

The Contemporary Face of Social Security and Personal Injury Claimants: Insights for Vocational Experts

Irmo Marini, Danielle D. Fox, and Noel A. Ysasi

Abstract. Vocational experts who provide expert testimony either in litigated personal injury cases or for the Social Security Administration have likely witnessed an increase in the frequency of individuals presenting with similar impairments over the last several years, perhaps specifically over the last decade. Trends have been noted within several particular areas. As an example, the ever-growing increase in obesity related and complementary secondary complications in the U.S. have been noted, and these trends are predicted to increase particularly according to the Center for Disease Control (CDC). Projections moreover, complaints of chronic pain, depression, and anxiety, in addition to Type II diabetes conditions, whether medically objectively supported or not, are most prevalent within Social Security claims. This paper focuses on characteristics of these conditions, in addition to the socioeconomic and psychosocial dynamics of such claimants. The vocational implications for vocational experts testifying in these scenarios regarding claimants in this ever-growing trend are further explored.

Keywords: Social Security, Vocational Rehabilitation Counselor roles, long term disability

During each Presidential election, the topic of rising Social Security costs and its imminent insolvency continues to be of interest to Americans, from the framework of both projections and actual costs. By the latest 2012 accounts, the Social Security Administration (SSA) projects that the Program began paying out more benefits and expenses than it collected in 2010, and that the Trust Fund will be exhausted by 2033 if changes are not made, specifically to decrease cost and increase payors or revenue. In addition, the 2012 Trustees Report indicates that after the 2033 insolvency, payroll taxes and other income will only be sufficient to pay 75% of the Programs' cost. The projected shortfall accounts for the next 75 years with a 2.67% taxable payroll (SSA, 2012a). Additional analysis is warranted regarding this issue.

Further analysis of the SSA annual report indicates that in 2011 there were over 55 million beneficiaries comprised of an estimated 64% retired workers and 15% with disabled workers. The remaining 21% were survivors or the spouses and children of retired or disabled workers. In 2011 alone, 5.6 million persons were awarded benefits; 46% retired workers and 18% work-

ers with disabilities, with the remaining 36% comprised of survivors and children. Overall, women accounted for 54% of the 8.1 million recipients covered under Supplemental Security Income (SSI, 2012). Applications for Social Security Disability Income (SSDI) have increased incrementally over the past six years since the 2008 recession with an increase of over 20% since then.

The final point of interest regarding SSA beneficiaries pertains to the types of disabilities most recipients are diagnosed under. In the past decade, the top three most frequent diagnoses of beneficiaries were mental disabilities excluding mental retardation at 26%, musculoskeletal disorders at 25%, and circulatory disorders at 11% (Marini, Feist, & Miller, 2004). By 2011; however, diagnosed beneficiary mental disorders now account for 32.3%, musculoskeletal disorders at 29%, and nervous system/sensory disorders rank third at 9.4%. Circulatory disorders have dropped to fourth place overall at 8.5% of total claims. When this is further broken down exploring individuals under age 50, mental disorders account for 48.4% or almost half of all claims, musculoskeletal at 17.6%, and nervous sys-

tem diagnoses at 10.8%. Over age 50, musculoskeletal disorders account for 33.8%, mental disorders for 25.5%, and circulatory system disorders at 10.5%. Clearly, age becomes a factor with what might be considered as bodily wear and tear as one gets older and has mostly performed arduous physical labor much of their life (SSA, 2012b; Marini et al., 2004).

The purpose of the present paper may be conceived as somewhat of a hybrid. Specifically, the first author who has been a vocational expert (VE) with SSA for almost 20 years cites a brief analysis of the types of cases he has testified in over the past 2 ½ years and then segues into a conceptual paper regarding the growing contemporary face of Worker's Compensation and SSA claimants. Four of the most frequent conditions are addressed including chronic pain, depression, anxiety, and obesity. These conditions are discussed in relation to their medical aspects and generally perceived functional limitations, psychosocial and socioeconomic factors of primarily low-wage workers, the impact on ability to perform jobs in the economy with these disabilities, and the typical hypotheticals posed by Administrative Law Judges (ALJs) in SSA hearings.

Docket Analysis Synopsis

The first author of this paper began collecting anonymous frequency data as well as information solicited at hearings for 564 claimant applicants during the third level of appeal before an ALJ, from February 2011 through November 2013 throughout four states in the mid-south and southeastern US. This analysis was prompted from previous years' observations of the high frequency of medical complaints offer by claimants, indicating their most frequently expressed limitations were related to depression, anxiety, chronic pain, and the functional limits and secondary complications pertaining to obesity. It is important to note that claimant concerns may or may not have been supported in their medical history, and aside from obesity measured by body mass index (BMI), the remaining three conditions were, and have historically been difficult to measure objectively, from a personal perspective. Although discussed in more detail later in the present report, suffice it to note that obesity is classified with a BMI of 30 kg/m² or greater, and severe obesity is classified as having a BMI of 40kg/m² or more (Visscher & Seidell, 2001). In this regard, including height and weight cited in their record and sometimes supported by a medical expert, approximately 74% of applicants in this region during this period were classified as obese or morbidly obese. These numbers essentially double the 2009-2010 Centers for Disease Control statistics regarding obesity by age and gender (Ogden, Carroll, Kit, & Flegal, 2012).

