IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

BONNIE VREELAND,

Plaintiff,

v.

MICHAEL J. ASTRUE,
Commissioner of Social Security,[1]

Defendant.

REPORT AND
RECOMMENDATION

06-C-466-C

REPORT

Plaintiff Bonnie Vreeland seeks judicial review of an adverse decision of the Commissioner of Social Security pursuant to 42 U.S.C. § 405(g). Plaintiff, a 21-year old who has been diagnosed with various mental impairments, challenges the commissioner's determination that she is not disabled and therefore ineligible for supplemental security income under Title XVI of the Social Security Act. Plaintiff has filed a motion for summary judgment reversing the commissioner's decision on the ground that it is not supported by substantial evidence and contains errors of law. More specifically, plaintiff contends that the administrative law judge who denied her claim improperly rejected evidence favorable to plaintiff, including the testimony of the neutral medical expert concerning plaintiff's likely absenteeism; failed to account for plaintiff's learning disability when arriving at his residual functional capacity assessment; and made an improper credibility determination. For the reasons explained below, I am recommending that the court reject plaintiff's arguments and affirm the commissioner's decision.

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[1] Michael Astrue became Commissioner of Social Security on February 12, 2007. The case caption has been changed to reflect the new defendant.

LEGAL AND STATUTORY FRAMEWORK

To be entitled to either disability insurance benefits or supplemental security income payments under the Social Security Act, a claimant must establish that she is under a disability. The Act defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3)(A). A physical or mental impairment is "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 1382c(a)(3)(c).

The commissioner has promulgated regulations setting forth the following five-step sequential inquiry to determine whether a claimant is disabled:

(1) Is the claimant currently employed?

(2) Does the claimant have a severe impairment?

(3) Does the claimant's impairment meet or equal one of the impairments listed by the SSA?

(4) Can the claimant perform her past work? and

(5) Is the claimant is capable of performing work in the national economy?

See 20 C.F.R. §§ 404.1520, 416.920.

The inquiry at steps four and five requires assessment of the claimant's "residual functional capacity," which the commissioner defines as "an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and

continuing basis." Social Security Ruling 96-8p. "A 'regular and continuing basis' means 8 hours a day, for 5 days a week, or an equivalent work schedule." *Id*.

In seeking benefits, the initial burden is on the claimant to prove that a severe impairment prevents her from performing past relevant work. If she can show this, then the burden shifts to the commissioner to show that the claimant was able to perform other work in the national economy despite the severe impairment. *See Stevenson v. Chater*, 105 F.3d 1151, 1154 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1391 (7th Cir. 1997).

The following facts are drawn from the administrative record ("AR"):

FACTS

I. Procedural History

Plaintiff filed an application for supplemental security income on September 9, 2002, alleging that she was disabled because she was a non-phonetic reader and was depressed. Plaintiff noted on her application that, according to her mother, she was "medicly [*sic*] crazy." AR 72. After the local disability agency denied her application initially and on reconsideration, plaintiff requested a hearing before an administrative law judge ("ALJ"). The ALJ, Arthur Schneider, convened a hearing on January 14, 2004, at which plaintiff, a medical expert and a vocational expert testified. Plaintiff was represented by a lawyer at the hearing.

On February 26, 2004, the ALJ issued a decision finding that plaintiff was not disabled because she could perform a significant number of jobs existing in the national economy. That decision became the final decision of the commissioner when the Appeals Council denied plaintiff's request for review.

II. Background and Medical Evidence

Plaintiff was born January 7,1983, making her 21 years old on the date of the ALJ's decision. She testified that she had obtained a general high school equivalency diploma. Her past work experience consisted of short-term jobs as a waitress, dishwasher, cashier, collection clerk and cook. Plaintiff's last job was at the Occupational Development Center, a sheltered workshop where she worked as a general laborer.

The record before the ALJ included records from the Stevens Point Area Public School District, where plaintiff had attended school from at least fifth through ninth grade. These records showed that in fifth grade, plaintiff was found in need of special education services for a learning disability. However, special education services were discontinued in eighth grade, after staff determined that plaintiff did not have any severe deficits in any area and could succeed in regular education classes. AR 167-191.

