

IDENTITY AND NARRATIVE: TURNING OPPRESSION INTO  
CLIENT EMPOWERMENT IN SOCIAL SECURITY DISABILITY  
CASES

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Social Security disability law and practice is disabling. The common understanding is that successful claims require fitting a case and a client's story into a master narrative that embraces stereotypic victimization and helplessness, and requires disclosure of embarrassing details of disability as the individual's defining identity.<sup>1</sup> Subjecting oneself to the system as it is presently practiced is often at odds with disabled individuals' instincts, desires, and mental well-being, and is at odds with the goals of lawyers who seek to empower clients through their advocacy.<sup>2</sup> It re-victimizes and stigmatizes the clients we seek to benefit. Serious criticisms have been leveled at anti-poverty lawyers who routinize the practice of law on behalf of individuals seeking Social Security disability benefits.<sup>3</sup> And serious criticism of the medically-based construct of Social Security disability has grown out of the disability rights movement, so much so that many disability rights scholars reject the basic

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<sup>1</sup> Matthew Diller, *Dissonant Disability Policies: The Tensions Between the Americans with Disabilities Act and Federal Disability Benefit Programs*, 76 TEX. L. REV. 1003, 1014 (1998); see also Spencer Rand, *New Directions in Clinical Legal Education: Creating My Client's Image: Is Case Theory Value Neutral in Public Benefits Cases?*, 28 WASH. U. J.L. & POL'Y 69, 77 (2008) ("In Supplemental Security Income ("SSI") and Social Security Disability cases, clients must testify to their own failings and their lack of hope of ever overcoming those failings to show that they are not just trying to beat the system."); Laura Ackerman Sherwood, *A Counterstory to Master Narratives for Persons with Disability: Carolyn Scheidies' Life History*, at ii, viii (April 2009) (unpublished Ph.D. dissertation, Regent University) (on file with the School of Communications and the Arts, Regent University) ("[O]ppressive master narratives about persons with physical or mental disabilities often dominate these marginalized groups of individuals.").

<sup>2</sup> See Rand, *supra* note 1, at 77, 110.

<sup>3</sup> See, e.g., Anthony V. Alfieri, *Impoverished Practices*, 81 GEO. L.J. 2567, 2608–09, 2634, 2658 (1993).

premises of the program.<sup>4</sup>

While this paper acknowledges the bases of those criticisms, it argues that because of the economic importance of the Social Security programs to the disabled, client-centered advocates who strive to empower communities should not abandon the practice of Social Security disability law. Rather, this paper encourages anti-poverty lawyers to focus on client narratives and to reframe their practice, thus helping, as Laura Rovner urges, the nation re-learn and re-understand disability.<sup>5</sup>

I begin with a review of the disabling meta-narrative that infuses Social Security proceedings. The legal standard for disability requires persons with a disability to present as the sum of their impairments and to profess that they cannot function in the workplace.<sup>6</sup> As practitioners struggle to present cases that conform to the legal standards without questioning the frame of those standards, they disable and disempower their clients, and push their clients to present their narratives in a disabling and disempowering manner.

I then discuss the possibilities for framing these issues differently, by referencing the disability rights movement and human rights norms. The paper concludes with suggestions for practitioners for the reframing of their practice and client narrative that is consistent with principles of client autonomy, attorney-client collaboration, and infused with more empowering client counter narratives that reject or co-opt the disabling master narratives urged by the Social Security system.

## I. DISABLING NORMS INFUSE SOCIAL SECURITY DISABILITY CASES

### A. *The Standard*

Social Security Disability Insurance (“SSDI”) and Supplemental Security Income (“SSI”) cannot be ignored in conversations about the rights of the disabled because they are the largest source of assistance to persons with disabilities in the United States,<sup>7</sup> and more individuals seek and rely on disability benefits to meet their

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<sup>4</sup> See Jonathan C. Drimmer, Comment, *Cripples, Overcomers, and Civil Rights: Tracing the Evolution of Federal Legislation and Social Policy for People with Disabilities*, 40 UCLA L. REV. 1341, 1344–45 (1993); see *infra* text accompanying notes 101–02.

<sup>5</sup> Laura L. Rovner, *Disability, Equality, and Identity*, 55 ALA. L. REV. 1043, 1090 (2004).

<sup>6</sup> Diller, *supra* note 1, at 1014.

<sup>7</sup> See *Benefits for People with Disabilities*, U.S. SOC. SEC. ADMIN., <http://www.ssa.gov/disability> (last visited March 22, 2016).

basic needs every day.<sup>8</sup> “People with disabilities overwhelmingly remain poor, and . . . [p]overty among people with disabilities is worse in the United States than elsewhere in the developed world.”<sup>9</sup> Far from the shift anticipated by some in the disability rights movement from welfare or Social Security Disability Insurance rolls to employment after the Americans with Disability Act (“ADA”) was enacted, more people with disabilities receive SSI and SSDI and the employment rolls have not increased for the disabled.<sup>10</sup>

SSI and SSDI differ in their conceptualization, history, and funding source. SSDI is an entitlement funded through Federal Insurance Contribution Act (“FICA”) taxes under Title II of the Social Security Act<sup>11</sup> that has been available since 1956.<sup>12</sup> SSI is a means-tested welfare benefit<sup>13</sup> created in 1972 as part of the Nixon Administration’s attempt to standardize state disability-related welfare payments.<sup>14</sup> By 2012, there were approximately 8.3 million persons receiving SSI benefits—7.1 million on the basis of disability.<sup>15</sup> Even though the two disability benefits are paid out of different funds, the standards for disability determinations are the

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<sup>8</sup> See *Selected Data from Social Security’s Disability Program*, U.S. SOC. SEC. ADMIN., <http://www.ssa.gov/oact/STATS/dibStat.html> (last visited Mar. 22, 2016). In recent years the number of applications for social security disability insurance has nearly doubled. In 2000 there were 1,330,558 applications; by 2014, that number had increased to 2,521,459. *Id.* While the reasons for this dramatic increase are complex, and include, inter alia, changes to the domestic labor market, see, for example, Chana Joffe-Walt, *Unfit for Work: The Startling Rise of Disability in America*, NPR, <http://apps.npr.org/unfit-for-work> (last visited Mar. 22, 2016), the increasing importance of SSI and SSDI to impoverished persons with a disability cannot be gainsaid.

<sup>9</sup> Mark C. Weber, *Disability Rights, Welfare Law*, 32 CARDOZO L. REV. 2483, 2485–86 (2011).

<sup>10</sup> Samuel R. Bagenstos, *The Americans with Disabilities Act as Welfare Reform*, 44 WM. & MARY L. REV. 921, 923 (2003).

<sup>11</sup> 42 U.S.C. § 401 (2014); *Deputy Commissioner for Disability and Income Security Programs, Martin Gerry’s Testimony*, U.S. SOC. SEC. ADMIN., [https://www.ssa.gov/legislation/testimony\\_071102a.html](https://www.ssa.gov/legislation/testimony_071102a.html) (last visited Mar. 22, 2016); *Disability Insurance Trust Fund*, U.S. SOC. SEC. ADMIN., <https://www.ssa.gov/oact/progdata/describedi.html> (last visited Mar. 22, 2016).

<sup>12</sup> *Historical Background and Development of Social Security*, U.S. SOC. SEC. ADMIN., <https://www.ssa.gov/history/briefhistory3.html> (last visited Mar. 22, 2016).

<sup>13</sup> See *Understanding Supplemental Security Income (SSI) Overview—2015 Edition*, U.S. SOC. SEC. ADMIN., <http://www.socialsecurity.gov/ssi/text-over-ussi.htm> (last visited Mar. 22, 2016).

<sup>14</sup> See EILEEN P. SWEENEY & SHAWN FREMSTAD, CTR. ON BUDGET & POL’Y PRIORITIES, SUPPLEMENTAL SECURITY INCOME: SUPPORTING PEOPLE WITH DISABILITIES AND THE ELDERLY POOR 1, 6 n.1 (Aug. 17, 2005), <http://www.cbpp.org/files/7-19-05imm.pdf>; Donna Meltzer, *Happy Birthday, SSI: A Safety Net for Vulnerable Americans*, HUFFINGTON POST (Oct. 30, 2012, 12:24 PM), [http://www.huffingtonpost.com/donna-meltzer/supplemental-security-income\\_b\\_2038214.html](http://www.huffingtonpost.com/donna-meltzer/supplemental-security-income_b_2038214.html).