In addition, a frequency count of 77% and 72% was noted in the records by claimant's subjective com-

plaints of depression and anxiety, respectively. The majority of these reported complaints (71%) was not cited as the primary disability, and therefore was not accompanied by a psychological comprehensive exam and mental residual functional capacity evaluation, again based on personal observations of the reported numbers. Nevertheless, with or without a psychologist present to testify to these issues, the majority of ALJ hypotheticals typically included unskilled, repetitive work, with only occasional contact with coworkers and little or no contact with the public. Although not specifically reported, the majority of claimant's associated their mood disorder with some other primary disability which included chronic pain in an estimated 78% of cases. Overall, claimant characteristics for these dockets somewhat mirrored SSA statistics regarding the majority of younger persons under 40 reporting psychiatric disabilities, and those over 50 reporting more musculoskeletal and related chronic pain problems (Marini et al., 2004; SSA, 2012b).

Medical Aspects

Depression and Anxiety

Larzelere and Wiseman (2002) reported that approximately 25% of all Americans report mild to moderate levels of stress, anxiety, and depression. Primary care physician's report depression, anxiety, and insomnia as the three most commonly reported conditions for doctor's visits. The clinical definition of depression as stated in the American Psychology Association (APA) Dictionary of Psychology (2007) is, "depression: 1) Dysphoria that can vary in severity from a fluctuation in normal mood to an extreme feeling of sadness, pessimism, and despondency; 2) In psychiatry, any of the depressive disorders" (p. 269). The APA Dictionary of Psychology (2007) defines anxiety as, "anxiety: n. a mood state characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune. The future threat may be real or imagined, internal or external. It may be an identifiable situation or a more vague fear of the unknown (e.g., a general sense of impending doom). The body often mobilizes itself to meet the threat: Muscles become tense, breathing is faster, and the heart beats more rapidly. Anxiety may be distinguished from fear both conceptually and physiologically, although the two terms are often mistakenly used interchangeable" (p. 63). These definitions, along with mental health provide feedback, may guide the rehabilitation professional towards understanding the psychological overlay. For all intents and purposes of this discussion, the term "depression" will be used as a general term pertaining to Major Depressive Disorder as well as its related Depressive Disorders, and "anxiety" as a general term primarily regarding Generalized Anxiety Disorder as

set forth in the DSM-IV-TR. According to the Anxiety and Depression Association of America (ADAA), an estimated 40 million adults in the United States are affected by an anxiety disorder of some form, and approximately half of those affected by anxiety are also affected by depression or other depressive disorders (ADAA, 2013). Despite the estimates of those affected by anxiety and/or depression, it is estimated that only about one-third seek some form of treatment (Young, Klap, Shuai, & Wells, 2008). Bossolo (2012) notes that between 1996 and 2008, antidepressant prescriptions tripled from 55.9 million to 154.7 million. Over 150 million physician visits occur each year for stress, depression and anxiety related problems. The majority of these prescriptions; however, are issued by a family physician with little training in mental illness, and the majority of patients do not seek psychotherapy. Aina and Susman (2006) report:

Physicians often attempt to separate depression from anxiety. Unfortunately, such distinctions are often challenging and artificial. Anxiety symptoms are common in patients with major depression: 72% worry, 62% present with psychic anxiety, 42% have somatic anxiety, and 29% have panic attacks (p.510).

According to the National Institute of Mental Health (2010), women are 70% and 60% more likely than men to report depressive and anxiety disorders respectively. Doornbos, Zandee, and DeGroot (2012) report, "Urban, ethnically diverse, impoverished women are particularly vulnerable to depression and anxiety" (p. 437). Approximately 30% of all American households are now comprised of a single parent with one or more children, the majority of which are females living under the federal poverty level (U.S. Census Bureau, 2010). Although women are statistically 50% more likely to be affected by depression and/or anxiety, males are also impacted and likely underreport such symptoms (Gwynn et al., 2008). Family physicians prescribed antidepressant medication for those with insurance for such treatment may be seen as a quick fix without accurate identification and diagnosis (Lowe et al., 2008; Collins, Westra, Dozois, & Burns, 2004; Coyne, Thompson, Palmer, Kagee, & Maunsell, 2000). Aina and Susman (2006) cite a number of barriers to effective treatment such as social stigma, lengthy time needed to accurately diagnose, time constraints (faster for physician to prescribe medication), and lack of reimbursement for mental health issues. Medication usage remains a contemporary issue in both Worker's Compensation and Social Security.

There are often overlapping and co-occurring health issues and symptoms, leaving a gap in the referral system for depression and/or anxiety (Druss, Rask, & Katon, 2008; Hallford, McCabe, Mellor, Davidson, & Goldhammer, 2012; Kravitz et al., 2013; Shim, Baltrus, & Rust, 2011; Seekles, Van Straten,

Beekman, van Marwijk, & Cuijpers, 2011). Depression and/or anxiety are commonly associated with other chronic illnesses. For example, the association between diabetes and depression and/or anxiety appears to be strong, with an estimated 10-25% of those diagnosed with diabetes also diagnosed with depression and/or anxiety (Edge & Ellis, 2010; Fisher, Chan, Nan, Sartorius, & Oldenburg, 2012; Hermanns et al., 2013). A positive correlation also exists with diabetes increased symptoms or complications accompanied by a rise in depression and/or anxiety symptoms (Hermanns et al., 2013).

