociology: A Selective View. New York: Free Press.
66. Mechanic, David and Linda H. Aiken. 1991. “Social Science, Medicine, and Health Policy.” Pp. 1–9 in Applications of Social Sciences to Clinical Medicine and Health Policy, edited by L. H. Aiken and D. Mechanic. New Brunswick, NJ: Rutgers University Press.
67. Nagi, Saad Z. 1965. “Some Conceptual Issues in Disability and Rehabilitation.” Pp. 100–13 in Sociology and Rehabilitation, edited by M. B. Sussman. Washington, DC: American Sociological Association.
68. Nagi, Saad Z. 1979. “The Concept and Measurement of Disability.” Pp. 1–15 in Disability Policies and Government Programs, edited by E. D. Berkowitz. New York: Praeger.
69. New, Peter, Anthony Ruscio, Rhea P. Priest, Dora Petritsi, and Linda George. 1968. “The Support Structure of Heart and Stroke Patients.” Social Science and Medicine 2:185–200.
70. O’Brien, Mary Elizabeth. 1983. The Courage to Survive: The Life Career of the Chronic Dialysis Patient. New York: Grune & Stratton.
71. Parsons, Talcott. 1951. The Social System. Glencoe, IL: Free Press.
72. Petersen, Yen. 1979. “The Impact of Physical Disability on Marital Adjustment: A Literature Review.” Family Coordinator 28:47–51.
73. Pope, Andrew M. and Alvin R. Tarlov, eds. 1991. Disability in America. Washington, DC: National Academy Press.
74. Richardson, Stephen A. 1970. “Age and Sex Differences in Values toward Physical Handicaps.” Journal of Health and Social Behavior 11:207–14.
75. Richardson, Stephen A. 1971. “Children’s Values and Friendships: A Study of Physical Disability.” Journal of Health and Social Behavior 12:253–58.
76. Richardson, Stephen A. and Jacqueline Royce. 1968. “Race and Physical Handicap in Children’s Preference for Other Children.” Child Development 39:467–80.
77. Roth, Julius A. 1963. Timetables. Indianapolis, IN: Bobbs-Merrill.
78. Safilios-Rothschild, Constantina. 1970. The Sociology and Social Psychology of Disability and Rehabilitation. New York: Random House.
79. Safilios-Rothschild, Constantina. 1976. “Disabled Persons’ Self- Definitions and Their Implications for Rehabilitation.” Pp. 39–56 in The Sociology of Physical Disability and Rehabilitation, edited by G. L. Albrecht. Pittsburgh, PA: University of Pittsburgh Press.

80. Scheff, Thomas J. 1965. “Typification in the Diagnostic Practices of Rehabilitation Agencies.” Pp. 139–47 in Sociology and Rehabilitation, edited by M. B. Sussman. Washington, DC: American Sociological Association.
81. Scheff, Thomas J. 1966. Being Mentally Ill. London, England: Weidenfeld & Nicolson.
82. Schneider, Joseph W. and Peter Conrad. 1983. Having Epilepsy: The Experience and Control of Illness. Philadelphia, PA: Temple University Press.
83. Schroedel, John G., ed. 1978. Attitudes toward Persons with Disabilities: A Compendium of Related Literature. Albertson, NY: Human Resources Center.
84. Scotch, Richard W. 1989. “Politics and Policy in the History of the Disability Rights Movement.” The Milbank Quarterly 67 (suppl 2, part 2):380–400.
85. Scotch, Richard W. 2001. From Good Will to Civil Rights: Transforming Federal Disability Policy. 2d ed. Philadelphia, PA: Temple University Press.
86. Scott, Robert A. 1965. “Comments about Interpersonal Processes of Rehabilitation.” Pp. 132–38 in Sociology and Rehabilitation, edited by M. B. Sussman. Washington, DC: American Sociological Association.
87. Scott, Robert A. 1969. The Making of Blind Men. New York: Russell Sage.
88. Shears, Loyda M. and Carl J. Jensema. 1969. “Social Acceptability of Anomalous Persons.” Exceptional Children 36:91–96.
89. Siller, Jerome and Abram Chipman. 1964. “Factorial Structure and Correlates of the Attitudes toward Disabled Persons Scale.” Educational and Psychological Measurement 24:831–40.
90. Smith, Richard T. 1979. “Disability and the Recovery Process: Role of Social Networks.” Pp. 218–26 in Patients, Physicians and Illness, 3d ed., edited by E. G. Jaco. New York: Free Press.
91. Smith, Richard T. 1981. “The Role of Social Resources in Cardiac Rehabilitation.” Pp. 221–32 in Physical Conditioning and Cardiovascular Rehabilitation, edited by L. S. Cohen, M. B. Mock, and I. Ringqvist. New York: John Wiley.
92. Starkey, Pearl D. 1968. “Sick-Role Retention as a Factor in Nonrehabilitation.” Journal of Counseling Psychology 15:75–79.
93. Stone, Deborah A. 1984. The Disabled State. Philadelphia, PA: Temple University Press.
94. Stroman, Duane F. 1982. The Awakening Minorities.Washington, DC: University Press of America.
95. Tolsdorf, Christopher C. 1976. “Social Networks, Support and Coping: An Exploratory Study.” Family Process 15:407–409.
96. Turner, Bryan S. 2001. “Disability and the Sociology of the Body.” Pp. 252–66 in The Handbook of Disability Studies, edited by G. L. Albrecht, K. D. Seelman, and M. Bury. Thousand Oaks, CA: Sage.
97. Verbrugge, Lois M. 1990. “The Iceberg of Disability.” Pp. 55–75 in The Legacy of Longevity: Health and Health Care in Later Life, edited by S. M. Stahl. Newbury Park, CA: Sage.
98. Williams, Gareth. 2001. “Theorizing Disability.” Pp. 123–44 in The Handbook of Disability Studies, edited by G. L. Albrecht, K. D. Seelman, and M. Bury. Thousand Oaks, CA: Sage.
99. World Health Organization (WHO). 1980. International Classification of Impairments, Disabilities and Handicaps. Geneva, Switzerland: WHO.
100. Yuker, Harold E., Janet R. Block, and William J. Campbell. 1960. A Scale to Measure Attitudes toward Disabled Persons. Albertson, NY: Human Resources Foundation.
101. Yuker, Harold E., Janet R. Block, and Janet H. Younng. 1966. The Measurement of Attitudes toward Disabled Persons. Human Resources Study No. 7. Albertson, NY: Human Resources Center.
102. Zahn, Margaret A. 1973. “Incapacity, Impotence and Invisible Impairment: Their Effects upon Interpersonal Relations.” Journal of Health and Social Behavior 14:115–23.
103. Zola, Irving K. 1982. Missing Pieces: A Chronicle of Living with a Disability. Philadelphia, PA: Temple University Press.
104. Zola, Irving K. 1989. “Toward the Necessary Universalizing of Disability Policy.” The Milbank Quarterly 67:401–26.
105. Zola, Irving K. 1991. “Bringing Our Bodies and Ourselves Back In: Reflections on a Past, Present, and Future ‘Medical Sociology.’” Journal of Health and Social Behavior 32:1–16.

106. Zola, Irving K. 1993. “Disability Statistics, What We Count and What It Tells Us.” Journal of Disability Policy Studies 4:9–29.

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