<sup>15</sup> SHIRLEY TURPIN, U.S. SOC. SEC. ADMIN., PUB. NO. 13-11785, FAST FACTS & FIGURES ABOUT SOCIAL SECURITY, 2013, at 26, 27 (2013), [https://www.socialsecurity.gov/policy/docs/chartbooks/fast\\_facts/2013/fast\\_facts13.pdf](https://www.socialsecurity.gov/policy/docs/chartbooks/fast_facts/2013/fast_facts13.pdf).

same and are made by the same administrative process and officials.<sup>16</sup> The standard to qualify as disabled for Social Security purposes is difficult to articulate, to decide, and to meet.<sup>17</sup> To qualify as disabled for Social Security purposes, an individual must establish that he or she is unable “to engage in *any* substantial gainful activity” due to a physical or mental impairment that has lasted or is expected to last for a year or more, or is expected to result in death.<sup>18</sup> Social Security’s definition of disability relies on the medical view of disability, focusing on the impairment, and what is wrong with the individual.<sup>19</sup>

Individuals must show not only that they cannot perform their previous work but also that their impairment(s) are so severe that they cannot perform *any* job that “exists in the national economy, regardless of whether such work exists in the immediate area,” or whether the individual would be hired if he applied.<sup>20</sup> As Spencer Rand has noted, clients seeking disability benefits are thus “constrained to describe themselves as incompetent people who cannot cope with their impairments.”<sup>21</sup>

### B. *The Process*

The administrative process for Social Security disability and SSI disability claims consists of a series of claim evaluators and appeals.<sup>22</sup> There are “two critical decision points” in the process for disability determinations: “the initial administrative decision and the ALJ

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<sup>16</sup> Compare *Understanding Supplemental Security Income (SSI) Overview—2015 Edition*, *supra* note 13 (explaining that SSI benefits are funded by the general funds of the Treasury, but both programs are administered by the Social Security Administration and have similar criteria for determining disability), and Meltzer, *supra* note 14 (noting the Social Security Administration’s need for increased funding to better administer SSI), with U.S. SOC. SEC. ADMIN., PUB. NO. 05-10024, UNDERSTANDING THE BENEFITS 9, 12, 17 (2015), <http://www.socialsecurity.gov/pubs/EN-05-10024.pdf> (explaining that Social Security benefits are based on how much an individual has worked, and thus, paid into the program over the course of his or her career).

<sup>17</sup> See Frank S. Bloch et al., *The Social Security Administration’s New Disability Adjudication Rules: A Significant and Promising Reform*, 92 CORNELL L. REV. 235, 236 (2007).

<sup>18</sup> 42 U.S.C. § 423(d)(1)(A) (2014) (emphasis added).

<sup>19</sup> Laura L. Rovner, *Perpetuating Stigma: Client Identity in Disability Rights Litigation*, 2001 UTAH L. REV. 247, 273 (“[T]he use of the term ‘impairment’ in the statute immediately invokes the stereotypes associated with the medical model of disability—images of a person who is broken in some fashion, and who needs to be fixed.”).

<sup>20</sup> 42 U.S.C. § 423(d)(2)(A); see also 20 C.F.R. § 416.960(b) (2015) (explaining how the determination as to whether or not the applicant can perform his or her previous work will be determined and what happens next in the evaluation process).

<sup>21</sup> Rand, *supra* note 1, at 94–95.

<sup>22</sup> See *Disability Determination Process*, U.S. SOC. SEC. ADMIN., <http://www.ssa.gov/disability/determination.htm> (last visited Mar. 22, 2016).

hearing.”<sup>23</sup> To initiate a claim, an individual files an initial application for benefits with their local Social Security office.<sup>24</sup> The initial disability determination is made by a state agency called the Office of Disability Determination Services (“DDS”) in the claimant’s respective state.<sup>25</sup> Most claimants are unrepresented at this stage in the proceedings and the majority of the claims are denied.<sup>26</sup> Although the system is ostensibly designed to be penetrable by unrepresented individuals, it works well only as a means to screen out applicants and deny benefits, often because the applicant is unable to comply with the time frames and deadlines set by the agency or to provide sufficient proof of disability.<sup>27</sup> After initial denial, the claimant can request reconsideration within sixty days.<sup>28</sup> Typically this results in a different DDS officer reaching the same result as the initial determination.<sup>29</sup> The reconsideration step has been criticized, and recommended for elimination, based on the fact that it is “essentially repetitive” of the initial decision.<sup>30</sup> If denied after reconsideration, the claimant can, again within sixty days, request a hearing before an administrative law judge (“ALJ”).<sup>31</sup>

At this stage, the odds change dramatically. Claimants are approved well over fifty percent of the time.<sup>32</sup> The reasons for this discrepancy are manifold, but I believe the most important is the availability of counsel. Counsel makes a difference to the outcome of these cases in two seminal ways. Counsel develops the evidentiary record<sup>33</sup> and works with the claimant to present the client’s narrative

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<sup>23</sup> Bloch et al., *supra* note 17, at 238.

<sup>24</sup> S. Sandy Sanbar, *Winning Social Security Disability Cases*, 31 J. LEGAL MED. 91, 97 (2010).

<sup>25</sup> *Disability Determination Process*, *supra* note 22.

<sup>26</sup> Only 32.2 percent of claims are approved nationally at the initial application stage. *Social Security DDS Comparison Statistics: Wait Times and Approvals*, SSDFACTS.COM, <http://www.ssdfacts.com/dds> (last visited Mar. 22, 2016).

<sup>27</sup> See Bloch et al., *supra* note 17, at 237, 245; see *DDS Comparison Statistics: Wait Times and Approvals*, *supra* note 26.

<sup>28</sup> 20 C.F.R. § 416.1409(a) (2015).

<sup>29</sup> See *Social Security DDS Comparison Statistics: Wait Times and Approvals*, *supra* note 26 (noting that only 11 percent are approved on reconsideration).

<sup>30</sup> See, e.g., Bloch et al., *supra* note 17, at 238.

<sup>31</sup> 20 C.F.R. §§ 416.1430(a)(1), 416.1433(b).

<sup>32</sup> *Social Security DDS Comparison Statistics: Wait Times and Approvals*, *supra* note 26. The next step in the administrative process is an appeal to Social Security Appeals Council, again within sixty days. 20 C.F.R. §§ 416.1467, 416.1468(a). A claimant who prevails at this level often merely has their case remanded to an administrative law judge for a new hearing. See *id.* § 416.1477(a)–(b). Claimants whose request for relief from the Appeals Council is denied can file a claim in Federal district court under a substantial evidence standard of review. 42 U.S.C. § 405(g) (2014); 20 C.F.R. § 416.1481; *Valente v. Sec’y of Health & Human Servs.*, 733 F.2d 1037, 1041 (2d Cir. 1984).

<sup>33</sup> See *Social Security Disability Determination Process Improvements Before the Subcomm.*

regarding disability and how the client is affected by disability.<sup>34</sup> It is the only part of the administrative process that permits witness testimony before a decision maker.<sup>35</sup> It is the development and content of that narrative that I want to explore here.

### *C. The University of Miami's Health Rights Clinic*

The client narratives that appear in this article are drawn from my experiences as a clinical professor and anti-poverty lawyer working in the Health Rights Clinic at the University of Miami School of Law.<sup>36</sup> I want to contextualize my points by providing some information about my Clinic and what we do. The Health Rights Clinic is a Medical-Legal Partnership working collaboratively with health care providers in three medical settings—the adult Ryan White funded HIV care clinics (“Miami-Dade County has the third-highest serio-prevalence rate in the nation”),<sup>37</sup> the county community health center which treats the uninsured population, an organization devoted to assisting homeless veterans, and the Pediatric Mobile Clinic, which treats uninsured children.<sup>38</sup> All of our clients are impoverished, many are far below the federal poverty standard, many are female, many are immigrants, and many are language and/or racial minorities.<sup>39</sup> Our client population is more than 95 percent

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*on Soc. Sec., H. Comm. on Ways and Means*, 109th Cong. (2005) (statement of Marty Ford, Co-Chair, Soc. Sec. Task Force, Consortium for Citizens with Disabilities) (noting that even with counsel, many claimants have difficulty securing all their medical evidence, and without counsel it is virtually impossible).

<sup>34</sup> See *infra* Part II.

<sup>35</sup> Bloch, et al., *supra* note 17, at 244.

<sup>36</sup> The Health Rights Clinic, originally called the Community Health Rights Education Clinic by its founder Anthony Alfieri, was based on the model developed by Professors Gary Bellow and Jeanne Charn at Harvard Law School's Wilmer Hale Legal Services Center in the 1980s. Anthony V. Alfieri, *(Un)covering Identity in Civil Rights and Poverty Law*, 121 HARV. L. REV. 805, 821 n.50 (2008) (citing Gary Bellow & Jeanne Charn, *Paths Not Yet Taken: Some Comments on Feldman's Critique of Legal Services Practice*, 83 GEO. L.J. 1633, 1649 n.54, 1659–63 (1995) (describing the Medical-Legal Services Project)); see Anthony V. Alfieri, *Teaching Ethics/Doing Justice*, 73 FORDHAM L. REV. 851, 860–61 (2004) (describing the Community Health Rights Education Clinic).

<sup>37</sup> JoNel Newman, *Re-conceptualizing Poverty Law Clinical Curriculum and Legal Services Practice: The Need for Generalists*, 34 FORDHAM URB. L.J. 1303, 1319 (2007).

<sup>38</sup> The Clinic provides on-site legal services to patients treated at the University of Miami Miller School of Medicine's Adult HIV Clinic, at Jefferson Reaves Sr. Health Center, a community health center in Miami's historically black neighborhood of Overtown, the University of Miami Miller School of Medicine's Pediatric Mobile Clinic, and through Operation Sacred Trust, which assists homeless veterans. JoNel Newman, *Miami's Medical-Legal Partnership: Preparing Lawyers and Physicians for Holistic Practice*, 9 IND. HEALTH L. REV. 473, 476–78 (2012).

<sup>39</sup> JoNel Newman, Miami Sch. of Law Health Rights Clinic Client Intake Statistical Charts, (on file with author).

minority.<sup>40</sup> All of our clients are health-impaired or disabled, many with among the most stigmatized disabilities, such as HIV and mental health issues. Many have multiple disabilities. They often also have or presently engage in stigmatized conduct—many are homeless, many have a history of drug or alcohol dependence, and many have a criminal history. Many of our female clients struggle with a history of domestic violence.