Obesity

Obesity and obesity related secondary complications continue to rise in the United States (Ogden et al., 2012; Romero & Marini, 2012). As previously noted, obesity is measured by BMI, and SSA follows the Clinical Guidelines for classifying obesity by dividing an individual's weight by their height. For SSA (2012b) purposes, individuals with a BMI between 25 and 29.9 are considered overweight, a BMI of 30 - 39.9 considered obese, and a BMI over 40 considered as extreme obesity (Blouw, Rudolphe, Narr, & Sarr, 2003). In the Ogden et al., (2012) report, over 78 million American adults met the criteria for obesity in 2010 comprised of 41 million women and 37 million men. Prior to 1999, SSA used to consider obesity as a primary condition in and of itself and therefore subject to an award or enabling classification as disabled. This is no longer the case, previously obesity may have been listed as a primary condition; however, it must now be a secondary condition to some other primary condition (Federal Register, 2002). The Administration added a preface to respiratory, musculoskeletal, and cardiovascular system listings for ALJs and representatives, noting that obesity and its secondary complications can have a greater impact on functioning with these other conditions. The problem the Administration created for itself in having obesity equal a listing, deals with the semantics in its definitions. Specifically, although obesity can equal a listing if considered "severe" (versus non-severe) based on one's age, education, and past work history, BMI classifications list individuals only as overweight, obese, or extremely obesity. As such, ALJs are left to decide on an individual basis whether an individual's obesity is severe enough to equal a listing based on differing classification definitions.

The secondary complications for individuals who are obese are many, currently costing several hundred billion dollars per year in medical care and lost work productivity. The American Obesity Association (AOA, 2012) indicates that individuals who are obese have an increased risk of osteoarthritis in their hips, knees, hands, and back. These musculoskeletal problems are also highly associated with chronic pain. The AOA

also cites obesity is associated with several forms of cancer including colorectal cancer, endometrial cancer, inflammatory breast cancer, and esophagus and gastric cancer. Obese adults, and more recently obese children, are approximately six times more likely to develop hypertension and ultimately cardiovascular disease; in particular coronary heart disease, atherosclerosis, deep vein thrombosis, and stroke. Respiratory problems and difficulty breathing also become a concern for individuals who are obese with even minimal exertion (AOA, 2012). Vocational implications of this are noted later.

Perhaps the most deleterious health impact of obesity is the secondary complications created by Type II diabetes. It is estimated that approximately 80% of persons with a BMI over 30 evidence diabetes symptoms, and as high as 90% for Hispanics and Native Americans (Wittemore, Bak, Melkas, & Grey, 2003). This further complicates treating diabetes because it contributes to insulin resistance (AOA, 2012). Individuals with diabetes may suffer numerous other secondary complications including neuropathy, nephropathy, and diabetic retinopathy (AOA, 2012). The CDC (2010) indicates that at current projections of obesity and Type II diabetes, by 2050 three out of 10 Americans (instead of the current 10%) will have Type II diabetes, and the health care costs for this disability and its secondary complications alone will exceed \$3 trillion.

Chronic Pain

Like obesity, depression, and anxiety, chronic pain is the most commonly reported problem in the United States with an estimated 100 million sufferers costing over half a billion dollars annually in medical care and lost productivity (American Academy of Pain Medicine, n.d.). The most commonly reported pain is in the lower back (27%), headache or migraine pain (15%), neck pain (15%), and facial pain (4%). The International Classification of Disability (ICD-10-CM, 2010) lists a number of different types of diagnostic low back pain conditions including herniated discs (most frequently L4-L5), sciatica, degenerative changes like spondylosis, spinal stenosis, lumbago, lumbosacral joint instability, spondylolisthesis, sprains and strains. There are also nerve related injuries such as carpal tunnel syndrome, brachial plexus injuries, thoracic outlet syndrome, and ulnar nerve pain. Tendon and muscle related disorders include rotator cuffs tears, cervicgia (neck pain), bicipital tenosynovitis, and lateral epicondylitis (tennis elbow). Despite the belief by some that many persons complaining of chronic pain exaggerate or feign their symptoms, physician's estimate that this occurs less than 5% of the time (Fordyce, 1995; Hadjistavropoulos, 1999).

Since there is no definitive or objective way to measure pain, physicians can only infer its presence from

diagnostic tests such as nerve conduction studies and MRI; however, even then are left with patients' subjective ratings on a 1-10 visual analog scale. Researchers have found that only 20% of patients complaining of back pain had some physical basis to identify their pain, and 30% to 50% of patients who seek treatment have no diagnosable pain disorder (Dworkin & Massoth, 1994). Although there are several pain models, perhaps the biopsychosocial model describes the pain paradox best as to why two people with very similar injuries may respond in totally divergent ways. Pain in this model focuses on chronic pain as an illness, not a disease. Turk (1996) describes this illness as "a subjective experience or self-attribution that a disease is present; it yields physical discomfort, emotional distress, behavioral limitations, and psychosocial disruption" (p. 7). The interactions between the biological, social, and psychological variables describe the holistic experience of chronic pain. Specifically, the pain reaction paradox is largely influenced by individual cognitions/behaviors/emotions and the interactions one has with his or her environment. For example, statistics indicate the longer individuals are out of work, the less likely they will ever return to work (Waddell & Sawney, 2002). The fear of re-injury often leads to sedentary behaviors, deconditioning, weight gain, and a resulting vicious cycle of non-exertional behavior, financial and health related worries, and deteriorating health (Gatchel & Turk, 1996; Marini, 2012). Statistics also indicate that individuals take longer to return to work when involved in litigation as opposed to those who are not litigating, with similar statistics for those who are injured and collect Workers' Compensation benefits versus those who are not compensated for their injuries (Blackwell, Leierer, Haupt, & Kampitsis, 2003; Gribich, McGartland, & Polgar, 1998). Finally, several studies regarding chronic pain and a co-occurring reactive depression post-injury suggest the prevalence to range between 30% to 54% of cases involving injured workers (Banks & Kerns, 1996; Magni, Caldieron, Rigatti-Luichini, & Mirsky, 1990). A central question regarding chronic pain and depression relates to when, or if, an individual's depression eventually subsides to a point where they could become competitively employed. The testimony from the majority of SSA claimants would tend to suggest that their depression is integrally linked to their disability and unlikely to subside. Psychologically, individuals who continue to function with their pain and perceive the pain as controllable generally report a lower incidence of depression (Rudy, Kerns, & Turk, 1988). Conversely, individuals with a pre-injury history of depression or mental illness often show poorer rates of recovery with reported higher levels of pain and perceived disability (Turk, Okifuji, & Scharff, 1995).

Psychosocial and Socioeconomic Factors

Recent research regarding the impact of poverty, poor living conditions, and resulting physical and mental health implications has begun to demonstrate the deleterious effect of living under such circumstances (Kazak, Bosch, & Klonoff, 2012; Liu, 2011). For millions of Americans, the domino effect of poor opportunity and low education correlates highly with lower socioeconomic status (SES) and working in more physically demanding and hazardous jobs. This population often has little or no healthcare, poorer mental and physical health, obesity, and living under stressful and sometimes dangerous conditions (Liu, 2011; Smiley & West, 2012). Dowd, Palermo, and Aiello (2012) in their study of over 9,000 families living in poverty conclude that low SES is largely responsible for health disparities based on income, education, and race/ethnicity. Low family income and food insecurity was associated with decreased resistance of the immune system. This has arguably become the face of many SSI applicants as well as the several hundred thousand injured workers who are unable to return to work each year (Blackwell et al., 2003). Blackwell demonstrated that of the more than 500 workers' compensation files reviewed, age and education were the statistically significant factors in return to work as was attorney involvement and early intervention vocational rehabilitation. For many of the millions of individuals under age 65 applying for SSA benefits each year, this government safety net represents their last effort in obtaining healthcare and minimal living expense coverage.

The psychological implication for injured workers and SSA applicants regardless of type of disability often exacerbates their symptoms (Braubach & Fairburn, 2010; Laursen & Nielson, 2008; Lui, 2011). Perceived lack of control, learned helplessness and hopelessness regarding one's health and welfare circumstances negatively impacts behavior, cognitions, and emotions (Braubach & Fairburn, 2010; Laursen & Nielson, 2008; Marini, 2012). Lui (2011) cites numerous epidemiological studies regarding poverty and classism, noting poorer mental health, difficulty purchasing healthier foods, and higher disability and mortality rates at much younger ages. Living in poverty and under poor and/or oppressive living conditions tends to support many claimant symptoms of depression, anxiety, obesity and pain.

Vocational Implications

Testifying as a vocational expert with SSA does not allow for the expert to interview or assess the claimant, and is largely dependent on the hypothetical posed by the ALJ. Since SSA is based dichotomously on whether or not an individual can perform full-time

competitive employment or not, hypotheticals are posed in such a way that primarily limits the vocational expert's responses, and does not allot for reasonable accommodations, part-time work, or flex time at work. Some ALJs as well as medical and vocational experts may become stuck giving the same cookie-cutter hypotheticals and expert rendered opinions respectively for virtually every claimant with a somewhat similar disability. The vast majority of claimants observed during these three years held a high school education or less, supporting statistics that indicate individuals with lower levels of education experience a higher rate of work injuries and disability compared to persons with postsecondary education (Marini, 2012). Individuals with a psychiatric disability were most often perceived by ALJs and/or psychologists as being able to perform simple, routine tasks with occasional or incidental contact with the public. Persons with physical disabilities were typically (but not always) limited to light, unskilled work, with almost all non-exertional tasks limited to occasional or inability to perform (e.g., climbing, balancing, stooping, kneeling, crouching), and sometimes with a sit or stand option at will in ALJ hypotheticals. If the 564 cases observed from 2011-2013 are any indication of future trends, increasing numbers of claimants regardless of supporting medical records will be presenting with all four conditions discussed here. As such, the hypotheticals may continue to encompass both mental and physical limitations, and depending on individual circumstances, ultimately lead to sedentary or light unskilled hypotheticals with incidental public contact. Although these limitations still leave a number of unskilled job titles with significant numbers for those with a high school education or less, the combined disabilities begins to remove the fast-growing service industry job titles with public contact (e.g., food servers, cashiers), and this population does not qualify for the other skilled fast-growing industries in healthcare, computers, and professional jobs (Bureau of Labor Statistics, 2001). Conversely, unskilled manufacturing and production jobs have/are seeing a drastic decline due largely to a combination of outsourcing and robotics (Gore, 2013). With SSA and vocational experts still relying on a dated *Department of Labor* (1991) and no replacement available anytime soon, opinions may not accurately reflect our rapidly changing labor market.