Our representation and advocacy model tries to comprehensively address the client's legal needs and goals. Most of this work involves benefits and entitlements such as Social Security Supplemental Income and disability, immigration status adjustments affecting or related to disability or health care access, advance directives, anti-discrimination work in housing, employment and access to government services and benefits.<sup>41</sup> It is our goal to do this by genuinely engaging our clients in making advocacy choices and by presenting our client's narrative authentically and in a culturally sensitive and enabling way. The Clinic's signature pedagogies include holistic representation,<sup>42</sup> a high case volume for students,<sup>43</sup> and intense preparation for hearings, with mock hearings done with the client in an effort to engage the client as much as possible in the representation, and to give the client and the student helpful feedback in advance of the actual hearing.

Over and over again, as we did Social Security mock hearings, we found it difficult to escape contributing to further disabling the client through the development of client narratives that were designed to conform to Social Security's criteria for adjudicating disability claims favorably.<sup>44</sup> We saw the damaging toll caused by these narratives first-hand and on a daily basis. Working collaboratively with our clients, we have made some progress in disabling the master narrative that Social Security seems to demand, and this paper is

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<sup>40</sup> *Id.* In our last demographic survey, of 200 clients, 48 percent self-identified as Hispanic, 47 percent as Black, 3 percent as White, 1 percent as Asian and 1 percent as Other. 44 percent were Spanish speakers, 36 percent speak English, 19 percent speak Haitian Creole, and 1 percent speak other languages. *Id.*

<sup>41</sup> *Health Rights Clinic Medical Legal Partnership*, INST. FOR THE ADVANCEMENT OF THE AM. LEGAL SYS., <http://iaals.du.edu/educating-tomorrows-lawyers/projects/resources/health-rights-clinic-medical-legal-partnership> (last visited Mar. 22, 2016); Newman, *supra* note 39.

<sup>42</sup> See Newman, *supra* note 37, at 1312–16.

<sup>43</sup> JoNel Newman & Melissa Swain, University of Miami School of Law, Back to the Future in Clinical Education: What Legal Clinicians (Still) Have to Learn from the Medical Clinical Model (Dec. 2010) (on file with author).

<sup>44</sup> Robert Dinerstein discusses the interaction between lawyer and client to frame a client narrative that “both captures the person's experience and that will satisfy the criteria established by the relevant legal doctrine.” Robert D. Dinerstein, “*Every Picture Tells a Story, Don't It?*”: *The Complex Role of Narratives in Disability Cases*, 15 NARRATIVE 40, 42 (2007).

written for practitioners who want to work with their clients to overcome some of the damaging and stereotypical narratives often used in Social Security cases. To understand how the process demands demoralizing stereotypes, it is helpful to understand the hearing process before an administrative law judge in Social Security cases.

#### *D. The Administrative Law Judge Hearing*

In making a determination as to whether a claimant is disabled, the ALJ is required to use a five-step process that interrogates the individual, the disability, and past and potential work.<sup>45</sup> The judge must make at least three and up to five sequential decisions to determine whether a person is disabled.<sup>46</sup> First, the claimant must establish she is not engaged in “substantial gainful activity.”<sup>47</sup> The Social Security Act defines “substantial work activity” as any “work activity that involves doing significant physical and mental activities” and “gainful work activity” as “work activity that you do for pay or profit.”<sup>48</sup> Income is strictly limited. If a claimant earns as much as \$1,130 per month, then they are considered to have substantial gainful activity.<sup>49</sup> Even at this stage, the process discounts the value of many women and others who do not conform to stereotypic work norms as activities including, “taking care of yourself, household tasks, hobbies, therapy . . . or social programs [are not considered] to be substantial gainful activity.”<sup>50</sup>

At the second step in the process, the ALJ evaluates whether the claimant’s impairments are severe<sup>51</sup> and are either expected to result in death or last a continuous period of at least twelve months.<sup>52</sup> A “severe impairment” is defined as “any impairment or combination of impairments which significantly limits [the claimant’s] physical or mental ability to do basic work activities . . . .”<sup>53</sup> At this step, “age,

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<sup>45</sup> 20 C.F.R. § 416.920(a)(4)(i)–(v) (2015).

<sup>46</sup> *Id.*

<sup>47</sup> *Id.* § 416.920(a)(4)(i).

<sup>48</sup> *Id.* § 416.972(a)–(b).

<sup>49</sup> *Substantial Gainful Activity*, U.S. SOC. SEC. ADMIN., [www.ssa.gov/oact/cola/sga.html](http://www.ssa.gov/oact/cola/sga.html) (last visited Mar. 22, 2016).

<sup>50</sup> 20 C.F.R. § 416.972(c); see also Dara E. Purvis, *A Female Disease: The Unintentional Gendering of Fibromyalgia Social Security Claims*, 21 *TEX. J. WOMEN & L.* 85, 114 (2011) (describing hurdles faced by female claimants).

<sup>51</sup> 20 C.F.R. § 416.920(a)(4)(ii).

<sup>52</sup> *Id.* §§ 416.909, 416.920(a)(4)(ii).

<sup>53</sup> *Id.* § 416.920(c).



education, and work experience” are not considered.<sup>54</sup>

At step three, the ALJ determines whether the claimant’s impairment meets or equals one of the Social Security “Blue Book” listings.<sup>55</sup> These qualifying standards are framed in medical terms, with listings of medical conditions and specification of medical test results.<sup>56</sup> This is a key step in the process, since if the ALJ finds the claimant meets or equals a listing, the individual will be successful at the hearing and determined disabled without considering a claimant’s “age, education, or work experience.”<sup>57</sup> If the ALJ finds that the claimant is disabled at step three, the case does not proceed to the next step.<sup>58</sup> This step in the process considers primarily the client’s medical file and any medical reports by treating physicians or experts.<sup>59</sup> It ostensibly does not focus so much on how an individual’s disability has affected him or her as it does on whether the condition meets certain specified criteria.<sup>60</sup> Subjectivity comes into play in this step when the listing itself contains criteria that require evaluation of the impact of the particular condition on an individual.<sup>61</sup> This is particularly notable in the mental health listings. Thus, the listing for anxiety disorder requires:

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<sup>54</sup> *Id.*

<sup>55</sup> *Id.* § 416.920(a)(4)(iii); 20 C.F.R. pt. 404, subpt. P, app. 1.

<sup>56</sup> See Frank S. Bloch, *Medical Proof, Social Policy, and Social Security’s Medically Centered Definition of Disability*, 92 CORNELL L. REV. 189, 223, 225 (2007).

<sup>57</sup> 20 C.F.R. § 416.920(d).

<sup>58</sup> *Id.* § 416.920(a)(4).

<sup>59</sup> *Id.* §§ 416.920(e), 416.945(a)(3).

<sup>60</sup> For example, the listing for congenital heart disease is expressed as follows:

4.06 *Symptomatic congenital heart disease* (cyanotic or acyanotic), documented by appropriate medically acceptable imaging (see 4.00A3d) or cardiac catheterization, with one of the following:

A. Cyanosis at rest, and:

1. Hematocrit of 55 percent or greater; or

2. Arterial O<sub>2</sub> saturation of less than 90 percent in room air, or resting arterial PO<sub>2</sub> of 60 Torr or less.

OR

B. Intermittent right-to-left shunting resulting in cyanosis on exertion (e.g., Eisenmenger’s physiology) and with arterial PO<sub>2</sub> of 60 Torr or less at a workload equivalent to 5 METs or less.

OR

C. Secondary pulmonary vascular obstructive disease with pulmonary arterial systolic pressure elevated to at least 70 percent of the systemic arterial systolic pressure.

20 C.F.R. pt. 404, subpt. P, app. 1, § 4.06 (2012).

<sup>61</sup> See *id.* § 12.06.

12.06 *Anxiety Related Disorders*: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

- a. Motor tension; or
- b. Autonomic hyperactivity; or
- c. Apprehensive expectation; or
- d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration.

OR

C. Resulting in complete inability to function independently

outside the area of one's home.<sup>62</sup>

Client testimony and narrative is essential to establishing entitlement to disability where there are subjective elements involved in the listing, such as difficulties in maintaining social functioning or concentration.<sup>63</sup> Indeed, as Matthew Diller has noted, a claimant's subjective response to the objective medical tests is almost always relevant in some way to disability determinations, as is the ALJ's own subjective view.<sup>64</sup> Subjective criteria are also essential at steps four and five, in the event that the ALJ does not determine that the claimant meets or equals a listing.<sup>65</sup>

At step four, the ALJ must evaluate whether the claimant has "residual functional capacity" ("RFC") to do "past relevant work" ("PRW").<sup>66</sup> The RFC of a claimant is her ability to perform the requisite physical acts day in and day out, in the competitive and stressful conditions in which real people work in the real world.<sup>67</sup>

An individual is deemed capable to perform PRW if there exists sufficient RFC to perform: (1) the functional demands of a past relevant job as they actually performed it or; (2) the functional demands of the occupation as it is performed in the national economy.<sup>68</sup> The assessment of RFC must include the individual claimant's physical, mental, and sensory limitations.<sup>69</sup> The

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<sup>62</sup> *Id.*

<sup>63</sup> See Oren R. Griffin, *Social Security Disability Law and the Obstacles Facing Claimants with Mental Disabilities*, 36 L. & PSYCHOL. REV. 147, 172 (2012) (discussing claimants failure to prove her anxiety-related disorder through discussion of her difficulties in maintaining social functioning and concentration); Kathleen D. Zylan, *Legislation That Drives Us Crazy: An Overview of "Mental Disability" Under the Americans with Disabilities Act*, 31 CUMB. L. REV. 79, 85 (2001) ("Moreover, the diagnosis of many disorders hinges on the personal, subjective distress and experience of the patient.").