Conclusion

With aging baby boomers over age 65 expected to double by 2030 as well as the continued increase in disabled worker applicants, unquestionably changes have to be made to the already deficit running system of SSA. SSA statistics indicate that disabled worker applications were over 1.3 million in the year 2000 and by 2012 with annual steady increases reached

over 2.8 million applicants. Conversely, the number of awards has steadily dropped over the past decade from approximately 50% in 1999 to 34% in 2012 (Social Security Administration, 2012a). These opposite trending statistics would seem to indicate that despite growing applications for benefits; successfully obtaining an award has become more difficult to prove. Despite mental illness representing almost 1/3 of all beneficiaries, and the majority of them being younger than age 50, proving one has depression, anxiety, and chronic pain that render them unemployable is becoming more stringent to do. Regardless of alleged claimant complaints, vocational experts appear to continue to have a significant number of job titles and employment numbers to assist the ALJ in making work determinations. Since much of the epidemiological literature concerning low income and low education individuals does support environmentally facilitated depression and anxiety problems, the central question becomes whether or not claimant perceived limitations in fact preclude them from sustaining competitive employment (Liu, 2011). This will of course continue to be debated on an individualized basis. Vocational experts should continue to research and build their commonly cited job base to include jobs where workers are working more with their hands than dealing with people or the public. As the US continues to bring outsourced jobs home as well as increasing manufacturing jobs in sustainable energy, the landscape of job titles will continue to change.

There are several study limitations worth noting. First, the 564 claimant frequency count described earlier for its characteristics contained 78% of individuals with Hispanic names. Since Hispanics are genetically predisposed to diabetes, the overrepresentation of this population is likely somewhat higher than the general population therefore generalizability to the rest of the nation is limited. Second, since vocational experts do not receive medical records, the percentages noted concerning depression, anxiety, and chronic pain were obtained from claimant written limitations in their file as well as their testimony in court. It therefore cannot be confirmed or denied that these claimants indeed had such a history of impairments as they opined.

References

- Aina, Y., & Susman, J. L. (2006). Understanding comorbidity with depression and anxiety disorders. *Journal of American Osteopathic Association*, 106(5), S9-S14. American Academy of Pain Medicine (n.d.). Retrieved from <http://www.painmed.org/patient/facts.html>
- American Obesity Association. (2012). Retrieved from http://www.obesity.org/subs/fastfacts/obesity_US.html
- American Psychological Association. (2007). *APA Dictionary of Psychology*. Washington, DC: Author.
- Anxiety and Depression Association of America. (2013). Retrieved from <http://www.aada.org/finding-help>
- Banks, S. M., & Kerns, R. D. (1996). Explaining high rates of depression in chronic pain: A diathesis-stress framework. *Psychological Bulletin*, 119, 95-110.
- Blackwell, T. L., Leierer, S. J., Haupt, S., & Kampitsis, A. (2003). Predictors of vocational return to work outcomes in workers' compensation. *Rehabilitation Counseling Bulletin*, 46(2), 108-114.
- Blouw, E. L., Rudolphe, A. D., Narr, B. J., & Sarr, M. G. (2003). The frequency of respiratory failure in patients with morbid obesity undergoing gastric bypass. *American Association Nurse Anesthetists Journal*, 71, 45-50.
- Bossolo, L. (2012). Psychotherapy works. *Monitor on Psychology*, 43(10), 17.
- Braubach, M., & Fairburn, J. (2010). Social inequities in environment risks associated with housing and residential location: A review of evidence. *European Journal of Public Health*, 20, 36-42.
- Bureau of Labor Statistics. (2001). *2000 - 2010 employment projections*. USDL 01-443. Retrieved from http://www.bls.gov/news.release/history/ecopro_12032001.txt
- Centers for Disease Control (2010). *Older, more diverse population and longer lifespans contribute to increase*. Centers for Disease Control and Prevention. Retrieved from <http://www.cdc.gov/media/pressrel/2010/r101022.html>
- Collins, K. A., Westra, H. A., Dozois, D. J. A., & Burns, D. D. (2004). Gaps in accessing treatment for anxiety and depression: Challenges for the delivery of care. *Clinical Psychology Review*, 24, 583-616. doi:10.1016/j.cpr.2004.06.001
- Coyne, J. C., Thompson, R., Palmer, S. C., Kagee, A., & Maunsell, E. (2000). Should we screen for depression? Caveats and potential pitfalls. *Applied & Preventative Psychology*, 9, 101-121.
- Department of Labor. (1991). *Dictionary of Occupational Titles*. Retrieved from <http://www.oalj.dol.gov/libdot.htm>
- Doornbos, M. M., Zandee, G. L., & DeGroot, J. (2012). Clinging to any bit of joy: Urban, ethnically diverse, impoverished women's descriptions of anxiety and depression. *Archives of Psychiatric Nursing*, 26(6), 437-447. doi:10.1016/j.apnu.2011.12.007
- Dowd, J. B., Palermo, T. M., & Aiello, A. E. (2012). Family poverty is associated with cytomegalovirus antibody titers in U.S. children. *Health Psychology*, 31(1), 5-10.
- Druss, B. G., Rask, K., & Katon, W. J. (2008). Major depression, depression treatment and quality of primary medical care. *General Hospital Psychiatry*, 30, 20-25. doi:10.1016/j.genhosppsych.2007.08.15