<sup>64</sup> Diller, *supra* note 1, at 1061, 1062, 1063.

<sup>65</sup> See 20 C.F.R. § 416.920(a)(4)(iv)–(v) (2015).

<sup>66</sup> *Id.* § 416.920(a)(4)(iv). PRW is defined by the SSA as work that: (1) was performed within the relevant work period (15 years); (2) "was substantial gainful activity (SGA);" and, (3) "lasted long enough for the person to learn" to do it. U.S. SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYSTEM, DI 25001.001(B)(60) MEDICAL-VOCATIONAL QUICK REFERENCE GUIDE (2015), <https://secure.ssa.gov/poms.nsf/lnx/0425001001>.

<sup>67</sup> 20 C.F.R. § 404.1545.

<sup>68</sup> U.S. SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYSTEM, DI 25005.001(B) DETERMINATION OF CAPACITY FOR PAST RELEVANT WORK (PRW)—BASICS OF STEP 4 OF THE SEQUENTIAL EVALUATION PROCESS (2011), <https://secure.ssa.gov/apps10/poms.nsf/lnx/0425005001>.

<sup>69</sup> 20 C.F.R. § 416.945(a)–(d). SSA looks to the "nature and extent" of the physical limitations including the claimant's ability to perform the "physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions." *Id.* § 416.945(b). In assessing the claimant's mental abilities, SSA looks to the "nature and extent" of the "mental limitations and restrictions" are considered including "limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, coworkers, and work pressures in a work setting." *Id.* §

Department of Labor's Dictionary of Occupational Titles ("DOT") is used to establish the functional demands of the occupation.<sup>70</sup> If the ALJ determines that the claimant possesses residual functional capacity to perform her past relevant work, then the claimant loses her case at step four.<sup>71</sup> If, on the other hand, the ALJ determines that the claimant lacks residual functional capacity to perform past relevant work, then the hearing proceeds to step five.<sup>72</sup>

At the fifth step, the ALJ considers the claimant's RFC, "age, education, and work experience" to determine if the claimant can adjust to other work.<sup>73</sup> The ALJ must determine whether the claimant can adjust to any other occupation.<sup>74</sup> If the ALJ finds the claimant cannot adjust to other work then the ALJ will find the claimant to be disabled.<sup>75</sup> The claimant's entitlement to disability benefits must be preceded by a finding that she cannot perform any other occupation.<sup>76</sup>

As a result of the medically-derived legal norms that infuse Social Security proceedings, successful claimants must evoke sympathy, availing themselves of "deserving poor" norms that require the claimant to be portrayed as enfeebled and powerless.<sup>77</sup> Social Security uses an outdated medical view of disability<sup>78</sup> that "treats the individual as deficient and inherently inferior."<sup>79</sup> "Particularly damaging to people with disabilities are the stereotypes of 'dependence on others and a general incapacity to perform social and economic activities . . . .'"<sup>80</sup> Fitting their narrative into this construct

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416.945(c). In assessing the claimant's sensory limitations, SSA looks to the nature and extent of the claimant's medically determinable impairments and restrictions are considered such as "skin impairment(s) [and] impairment(s) of vision, hearing . . . [and other] impairment(s) which impose environmental restrictions." *Id.* § 416.945(d).

<sup>70</sup> *Id.* § 416.960(b)(2).

<sup>71</sup> *Id.* § 416.920(a)(4)(iv).

<sup>72</sup> *See id.*

<sup>73</sup> *Id.* § 416.920(a)(4)(v).

<sup>74</sup> *Id.* § 416.920(g).

<sup>75</sup> *Id.* § 416.920(a)(4)(v).

<sup>76</sup> *See id.*

<sup>77</sup> *See* Rand, *supra* note 1, at 87–88.

Clients applying for welfare benefits do so despite their demonization by several hundred years of thinkers who have dehumanized both people seeking these benefits and the process of applying for and retaining the benefits. We in the United States provide money and access to medical care only to those who have met specific criteria that show they are worthy of obtaining them.

*Id.* at 75–76.

<sup>78</sup> *See* Weber, *supra* note 9, at 2487.

<sup>79</sup> Drimmer, *supra* note 4, at 1348.

<sup>80</sup> Rovner, *supra* note 5, at 1056 (quoting Richard K. Scotch, *Models of Disability and the Americans with Disabilities Act*, 21 BERKELEY J. EMP. & LAB. L. 213, 215–16 (2000)).

has created a practice that disempowers clients and communities, and encourages lawyers to create a routinized practice that further re-enforces disabling stereotypes and disables their clients.

## II. DISABLING PRACTICES

As Christopher Gilkerson has observed, a lawyer “traditionally transforms and recomposes her client’s story by devising a script that fits whichever universalized legal narrative the lawyer believes is advantageous for winning the case.”<sup>81</sup> Thus, the lawyer “tells a prototypical story, one that resonates with dominant values, to evoke a desired response such as pity, contempt, or admiration.”<sup>82</sup>

In the context of Social Security disability, the types of winning stories previously told focus almost exclusively on the incompetence and/or victimization of the claimant.<sup>83</sup> As a result, poverty lawyers seeking to effectively represent a client in a Social Security matter often conform the client narrative presented to this universal narrative,<sup>84</sup> and our clinic was no exception.

An ALJ hearing may begin with an opening statement, which offers the claimant and her advocate an opportunity to frame the claimant’s case and narrative before testimony is taken.<sup>85</sup> While a study of some hearing transcripts has revealed that many advocates do not take advantage of this opportunity,<sup>86</sup> it is the regular practice of our clinic. Following the opening, the ALJ typically questions the claimant to establish basic information, including past work history and educational attainment.<sup>87</sup> Then, if the claimant is represented, the ALJ will typically turn any additional questioning of the claimant

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<sup>81</sup> Christopher P. Gilkerson, *Poverty Law Narratives: The Critical Practice and Theory of Receiving and Translating Client Stories*, 43 HASTINGS L.J. 861, 868–69 (1992).

<sup>82</sup> *Id.* at 912; see Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2413 (1989) (noting that master narratives become so entrenched that they are rarely focused on).

<sup>83</sup> See Rand, *supra* note 1, at 83–84.

<sup>84</sup> See, e.g., *id.* at 77 (“In Supplemental Security Income (SSI) and Social Security Disability cases, clients must testify to their own failings and their lack of hope of ever overcoming those failings to show that they are not just trying to beat the system.”); Anthony V. Alfieri, *Disabled Clients, Disabling Lawyers*, 43 HASTINGS L.J. 769, 811–12 (1992) (explaining the need for presenting a widow as a victim when representing a client seeking widows disability benefits).

<sup>85</sup> See Linda S. Durston & Linda G. Mills, *Toward a New Dynamic in Poverty Client Empowerment: The Rhetoric, Politics, and Therapeutics of Opening Statements in Social Security Disability Hearings*, 8 YALE J.L. & FEMINISM 119, 119–20 (1996).

<sup>86</sup> *Id.* at 120 (reporting that a study of transcripts from Social Security hearings in three major cities revealed that claimant representatives almost without exception gave no introductory remarks).

<sup>87</sup> *Id.* at 129.

to the claimant's advocate.<sup>88</sup> It is through this testimony that the client's narrative is further developed and presented. Both the opening statement and the presentation of client testimony run the risk of disempowering, re-victimizing, stigmatizing, or humiliating our clients.

While most of our clients have worked throughout their adult lives, many have not had regularized employment. When we assist clients with disability benefits claims, they have become unable to support themselves, have no income, and have no access to health insurance of any kind. Because it typically takes at least 18 months to get a hearing before an ALJ for Social Security,<sup>89</sup> clients have typically been without any income or insurance for two years or more. They feel particularly vulnerable as the hearing is their only chance to recover even a modest income. Our efforts to develop client narrative in the light most favorable to them, legally, often had the adverse effect of disempowering or re-victimizing our clients. Some examples drawn from our case files follow:<sup>90</sup>

### *David*

We met David when he was forty-two years old. A proud African American man who had held a series of jobs as a valet, a car wash attendant and a carpet installer, David struggled with a drug problem in his twenties and early thirties. He had been diagnosed with AIDS at the age of thirty-five, after he was hospitalized with AIDS-related pneumonia ("PCP"). David received care through the Ryan White program for his HIV, but had no other access to healthcare. When we met him, his viral load was undetectable, but he had a number of ancillary health issues. His HIV infection and the anti-retrovirals he had to take to survive caused severe diarrhea, often several times a day. He had frequent headaches, fatigue and generalized weakness, as well as hypertension that could not be controlled by medication. Over the last year, David had become unable to work to support himself. He alternated living in a homeless shelter and staying with an aunt who was in her seventies. We believed that in addition to his physical problems, David was severely depressed, but we were unable to secure any mental health care or

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<sup>88</sup> *Id.* at 128.

<sup>89</sup> Sanbar, *supra* note 24, at 104.

<sup>90</sup> All names used within this article have been changed to protect client confidentiality. All information related to the cases of "David" and "Maria" is from client case files on file with the author.

an evaluation for him due to his lack of insurance and his own cultural disinclination to seek mental health treatment. The clinic assisted David in applying for Social Security disability benefits, Medicaid, and food stamps. The food stamps were an immediate success for David because he felt he was able to contribute something to the household when he stayed at his aunt's place. He was denied Medicaid because his initial Social Security application was denied. His Social Security disability claim was scheduled for a hearing before an administrative law judge and was his only hope of securing subsistence income and health insurance. The clinic began to work with him to prepare for the hearing, and scheduled a mock hearing for him in advance of the hearing date. And that is where we began our Faustian negotiations with David, as we do with so many clients.

Because David felt that he should work and in fact wanted to work, the narrative called for by the Social Security law ran counter to the image of strength and self-reliance David wished to present. Our practice session with David went something like this:

LAWYER. David, do you think there is some kind of job you could do?

DAVID. Maybe.

LAWYER. [*interrupting out of role*] David, that won't work. If you tell the Judge you can work, then you will lose your hearing and get no benefits. I know you *wish* you could hold down a job but you really can't, can you?

DAVID. No, but I don't like feeling this way, and I don't like to say I can't do anything. I feel like a burden on my Aunt.

LAWYER. I understand, I'm sorry, but we only get one chance to explain this to the Judge. Let's try it again.

LAWYER. David, is there any work you can do?

DAVID. Not really. Not anymore.

LAWYER. Why is that?

DAVID. Well, I get tired a lot, and I don't feel strong like I used to.

LAWYER. Any other reasons you can't work?

DAVID. No, I just don't have my strength any more.

LAWYER. Now it sounds like you just need a job where you can do light work. That won't qualify. David, I know from your medical records that you have diarrhea a lot, is that right?

DAVID. [*looking down*] Yes. Real bad.

LAWYER. Do you have to take a lot of "breaks" to go to the bathroom?

DAVID. [*whispering*] Yeah.

LAWYER. I know it is hard to talk about these things with

strangers, but the Judge needs to know that you would need to take a lot of unscheduled breaks because of your medical condition. It is one of the factors the Judge will use to decide if you can keep a job. Also, we need to tell the Judge about how bad your headaches are, and what you told me about the fact that you feel sad a lot, sometimes too sad to get out of bed in the morning. Do you think you will be able to do that?

DAVID. I guess.

In pushing David to be more forthcoming about his disabilities and how they impacted him, we succeeded in presenting a case that conformed to Social Security disability listings. We also reinforced David's feelings of helplessness in the face of the way his disabilities affected him. In the course of representing David, we came to understand that he equated his own dignity and self-worth with the ability to work to provide for himself and others. Instead of affirming that, we encouraged him to present as an individual who could no longer do that which was important for his self-worth.

### *Maria*

Similarly, a student developing a client's narrative for her opening statement began with this introduction of Maria:

- Sadly, Maria was sexually abused for over a decade starting at age four by an older brother, and suffers from post-traumatic stress disorder as a result. She was diagnosed with HIV as a young adult, which further traumatized her. Moreover, she has been depressed for most of her life and her diagnosis of major depressive disorder was recently confirmed when she began seeking regular psychiatric treatment.
- Maria suffers from at least fifteen serious medical impairments, including but not limited to, HIV, major depressive disorder, PTSD, panic disorder without agoraphobia, vulvar intra-epithelial neoplasia stage III (which has manifested into cervical cancer in the past), chronic fatigue syndrome, insomnia, chronic back and joint pain, hypertension, glaucoma, and arthritis of her right knee and hip.
- Maria has not performed any substantial work since late 2009. In fact, due to her pervasive medical impairments and history, she has never been able to perform full-time work or earn a proper living for



herself.

Maria sat through this practice opening with downcast eyes and began to softly cry as she was transformed into a list of impairments. She went on in her testimony to describe tearfully how she felt that her childhood had been stolen from her and how feelings of guilt and worthlessness frequently overwhelmed her so that she could not get out of bed or leave her home. In our conversations with Maria, we encouraged her testimony, asking and probing for details that would portray her victim status, encouraging the judge to see Maria as one or more of the listings, or the long laundry list of impairments the student recited. For example, meeting the listing for depression alone in Maria's case required the clinic to prove the following (largely through Maria's testimony about herself):

1. Depressive syndrome characterized by at least four of the following:
  - a. Anhedonia or pervasive loss of interest in almost all activities; or
  - b. Appetite disturbance with change in weight; or
  - c. Sleep disturbance; or
  - d. Psychomotor agitation or retardation; or
  - e. Decreased energy; or
  - f. Feelings of guilt or worthlessness; or
  - g. Difficulty concentrating or thinking; or
  - h. Thoughts of suicide; or
  - i. Hallucinations, delusions, or paranoid thinking . . .

AND

- B. Resulting in at least two of the following:
  1. Marked restriction of activities of daily living; or
  2. Marked difficulties in maintaining social functioning; or
  3. Marked difficulties in maintaining concentration, persistence, or pace; or
  4. Repeated episodes of decompensation, each of extended duration.<sup>91</sup>

Instead of portraying Maria as a woman with hope for a better future despite her disabilities, the clinic needed to present her as a depressed individual who had no chance at a functional and independent life. Maria suffered from a "pervasive loss of interest in almost all activities" and had "thoughts of suicide" or "feelings of guilt

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<sup>91</sup> 20 C.F.R. pt. 404, subpt. P, app. 1, § 12.06 (2015).

or worthlessness,” instead of championing herself as a brave woman who looked forward to a better future with positive hopes and dreams, despite her disease causing guilt and suicidal thoughts. Maria spoke about how she suffered from “marked restriction of activities of daily living” and “marked difficulties in maintaining social functioning,” instead of highlighting aspects of her life where she took pride in maintaining a responsible or positive lifestyle, despite the constant struggle caused by her depression. In other words, we asked the judge to see Maria as her disability rather than herself and to situate Maria as a disabled individual in a “normal” setting.<sup>92</sup> Significantly, we also urged Maria to downplay her volunteer work at the AIDS clinic where she got treatment for fear that it would suggest some type of employability.

Unpacking our dialogue with David and Maria reveals how in an effort to conform to Social Security’s disability norms, we sought to fit each case and client into a master narrative that embraces stereotypic victimization and disclosure of embarrassing details of disability as the individual’s defining identity. For disabled women who have been victims of domestic violence (“DV”), they must often become the DV victim who never recovered or risk losing their claim; for children, it often involves adopting the mantle of the child who will never be successful in school.

We began asking is this wrong? Does this damage the clients we strive to empower through our work? In asking these questions I want to push back a little against critical scholars who sometimes refer to lawyers who represent vulnerable communities as “regnant” hierarchical actors who silence authentic and empowering client narratives in the service of winning a legal claim.<sup>93</sup> I believe this view in itself is overly paternalistic. Clients are fully capable of making these advocacy choices. They have both the power and the right to adopt an instrumental “self” for the purpose of prevailing in

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<sup>92</sup> Paula E. Berg, *Ill/Legal: Interrogating the Meaning and Function of the Category of Disability in Antidiscrimination Law*, 18 YALE L. & POL’Y REV. 1, 4–5 (1999) (“Specifically, the restrictive category of disability reflects and reinforces the notion that disability is an objective biomedical phenomenon that constitutes an essential aspect of the individual. In keeping with this assumption, a principal function of the category of disability is not to inquire into the existence of prejudice or an exclusionary physical environment, but rather to establish the exact nature and severity of the impairment itself, because it is the impairment—not the environment—that is seen as the root cause of the social and economic problems faced by the disabled individual.”).

<sup>93</sup> See, e.g., GERALD P. LOPEZ, REBELLIOUS LAWYERING: ONE CHICANO’S VISION OF PROGRESSIVE LAW PRACTICE 61 (1992); Alfieri, *supra* note 3, at 2615–16, 2634; Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 BUFF. L. REV. 1, 27 (1990).

their case that may not be authentic or portray fully their aspirations.<sup>94</sup> It is the role of the advocate to give clients an authentic choice in that regard, with the full understanding of what it means legally.<sup>95</sup>

However, dissonance theory suggests that the unmitigated use of disabling master narratives in the service of prevailing legally is harmful to clients and their advocates, and in our case clinical students, by reconfirming and encouraging the internalization of harmful stereotypes.<sup>96</sup> The use of disabling individual client narratives can be harmful for it is through narrative, the telling, recounting and re-construction of past events, that humans derive meaning from experience and construct self-identity.<sup>97</sup> If the individual's lawyer, upon whom a client relies to interpret and navigate a system that often seems impenetrable, actively (and perhaps even hierarchically) encourages a client to self-construct and present as helpless and hopeless, then there is a very real danger that the client will internalize at least some aspects of this disabling identity.<sup>98</sup>

We asked: How do we mitigate this? How do we change it? How, as a clinic, we struggled with reframing both the universalist legal construct at work in the cases and our client's narratives may be helpful to other practitioners.

First, we considered the disability rights movement and its nomenclature. We also considered the similar focus of human rights

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<sup>94</sup> See Rand, *supra* note 1, at 107 ("Clients may accept damage to their self-images for the sake of their cases.").

<sup>95</sup> See Brook K. Baker, *Traditional Issues of Professional Responsibility and a Transformative Ethic of Client Empowerment for Legal Discourse*, 34 NEW ENG. L. REV. 809, 890 (2000) ("Empowering outsider clients always and necessarily involves moral choice about the goals of representation. Because moral *choice* involves reconciliation of conflicting values and because the paths to social justice are uncertain, principled moral decision-making ordinarily involves contested moral dialogue.").

<sup>96</sup> Rovner, *supra* note 19, at 303–04.

<sup>97</sup> Dan P. McAdams, *Personal Narratives and the Life Story*, in HANDBOOK OF PERSONALITY: THEORY AND RESEARCH 242, 242, 244 (Oliver P. John et al. eds., 3d ed. 2008); DONALD E. POLKINGHORNE, *NARRATIVE KNOWING AND THE HUMAN SCIENCES* 1, 13, 14 (1988).