- Dworkin, S. F., & Massoth, D. L. (1994). Temporomandibular disorders and chronic pain: Disease or illness? *Journal of Prosthetic Dentistry*, 7, 29–38.
- Edge, L. E., & Ellis, C. (2010). Diabetes and depression: Global perspectives. *Diabetes Research and Clinical Practice*, 87, 302–312. doi:10.1016/j.diabres.2010.01.024
- Federal Register. (2002). *SSR 02-01 p: Policy ruling Titles II and XVI: Evaluation of obesity*. Retrieved from http://www.ssagov/OP_Home/rulings/di/01/SSR2002-01-di-01.html
- Fisher, E. B., Chan, J. C. N., Nan, H., Sartorius, N., & Oldenburg, B. (2012). Co-occurrence of diabetes and depression: Conceptual considerations for an emerging global health challenge. *Journal of Affective Disorders*, 142S1, S57–S66.
- Fordyce, W. E. (1995). *Back pain in the workplace*. Seattle, WA: IASP Press.
- Gatchel, R. J., & Turk, D. C. (1996). *Psychological approaches to pain management: A practitioner's handbook*. New York, NY: Guilford Press.
- Gore, A. (2013). *The future: Six drivers of global change*. New York, NY: Random House.
- Gribich, C., McGartland, M., & Polgar, S. (1998). Regulating workers compensation: The medico legal evaluation of injured workers in Victoria. *Australian Journal of Social Issues*, 33(3), 241–263.
- Gwynn, R. C., McQuiston, H. L., McVeigh, K. H., Garg, R. K., Frieden, T. R., & Thorpe, L. E. (2008). Prevalence, diagnosis, and treatment of depression and generalized anxiety disorder in a diverse urban community. *Psychiatric Services*, 59(6), 641–647.
- Hadjistavropoulos, T. (1999). Chronic pain on trial: The influence of litigation and compensation on chronic pain syndromes. In A. R. Bolck, E. F. Kremer, & E. Fernandez (Eds.), *Handbook of pain syndromes* (pp. 59–76). Mahwah, NJ: Lawrence Erlbaum.
- Hallford, D. J., McCabe, M. P., Mellor, D., Davison, T. E., & Goldhammer, D. L. (2012). Depression in palliative care settings: The need for training for nurses and other health professionals to improve patients' pathways to care. *Nurse Education Today*, 32, 556–560. doi:10.1016/j.nedt.2011.07.011
- Hermanns, N., Caputo, S., Dzida, G., Khunti, K., Meneghini, L. F., & Snoek, F. (2013). Screening, evaluation and management of depression in people with diabetes in primary care. *Primary Care Diabetes*, 7, 1–10. doi:10.1016/j.pcd.2012.11.002
- International Classification of Disability-10-CM. (2010). Eden Prairie, MN: Ingenix.
- Kazak, J., Bosch, J., & Klonoff, E. A. (2012). Health psychology special series on health disparities. *Health Psychology*, 31(1), 1–4.
- Kravitz, R. L., Epstein, R. M., Bell, R. A., Rochlen, A. B., Duberstein, P., Riby, C. H., . . . Paterniti, D. A. (2013). An academic-marketing collaborative to promote depression care: a tale of two cultures. *Patient Education and Counseling*, 90, 411–419. doi:10.1016/j.pec.2011.07.003
- Laursen, B., & Nielson, J. W. (2008). Influence of sociodemographic factors on the risk of unintentional childhood home injuries. *European Journal of Public Health*, 18, 366–370.
- Lazelere, M. M., & Wiseman, P. (2002). Anxiety, depression, and insomnia. *Primary Care: Clinics in Office Practice*, 29, 339–360.
- Lowe, B., Spitzer, R. L., Williams, J. B. W., Mussell, M., Schellberg, D., & Kroenke, K. (2008). Depression, anxiety, and somatization in primary care: Syndrome overlap and functional impairment. *General Hospital Psychiatry*, 30, 191–199. doi:10.1016/j.genhosppsych.2008.01.001
- Liu, W. M. (2011). *Social class and classism in the helping professions: Research, theory, and practice*. Thousand Oaks, CA: Sage.
- Magni, G., Caldieron, C., Rigatti-Luchini, S., & Merskey, H. (1990). Chronic musculoskeletal pain and depressive symptoms in the general population: An analysis of the 1st National Health and Nutrition Examination survey. *Pain*, 43, 299–307.
- Marini, I. (2012). The psychosocial world of the injured worker. In I. Marini, N. M. Glover-Graf, & M. Millington (Eds.), *Psychosocial aspects of disability: Insider perspectives and counseling strategies* (pp. 235–256). New York, NY: Springer.
- Marini, I., Feist, A., & Miller, E. (2004). Vocational expert testimony for the Social Security Administration: Observations from the field. *Journal of Forensic Vocational Analysis*, 7(1), 25–34.
- National Institute of Mental Health [NIMH]. (2010). *Statistics on mental health*. Retrieved from http://www.nimh.nih.gov/statistics/1mdd_adult.shtm
- Ogden, C. L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2012). *Prevalence of obesity in the United States, 2009–2010*. Centers for Disease Control and Prevention. National Center for Health Statistics, Data Brief No. 82, 1–6.
- Romero, M. G., & Marini, I. (2012). Obesity as a disability: Medical, psychosocial, and vocational implications. In I. Marini & M. Stebnicki (Eds.), *The psychological and social impact of illness and disability* (6th ed., pp. 435–448). New York, NY: Springer.
- Rudy, T. E., Kerns, R. J., & Turk, D. C. (1988). Chronic pain and depression: Toward a cognitive-behavioral medication model. *Pain*, 35, 179–183.
- Seekles, W., Van Straten, A., Beekman, A., van Marwijk, H., & Cuijpers, P. (2011). Effectiveness of guided self-help for depression and anxiety disorders in primary care: A pragmatic randomized controlled trial. *Journal of Psychiatry Research*, 187, 113–120. doi:10.1016/j.psychres.2010.11.015
- Shim, R. S., Baltrus, P., Ye, J., & Rust, G. (2011). Prevalence, treatment, and control of depressive

- symptoms in the united states: Results from the national health and nutrition examination survey (NHANES), 2005-2008. *Journal of the American Board of Family Medicine*, 24(1), 33-38.
- Smiley, T. & West, C. (2012). *The rich and the rest of us: A poverty manifesto*. New York, NY: Smiley Books.
- Social Security Administration. (2012a). *Fast facts and figures about Social Security*. Retrieved from http://www.socialsecurity.gov/policy/docs/chartbooks/fast_facts/2012/fast_facts12.pdf
- Social Security Administration. (2012b). *Selected data from Social Security's disability program*. Retrieved from <http://www.ssa.gov/OACT/STATS/dibStat.html>
- Turk, D. C. (1996). Biopsychosocial perspective in chronic pain. In R. H. Dworkin & W. S. Breitbart (Eds.), *Psychosocial aspects of pain: A handbook for health care providers* (pp. 3-32). Seattle, WA: IASP Press.
- Turk, D. C., Okifuji, A., & Scharff, L. (1995). Chronic pain and depression: Role of perceived impact and perceived control in different age cohorts. *Pain*, 61, 93-102.
- U.S. Census Bureau. (2010). *U.S. quick facts from the U.S. Census Bureau*. Retrieved from <http://quickfacts.census.gov/qfd/states/00000.html>
- Visscher, T. L. S., & Seidell, J. C. (2001) The public health impact of obesity. *Annual Review Public Health*, 22, 355-375.
- Waddell, G. A., & Sawney, P. (2002). *Back pain, incapacity for work, and social security benefits: An international review and analysis*. London, England: Royal Society of Medicine Press.
- Wittemore, R., Bak, P. S., Melkas, G. D., & Grey, M. (2003). Promoting lifestyle change in the prevention and management of Type II diabetes. *Journal of the American Academy of Nurse Practitioners*, 15, 341-349.
- Young, A. S., Klap, R., Shoai, R., & Wells, K. B. (2008). Persistent depression and anxiety in the united states: Prevalence and quality of care. *Psychiatric Services*, 59(12), 1391-1398.

Author Notes

Irmo Marini, PhD, CRC, CLCP, is currently a professor in the Department of Rehabilitation at the University of Texas-Pan American. Danielle Fox is currently a PhD student in the Department of Rehabilitation at the University of Texas-Pan American. Noel Ysasi is currently a PhD candidate in the Department of Rehabilitation at the University of Texas-Pan American.

Editorial Comments:

Writers of the present article have offered several interesting points related not only to the field of vocational rehabilitation, but also features of workers with

disabilities themselves. Before going into specific content and feedback pertaining to the present article, I want to discuss conceptualization. At present, the field of vocational rehabilitation, in general, is lacking the range and diversity of the scientific practitioner that was perhaps typified 20 years ago are greater. Often times individuals will have to ask whether I am a counselor or a scientist and I happily respond but I fail to identify any differences. This article reflects an investigation into one's caseload, offering valuable information regarding identification of the present client, but also projection of whom future clients may indeed be. The methodology and the present article is not complex, but the results are not only revealing, but offer substance and a contribution to the field itself. It is encouraged for more articles, similarly reviewing individual caseloads are submitted to the present Journal. Readers are advised to follow ethical guidelines when reporting descriptive or extant data. Several observations will be discussed in the following paragraphs.