<sup>98</sup> For thoughtful discussions of the potential harm of disabling constructions of self-identity and their internalization (albeit often in the context of the politicization of disability rights), see Renee R. Anspach, *From Stigma to Identity Politics: Political Activism Among the Physically Disabled and Former Mental Patients*, 13 SOC. SCI. & MED. 765, 768-69 (1979); Paul K. Longmore, *A Note on the Language and the Social Identity of Disabled People*, 28 AM. BEHAV. SCIENTIST 419, 419 (1985); Donna Reeve, *Negotiating Psycho-Emotional Dimensions of Disability and their Influence on Identity Constructions*, 17 DISABILITY & SOC'Y 493, 495 (2002); Brian Watermeyer & Leslie Swartz, *Conceptualising the Psycho-Emotional Aspects of Disability and Impairment: The Distortion of Personal and Psychic Boundaries*, 23 DISABILITY & SOC'Y 599, 602 (2008); Irving Kenneth Zola, *Self, Identity and the Naming Question: Reflections on the Language of Disability*, 36 SOC. SCI. & MED. 167, 168 (1993).

framing, and tried to fit that into the Social Security process. Many authors have offered policy level suggestions for incorporating these principles into social policy.<sup>99</sup> But how does this look “from the ground floor?” If ever there were square pegs and round holes, those are they. However, our dialogue with our clients in this regard, and the stories we helped clients tell about themselves in the process, did, I believe, help disarm or at least mitigate the disabling master narratives that Social Security demanded, while we provided effective representation to our clients.

### III. DISABILITY RIGHTS, THE ADA, AND SOCIAL SECURITY DISABILITY

Much has been written from the disability rights perspective that criticizes and rejects the Social Security disability schema because of its focus on medical impairments.<sup>100</sup> As early as the 1950s Jacobus tenBroek criticized the social welfare sensibility that underlies the Social Security disability system as dooming the disabled to “economic dependence, and social isolation,” based on a view of the disabled as inherently inferior.<sup>101</sup> As James Leonard has observed,

Rejection of the medical/welfare model of disability policy by persons with disabilities was understandable and in many ways commendable. A public policy that views individuals with disabilities as permanently “sick,” however well intentioned, runs the risk of dispiriting and dehumanizing its would-be beneficiaries. Disability advocates have complained sharply about the paternalistic attitudes of caseworkers and about the culture of dependence caused by reliance on welfare programs. Perhaps the most striking complaint was that welfare-based systems deprive recipients of the full rights of citizenship by excusing them from performing certain social obligations, such as work.<sup>102</sup>

In his article that heralded the evolution of the disability rights movement, and the history of the Americans with Disabilities Act, Jonathan Drimmer explains the civil rights construct of disability as one that “views society, rather than the individual with a disability,

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<sup>99</sup> See, e.g., Diller, *supra* note 1, at 1066–68; Michael Ashley Stein, *Disability Human Rights*, 95 CALIF. L. REV. 75, 113–14, 119–21 (2007); Weber, *supra* note 9, at 2511–12.

<sup>100</sup> See, e.g., Drimmer, *supra* note 4, at 1347; Stein, *supra* note 99, at 86.

<sup>101</sup> See Michael Ashley Stein & Janet E. Lord, *Jacobus tenBroek, Participatory Justice, and the UN Convention on the Rights of Persons with Disabilities*, 13 TEX. J. C.L. & C.R. 167, 167, 171–72 (2008).

<sup>102</sup> James Leonard, *The Equity Trap: How Reliance on Traditional Civil Rights Concepts has Rendered Title I of the ADA Ineffective*, 56 CASE W. RES. L. REV. 1, 3–4 (2005).

as defective.”<sup>103</sup> The “disability” is a result of the dynamic between an individual and “social standards created by an ablist society.”<sup>104</sup> The focus, in this construct, is not on the individual or her disability, but rather on the social environment, and on changing the environment to accommodate the individual.<sup>105</sup> The disability rights movement perhaps reached its zenith with the passage of the Americans with Disabilities Act (“ADA”) in 1990.<sup>106</sup> The movement reacted to the medical model of disability that situates the disability in the individual, as something either to be fixed or to be the object of charity.<sup>107</sup>

The obvious tension between the disability rights movement and the system of disability compensation created by Social Security is so great that many disability rights scholars either express contempt for the programs or ignore them altogether in framing disability issues.<sup>108</sup> Indeed, for many disability rights advocates the ADA was hailed “as a triumph of a new ‘civil rights’ or ‘social’ model of disability over an older and outmoded ‘impairment’ or ‘public benefits’ model.”<sup>109</sup>

Other scholars, with whom I agree, argue that disability rights thinking should be reconciled with, in a transformative way, the welfare laws and the Social Security process.<sup>110</sup> Mark Weber urges reconsidering the Social Security disability related welfare system in light of the civil rights approach to disability ensconced in the ADA.<sup>111</sup>

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<sup>103</sup> Drimmer, *supra* note 4, at 1355.

<sup>104</sup> *Id.*

<sup>105</sup> Weber, *supra* note 9, at 2484.

<sup>106</sup> Rovner, *supra* note 5, at 1044; Weber, *supra* note 9, at 2485.

<sup>107</sup> Rovner, *supra* note 5, at 1047.

<sup>108</sup> See, e.g., Samuel R. Bagenstos, *Subordination, Stigma, and “Disability,”* 86 VA. L. REV. 397, 472 (2000). Mark Weber notes that:

Many prominent disability studies scholars have simply avoided the debates over welfare, with the result that developments are conceived and managed by technocrats or politicians who have little insight about the needs, desires, and grievances of persons with disabilities. The upshot is that welfare policy is one area in which the disability rights movement slogan “nothing about us without us” could not be further from reality.

Weber, *supra* note 9, at 2488–89.

<sup>109</sup> Linda Hamilton Krieger, *Backlash Against the ADA: Interdisciplinary Perspectives and Implications for Social Justice Strategies*, 21 BERKELEY J. EMP. & LAB. L. 1, 6 (2000).

<sup>110</sup> See Diller, *supra* note 1, at 1006 (“There is no inherent contradiction between the idea that some individuals should receive income support as a response to their disabilities and the notion that our society should remove obstacles faced by persons with disabilities in the job market and the workplace.”); Weber, *supra* note 9, at 2484.

<sup>111</sup> Weber, *supra* note 9, at 2500; accord Diller, *supra* note 1, at 1076 (“[T]he disability benefit programs inevitably deal with vocational and labor market barriers to success in the job market . . . .”); Theresa Glennon, *Race, Education, and the Construction of a Disabled Class*, 1995 WIS. L. REV. 1237, 1251–52 (discussing the overrepresentation of racial minorities among students identified as disabled).

He argues powerfully that Social Security disability and other welfare-related entitlements should be seen as part of an overall effort to address the legacy of discrimination against the disabled, and that such programs can be seen as promoting “autonomy, security, and personal dignity,” all worthy goals of any civil rights movement.<sup>112</sup> This reframing of the Social Security meta-narrative also resonates in human rights theory and practice.<sup>113</sup>

#### IV. SOCIAL SECURITY DISABILITY AND HUMAN RIGHTS

If you ask a self-identified human rights lawyer what legal work she does, in many parts of the world the answer will include assisting clients in the social welfare system of the country where the lawyer practices, securing life-sustaining benefits.<sup>114</sup> In the United States, a lawyer doing the same work is far more likely to describe her practice as relating to public benefits, entitlements, or disability.<sup>115</sup> The difference is more than semantic, and has influenced our legal culture and the way we advocate for, and relate to, the clients for whom we seek to secure basic human needs, including disability benefits. As domestic poverty and civil rights lawyers increasingly understand their work to be part of a larger human rights scheme, it may be possible to shed some of the disabling legal norms associated with U.S. practices and replace them with the more empowering language of human rights. This is especially important, as we increasingly understand our work in the disabled community to include grappling with the stigmatization and isolation of persons with disabilities from the perspective of our clients.

Many scholars and advocates who have worked in the areas of civil rights and poverty law have been attracted to the recent efforts of the “bringing human rights home” movement, and have considered various advocacy strategies and norms that are not just based on U.S. constitutional and statutory law, but that reference universal human rights principles and conventions.<sup>116</sup> The civil rights movement in

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<sup>112</sup> Weber, *supra* note 9, at 2501–02, 2504.

<sup>113</sup> *See id.* at 2530.

<sup>114</sup> *See, e.g. Human Rights*, DOUGHTY STREET CHAMBERS, <http://www.doughtystreet.co.uk/human-rights> (last visited Mar. 22, 2016); William Rowland, *South Africa: From Human Rights Lawyer to Librarian*, DISABILITY WORLD (June/Aug., 2003), [http://www.disabilityworld.org/06-08\\_03/access/southafrica.shtml](http://www.disabilityworld.org/06-08_03/access/southafrica.shtml); *see* Alberto Alesina et al., *Why Doesn't the U.S. Have a European-Style Welfare State?*, HARV. INST. ECON. RES. 3, 4, 34 (Discussion Paper No. 1933) (2001).

<sup>115</sup> *See* Alesina et al., *supra* note 114, at 4, 34 (noting the differences between American and European attitudes towards poverty).