Although I have not personally work cases within the Social Security system, I am very familiar with the process pertaining to identification of disability eligibility in both workers compensation and personal injury scenarios. While the Social Security system obviously has flaws, the identified system has a tried and true mechanism for identifying not only whom is our is not able to return to their preinjury line of work, but also work in the general labor market. Consideration of education, work history, current labor market trends, and transferable skills remains essential working units for the vocational counselor in any scenario. It would be encouraged for not only the student, but also the tenured professional to be aware of the Social Security guidelines for determining disability status, and incorporate these guidelines into the daily practice.

Purely, in my opinion, a major weakness in the current Social Security system is its continued dependence on *Dictionary of Occupational Titles*. This document was last published in 1991 with several updates dependent on data from the mid-1970s. Indeed, the world has changed since the mid-1970s, including the mechanisms that work activity is performed. Rehabilitation counselors would be encouraged to not only utilize more modern identifiers, such as O*Net, but also Internet itself, if available, when asked to establish employability. It is recognized that the Social Security administration has been evaluating alternatives to the *Dictionary of Occupational Titles*, but definitive action to utilize other options has not come to fruition. Similarly, those in private and public sectors may similarly be cautioned about using this outdated reference as a sole source of employment information.

Throughout the present paper, the concepts of obesity and chemical dependency were discussed at length. Several comments will be offered related to these two constructs. Pertaining to obesity the Social Security Administration has varied regarding whether it considers obesity as a primary or secondary disability. Society, perhaps, views obesity as a self-contained and self-dependent behavior, suggesting that obese individuals lack motivation or purpose, giving them propensity towards acceptance of disability as the norm. Most recently, research pertaining to weight bias has begun to creep up in the literature. The literature suggests that obese individuals witness similar discriminability and profiling, typified of workers and job applicants that are minorities based on race and gender. Literature has further demonstrated that work attitudes and motivation among obese individuals and the general population may not significantly vary, prompting the attitude that obese individuals are shiftless and perhaps choose to be nonproductive as not accurate.

It is acknowledged that obesity is generally reflected in both poor physical conditioning, and poor food selection choices. Considering the range of individuals that are obese in disability scenarios, perhaps nutritional services, alongside physical fitness programs may complement or even be a requirement for said individuals. While obesity often accompanies disability, sadly and consistently, so does alcohol and drug abuse.

Chemical dependency has similarly varied as a disability moderator in the Social Security system. At times chemical dependency and isolation was warranted attainment of disability and isolation of other conditions, the most recently chemical dependency must complement additional disabilities, such as respiration, gustatory, mental health, or kidney based disabilities. Multiple arguments may be made regarding whether chemical dependency is a personal choice or an overlay from specific diseases. Independent of political or medical foundations, is not without question that chemical dependency not only limits potentials for individuals, but also affects family members. As such, as nutritional and physical fitness services may be afforded to workers with disabilities, mandatory chemical treatment services may be also offered.

The concept of chronic pain has also been discussed as a contributing factor towards disability, particularly in the Social Security system. Admittedly, chronic pain is a difficult construct to define. In contrast, on a personal note, I can easily tell someone what I am and failed to be in pain. Within today's society chronic pain is most often treated through medications. Often times the medications are well-managed by a treating physician and other times the treating physician offers a very passive role in the medication follow-up protocol. Independent of these actions, unfortunately,

individuals become addicted to the pain medication, and, the pain associated with coming off of the medications may be greater than the pain of origin. Within the last two issues of the present Journal issue of medication and pain management and functionality of the worker with a disability has come to the forefront. This suggests as rehabilitation professionals we must not only be aware of pain management protocols through medication, but also perhaps, become advocates and investigators pertaining to this continuum.

Interestingly the present paper ends with comments pertaining to both the increased number of claims and is similar push to decrease awarding of plan benefits. It is agreed that workers with disabilities are more productive that are concurrently working, as opposed to individuals dependent on Social Security benefits. It is most important to note that several individuals simply cannot return to the workforce, even with modifications, whatever related to their psychological and physical disabilities. For those workers or individuals the Social Security system remains a vital resource and source of justified dependence. However, for individuals with disabilities that may be able to work with and without modifications the Social Security system remains a crutch, perhaps limiting independence.

Again, it is with excitement that the current article was reviewed and accepted in the present Journal. The Rehabilitation Professional encourages authors to critically examine their own caseloads and report their findings. Findings should be reported in a discernable format and be based on an educational goal as opposed to self-promotion or marketing. Self-promotion or marketing article will not be accepted by the present journal. You may contact Dr. Wesley Austin or me for further guidance on similar projects. Again, others are encouraged to submit similar articles to be reviewed and considered for publication similar to the current article.

When developing similar articles authors are encouraged to initially identify a methodology to pursue a similar project. Methods may include correlational, mixed methods, interview, or even case studies. Based upon a review of past issues of the present journal, few, if any case studies have been submitted, or printed as final copy. Case studies should succinctly focus on individual feature, but carefully to identify the client, in order to preserve confidentiality. If you choose to present a study for review in the present journal, within individual studies, authors are encouraged to consult with their respective Institutional Review Boards for consideration of ethical guidelines for similar studies. Authors are discouraged from assuming that virtue of private practice association and void of university affiliation that they are not required to meeting applicable research guidelines. Licensure and certification ethical codes are always applicable towards use of human subjects for research purposes.

Prospective authors are encouraged to consult with these codes prior to preparation or final submission of a paper.

Dr. T. Scott Smith, Editor