<sup>116</sup> *See, e.g.,* Scott L. Cummings, *The Internationalization of Public Interest Law*, 57 DUKE

the United States is no stranger to using this rhetoric, from the abolitionist movement<sup>117</sup> through *Brown v. Board of Education*.<sup>118</sup> But the history and future of this movement, though promising, is uncertain, in part for the very reasons that the self-described human rights lawyer in another country assists clients in social welfare programs and her U.S. counterpart does not. The human rights movement's history in the United States includes political leaders, concerned about America's international image and the Cold War, who sought to downplay the human rights connections between the struggles for racial equality as well as to disassociate human rights from economic entitlements.<sup>119</sup>

We need to raise human rights issues in our work, even if those claims are not met with success. Speaking about them reminds judges, our clients, the public, and ourselves that in most of the developed world economic and social security rights are recognized, including the right to an adequate standard of living. As Michael Stein advocates, we need to be particularly mindful of the importance of economic, social, and cultural human rights for the disabled, and not merely those that negate discrimination or promote equal treatment.<sup>120</sup> Social Security disability benefits can and should be viewed as part of the disability human rights framework existing in the United States. Indeed, the *Convention on the Rights of Persons with Disabilities* "recognize[s] the right of persons with disabilities to an adequate standard of living."<sup>121</sup>

At a policy level, we must advocate to change payment standards for SSI disability claims—why must the disabled be relegated to receiving payments 25 percent below the poverty level?<sup>122</sup> We need

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L.J. 891, 970 (2008); Risa E. Kaufman, Book Review, *Human Rights in the United States: Reclaiming the History and Ensuring the Future*, 40 COLUM. HUM. RTS. L. REV. 149, 151, 156 (2008) (reviewing BRINGING HUMAN RIGHTS HOME (Cynthia Soohoo et al. eds., 2007)).

<sup>117</sup> See Jenny S. Martinez, *Antislavery Courts and the Dawn of International Human Rights Law*, 117 YALE L.J. 550, 554, 555 (2008).

<sup>118</sup> *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954); Richard J. Goldstone & Brian Ray, *The International Legacy of Brown v. Board of Education*, 35 MCGEORGE L. REV. 105, 111, 112 (2004).

<sup>119</sup> See Caroline Bettinger-Lopez et al., *Redefining Human Rights Lawyering Through the Lens of Critical Theory: Lessons for Pedagogy and Practice*, 18 GEO. J. POVERTY L. & POL'Y 337, 343–44, 345 (2011).

<sup>120</sup> See Stein, *supra* note 99, at 77–78 ("Second-generation rights are traditionally the province of development agencies. These rights are understood as providing equal opportunity, and are often thought of as 'positive rights.' Second-generation rights generally focus on standards of living, including issues such as the availability of housing and education.")

<sup>121</sup> G.A. Res. 61/106, art. 28(1), *Convention on the Rights of Persons with Disabilities* (Jan. 24, 2007).

<sup>122</sup> In 2016, the federal poverty standard for a single person household is \$11,880, or \$990 per month. *Federal Poverty Guidelines*, FAMILIES USA (Feb. 2016),

to push the U.S. not only to give lip service to the UN Convention, which it did by signing the Convention in 2009,<sup>123</sup> but to ratify the Convention, thereby fully acknowledging the right to state assistance, integration and independent living, the need for special protection for disabled women and girls, and the right of persons with disabilities to an adequate standard of living for themselves and their families.<sup>124</sup>

Global fixes for many aspects of the de-humanizing and disabling ethos of the Social Security disability scheme can be readily imagined. As noted above, the payment standard of approximately 75 percent of poverty for SSI ensures that individuals who depend on it must live below the federal poverty level.<sup>125</sup> Congress could and should raise the payment rate to at least that of the poverty level.<sup>126</sup> Ratification of the Convention and ensuring its enforceability by individuals with disabilities would further dignify and empower persons who must rely on disability benefits. The very real, often devastating, hardships endured by individuals with a disability who frequently wait two years or more, sometimes without any income, to have their case “processed” and finally heard by an ALJ, contributes greatly to the dehumanization and, at times, desperation, of the claimant in a disability hearing.<sup>127</sup> Thus, sufficient funding of the administrative adjudicatory system to ensure that claims can be timely heard is also a much needed reform.

Revision of the disability listings in order to move away from the medical model of disability would, for the reasons described above, make the language used in the process less stigmatizing, as would eliminating the present financial disincentives for recipients of disability benefits to earn income. In this regard, other reformative cultural changes within the SSA, and particularly within its adjudicatory wing, could also positively impact the participants. The therapeutic jurisprudence movement provides a useful model for such a cultural reform.

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<http://www.familiesusa.org/product/federal-poverty-guidelines>. The maximum SSI payment to single individuals in 2016 is \$733 per month. *SSI Federal Payment Amounts for 2016*, U.S. SOC. SEC. ADMIN., <http://www.ssa.gov/oact/cola/SSI.html> (last visited Mar. 22, 2016).

<sup>123</sup> See *Convention on the Rights of Persons with Disabilities*, UNITED NATIONS, (Dec. 13, 2006), <https://treaties.un.org/doc/Publication/MTDGS/Volume%20II/Chapter%20IV/iv-15.en.pdf>

<sup>124</sup> See G.A. Res. 61/106, *supra* note 121, at annex (x), art. 5(1), 6(1)–(2), 19(a)–(b), 28(1).

<sup>125</sup> See *supra* note 122 and accompanying text.

<sup>126</sup> Recognizing this problem, California, for example, supplements SSI payments with state funds, making the monthly benefit closer to the federal poverty level. *Supplemental Security Income (SSI) in California*, U.S. SOC. SEC. ADMIN. (2016), [www.ssa.gov/pubs/EN-05-11125.pdf](http://www.ssa.gov/pubs/EN-05-11125.pdf).

<sup>127</sup> See *supra* Part II.



Therapeutic jurisprudence utilizes science, particularly behavioral science, to provide a foundation for law reform to reshape legal rules and practices in ways that minimize their anti-therapeutic effects and maximize their potential to enhance the emotional well-being of the individual and society.<sup>128</sup> In many ways, the Social Security adjudicatory system is ideally suited to therapeutic jurisprudence reform since it operates in the interstices of law, medicine, and behavioral science, and almost certainly “produc[es] antitherapeutic consequences for the people that the law was designed to help.”<sup>129</sup> Asking the legal actors in that court to consider the psychological consequences of their roles and actions on litigants with disabilities is not unreasonable. Indeed, the systemic reforms discussed above could also help the administration realize its own state goals of getting individuals who become able back to work more quickly if the process itself were less debilitating.

But this paper is concerned with individual practice, the dialogue and negotiations between lawyers and clients, and how practitioners representing individuals with disabilities might re-conceptualize their work and work with individual clients on the reframing of cases. Domestic disability benefits lawyers who understand their work in a more universal context may be able to alter elements of the lawyer-client conversation in disability rights cases. I urge reframing our work as on behalf of individuals who are powerfully vindicating their human rights to dignity, to social security, to life, and to health, and communicating that to our clients, even as we wait for certain domestic nomenclature to catch up.

## V. REFRAMING NARRATIVES

As alluded to above, this article suggests that reframing occur in two ways. First, that we reframe the legal master narrative surrounding Social Security disability and welfare cases in a critical, postmodernist<sup>130</sup> way to incorporate theories of civil and human rights, and second (and relatedly), that we work with our clients to present the client’s individual narrative in the most empowering way possible. In having these conversations, we are inviting the client

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<sup>128</sup> Bruce J. Winick & Ginger Lerner-Wren, *Do Juveniles Facing Civil Commitment Have A Right to Counsel?: A Therapeutic Jurisprudence Brief*, 71 U. CIN. L. REV. 115, 115 (2002).

<sup>129</sup> *Id.*; Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 FORDHAM URB. L.J. 1055, 1062 (2003); see Winick & Lerner-Wren, *supra* note 128, at 115.

<sup>130</sup> See J.M. Balkin, *What Is a Postmodern Constitutionalism?*, 90 MICH. L. REV. 1966, 1971–72 (1992).

into the discussion not only of client narrative, but also of case theory and how the case is framed.<sup>131</sup>

The concept of “framing,” labeled by sociologist Erving Goffman, to apply to the way human beings organize and interpret experience, and the role of rhetoric in that process,<sup>132</sup> is often now explicitly recognized and applied in fields such as journalism, politics and psychology.<sup>133</sup> Framing theory operates from the premise that a fact or issue can be viewed from a variety of perspectives, and that framing can be used to develop or encourage a particular conceptualization about the fact or issue, possibly reorienting an individual or group’s thinking about the matter.<sup>134</sup> In legal and social discourse, the utilization of framing has been recognized in a variety of contexts,<sup>135</sup> including the framing of a broad social movement such as the struggle for civil rights as one for rights and equality,<sup>136</sup> to the more specific identity-based framing often evoked today in gender-related cases.<sup>137</sup> Indeed, as discussed above, reframing of disability issues played a key role in the passage of the ADA.<sup>138</sup>

In this discussion of framing Social Security disability narrative, I begin by recognizing that in the course of legal representation the construction of client narrative is—and should be—a collaborative process between lawyer and client.<sup>139</sup> There is much room for client empowerment in this give and take between lawyers and clients with disabilities.<sup>140</sup> To be successful, this requires engaging our clients in a conversation about the social construct of the Social Security disability process and how it operates on stereotypical and disempowering notions of disability. At this stage, we can educate our clients about legal expectations and their realistic choices within

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<sup>131</sup> Binny Miller, *Give Them Back Their Lives: Recognizing Client Narrative in Case Theory*, 93 MICH. L. REV. 485, 485, 486–87 (1994); see MODEL RULES OF PROF’L CONDUCT r. 1.2(a) (AM. BAR ASS’N 2013) (“[A] lawyer shall abide by a client’s decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued.”).

<sup>132</sup> See ERVING GOFFMAN, *FRAME ANALYSIS: AN ESSAY ON THE ORGANIZATION OF EXPERIENCE* 10–11 (1974).

<sup>133</sup> Robert D. Benford & David A. Snow, *Framing Processes and Social Movements: An Overview and Assessment*, 26 ANN. REV. SOC. 611, 611 (2000).

<sup>134</sup> Dennis Chong & James N. Druckman, *Framing Theory*, 10 ANN. REV. POL. SCI. 103, 104 (2007).

<sup>135</sup> Benford & Snow, *supra* note 133, at 611.

<sup>136</sup> See Ian F. Haney Lopez, *Protest, Repression, and Race: Legal Violence and the Chicano Movement*, 150 U. PA. L. REV. 205, 213–14 (2001).

<sup>137</sup> See Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1241–42 (1991).

<sup>138</sup> See Bagenstos, *supra* note 10, at 1006–08; see *supra* Part III.

<sup>139</sup> Dinerstein, *supra* note 44, at 42; see Rand, *supra* note 1, at 73, 97–98.

<sup>140</sup> See Rovner, *supra* note 5, at 1094–95.

an imperfect system.

[U]ntil we recognize that there is a master narrative in place and that we have all been participants in the structuring and application of that master narrative can we call it into question, examine it, and ask ourselves whether or not we want to change it. Until this recognizing moment . . . the master narrative has been acting invisibly. In fact, . . . even those who are oppressed by the master narrative are complicit in its survival and effectiveness.<sup>141</sup>

While a client seeking disability related benefits from Social Security may remain subordinated to its master narrative, as Kimberle Crenshaw recognizes, the process of categorizing does not have to be unilateral:

Subordinated people can and do participate, sometimes even subverting the naming process in empowering ways. One need only think about the historical subversion of the category “Black” or the current transformation of “queer” to understand that categorization is not a one-way street. Clearly, there is unequal power, but there is nonetheless some degree of agency that people can and do exert in the politics of naming.<sup>142</sup>

Having the conversation about stereotypes and how they are used in Social Security takes away from their power over us as advocates and our clients as benefit-seekers. In making a conscious decision about how to situate their story within the law’s master narrative, clients are reminded of the difference between “living a story and telling a story.”<sup>143</sup> Awareness means that clients have a choice about how much and what kind of master narrative they wish to conform to in telling their story, and about how and whether they inject counter narrative within that framework.<sup>144</sup> Inserting a counter narrative is an act of resistance, one that can compete with the discriminatory master narrative for time and space.<sup>145</sup>

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<sup>141</sup> Elaine J. Lawless, *Transforming the Master Narrative: How Women Shift the Religious Subject*, 24 *FRONTIERS* 61, 61 (2003).

<sup>142</sup> Crenshaw, *supra* note 137, at 1297.

<sup>143</sup> David Herman, Book Review, 36 *LANGUAGE SOC’Y* 278, 279 (2007) (reviewing *CONSIDERING COUNTER-NARRATIVES* (Michael Bamberg & Molly Andrews eds., 2004)).

<sup>144</sup> See HILDE LINDEMANN NELSON, *DAMAGED IDENTITIES, NARRATIVE REPAIR* 150, 151 (2001). Counter narratives are used to consciously and more accurately recast individuals whose stories have been misrepresented or ignored in master narratives. See *id.*

<sup>145</sup> See *id.*; Lisa C. Ikemoto, *Traces of the Master Narrative in the Story of African American/Korean American Conflict: How We Constructed “Los Angeles,”* 66 *S. CAL. L. REV.* 1581, 1597 (1993).

Further, the reframing of our work as on behalf of individuals who are powerfully vindicating their human rights to dignity, to social security, to life, and to health, and communicating that to our clients changes the way we and our clients approach the claim for benefits. “Framing a request as rights-based imbues it both with legitimacy and morality.”<sup>146</sup>

Thus, our conversation with David about his testimony, reframed, went something like this:

LAWYER. David, the Social Security Disability program is for workers like you who aren’t able to work now because of a disability. You paid into the system all the times you worked, and now you have a right to ask for compensation. Even though it may seem wrong to you, the legal standard to get the compensation requires us to show and tell the judge that right now you are unable to work. But if you ever are able to go back to work, you can.

DAVID. Really, I could go back to work if I get better?

LAWYER. Absolutely, and we hope you will be able to someday.

One of the other questions that the judge will consider is whether you can go back to any of your old jobs. We need to be able to show the judge that certain things about managing your HIV make that impossible right now. So, it’s important that you need to take unscheduled breaks during the work day. It should help the judge understand why you can’t work. You’ll have to explain to the judge why you need to take the breaks, though. Is that something you are comfortable talking about? There will be about five people in the room—you, me, the judge, the judge’s clerk and the vocational expert. I know it’s embarrassing to talk about having to go to the bathroom but in your case, the law says if you need to take several unscheduled breaks during the day and you’re an hourly employee then you would have trouble holding down a job.

DAVID. That’s okay, I can talk about it.

LAWYER. David, could you please tell the judge what work you used to do?

DAVID. I’ve been working since I was sixteen years old, judge. I started out washing cars at a neighborhood place part time, then later when I finished high school I got a job as a valet downtown. My best job was working as a carpet installer. I made real good money doing that, but it’s hard work, you know, you got to lift and carry some heavy carpets, bend down a lot, and you breathe a lot of dust.

LAWYER. Did you like working?

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<sup>146</sup> Rovner, *supra* note 5, at 1085.

DAVID. I love working, I wish I could work now.

LAWYER. Could you go back to your old jobs, David?

DAVID. No, I had to quit because I couldn't keep up anymore, I get tired a lot, and I don't feel strong like I used to.

LAWYER. Any other reasons you can't work?

DAVID. Well, my boss said I was taking too many breaks. It's my condition, and my medicine, it makes me have to go to the bathroom two or three times a day, I don't have much warning, and I have to go for a long time.

LAWYER. David, are there any other jobs you think you could do?

DAVID. Not right now, maybe someday if I get better, but right now I have to manage my condition and I'm not able to work.

LAWYER. Do you wish you could work, David?

DAVID. Oh, yeah, I wish I could work right now.

Our conversations with David and Maria—and our presentation of their cases—were different when we, and they, were conscious of the master narrative at work, the possibilities for counter-narratives, resistance, and choice. After consulting with Maria and discussing with her how she wanted her case to be presented, our introduction of her, and her subsequent testimony, emphasized, rather than ignored, her volunteer work at the HIV clinic and how she had overcome her childhood abuse and was working hard on recovering from her past traumas.

In offering these case examples and suggestions, I do not want to appear panglossian. The Social Security system is disempowering, and the incremental changes suggested here will not fully resolve that. However, the incremental-change path through reframing, though a long one, has a venerable history in our country in the areas of civil rights and disability rights. Cultural paradigm shifts must begin somewhere. I believe that these shifts genuinely matter as judges, clients, and the next generation of advocates learn to work with client narratives in the most empowering way possible. As clinical educators, we can teach our students “new discourse strategies that might result in client empowerment.”<sup>147</sup>

And while the system remains disempowering, it is also essential that lawyers remember the enormous therapeutic value that can be realized by properly developed and presented client narrative,<sup>148</sup> as

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<sup>147</sup> Baker, *supra* note 95, at 858.

<sup>148</sup> Linda S. Durston and Linda G. Mills write of the “tremendous potential to heal” offered up by the presentation of client narrative in Social Security opening statements, Durston & Mills, *supra* note 86, at 127–28; *see also* Anthony V. Alfieri, *Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative*, 100 YALE L.J. 2107, 2146 (1991) (discussing a

well as the individual empowerment that can occur even when resistance is unsuccessful.<sup>149</sup> Poverty is oppressive; the difficulties associated with living with a disability are magnified by poverty.<sup>150</sup> But that isn't the only story to tell. There are stories of survival, of resilience, that can and should be woven into these narratives wherever possible. Moreover, embracing vulnerability itself can be empowering, as scholars remind us that we are all dependent—at least at some points in life—and we should understand this as a universal human condition.<sup>151</sup>

In conclusion, this paper urges lawyers and clinical students to connect with and understand their clients “as they are,” and to engage with their clients in dialogue and decisions about how to frame individual disability cases, and about how the client wishes to present his or her narrative in light of that framing. In embarking on these strategies, advocates must also be mindful of the power dynamics at work in their relationship and interaction with their clients, taking care that they do not coerce or unintentionally silence their clients. “Lawyers must actually listen to their clients and struggle to find out what they want.”<sup>152</sup> Thereafter they can collaboratively engage their clients in advocacy to achieve those goals, including the important presentation of the client's identity and narrative.

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hope that recasting the client's story will enhance their power to act independently); Delgado, *supra* note 82, at 2437, 2438 (demonstrating use of narrative and counter-narrative by oppressed groups, which can be therapeutic). A Social science validates the use of narrative therapy. *See, e.g.*, MICHAEL WHITE, *MAPS OF NARRATIVE PRACTICE* 76–77 (2007).

<sup>149</sup> *See* DERRICK BELL, *FACES AT THE BOTTOM OF THE WELL: THE PERMANENCE OF RACISM*, at xii, 198–99 (1992); Crenshaw, *supra* note 137 at 1297 (describing critical resistance strategy).

<sup>150</sup> Armantine M. Smith, *Persons with Disabilities as a Social and Economic Underclass*, 12 *KAN. J.L. & PUB. POL'Y* 13, 34–35 (2002).

<sup>151</sup> *See* MARTHA ALBERTSON FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY*, at xvii (2004).

<sup>152</sup> Dinerstein, *supra* note 44, at 53.