Plaintiff began attending an alternative high school in Stevens Point in ninth grade. Records from that school showed that plaintiff's last reported grades were a D+ in social science and B's and C's in all her other classes. AR 229. According to the report, plaintiff stopped going to school after the 9th grade. AR 229. Plaintiff testified that she then attended the Challenge Academy Program (an educational program for students with behavioral problems) but did not complete it. She said, however, that she had obtained her general equivalency diploma.

The earliest medical record of treatment is from October 14, 2002, when plaintiff's mother brought her to the St. Michael's Hospital emergency room because of plaintiff's increasing problems with depression and thoughts of suicide. Plaintiff reported that she used

Valium and Adderall on a regular basis and that she obtained these drugs on the street. She reported a history of depression dating back 5 years. Plaintiff reported consuming 2 gallons of vodka per week. Blood tests were positive for the presence of benzodiazepines, amphetamines and marijuana. Given the amount of substances that plaintiff claimed to have used and her threats of suicide, hospital staff decided to admit her for treatment and observation. Psychiatrist Dr. Gerald Kipnis noted that plaintiff was a "rather difficult historian tending to be somewhat vague at times, while at others overly embellishing." AR 201. Dr. Kipnis diagnosed plaintiff with a non-specific depressive disorder, alcohol abuse and drug abuse. At the time of discharge, He rated plaintiff at 45 on the Global Assessment of Functioning, which indicated serious symptoms or serious impairment in social, occupational or school functioning. Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision 32 (2000). Dr. Kipnis noted that plaintiff was not suicidal but would benefit from ongoing care. Plaintiff spent one day in the hospital. She was referred to social services. AR 201-02.

On October 29, 2002, plaintiff began counseling with Steven Pray, a social worker for Portage County Health and Human Services whom plaintiff had seen in the past. AR 226, 271-75. Plaintiff told Pray that her recent problems were brought on by the loss of her job and live-in boyfriend at roughly the same time. AR 271. She also said that she needed to deal with issues related to sexual abuse that she had suffered when she was five years old. Plaintiff endorsed symptoms of depression and anxiety, reporting that she had had nine panic attacks in a one-week period. At intake, Pray diagnosed plaintiff with major depressive disorder, recurrent; panic disorder without agoraphobia; post traumatic stress disorder; and polysubstance disorder;

he ruled out schizoaffective disorder. Pray assessed a GAF score of 35, indicating some impairment in reality testing or communication or major impairment in several areas. AR 274.

On November 13, 2002, plaintiff saw Richard W. Hurlbut, Ph.D., for a consultative mental status examination. AR 230-51. I.Q. testing placed plaintiff in the high average range, with a verbal I.Q. of 107, performance I.Q. of 113, and full-scale I.Q. of 110. Dr. Hurlburt noted that plaintiff's scores on various portions of the test suggested that plaintiff might have a learning disability in the area of reading. Plaintiff told Dr. Hurlburt that she had trouble reading and spelling, describing herself as a non-phonetic reader who could not put sounds to words by letters. She reported that she was in learning disability classes for English, spelling and reading in grade school and junior high. She then attended a special alternative school, where her exams were administered verbally.

Plaintiff reported that she had been living with her boyfriend from the time she was 17 until roughly October 2002. According to plaintiff, her boyfriend was physically and emotionally abusive. Plaintiff said that during one beating, her boyfriend crushed her eye socket, causing permanent damage to plaintiff's vision. She also reported that her boyfriend beat her in the abdomen, causing her to have a miscarriage, and another time cracked her pelvis. Plaintiff alleged that she had been pregnant nine times and miscarried every time. Plaintiff reported that she had obtained a restraining order against her boyfriend and that she had experienced a panic attack when she saw him in court.

Plaintiff reported that she had been molested when she was five years old by a 40-year old man living with her family. Plaintiff claimed occasional flashbacks to these incidents and

visual hallucinations of the man's face. Plaintiff described another hallucination involving a large man wearing a brown tuxedo. With respect to her work history, plaintiff reported various short terms jobs. Plaintiff said that she usually quit her jobs because she got frustrated with her inability to read. She reported that she had been able to work at A&W for nine months because another employee helped her a lot, and had been able to work at Opportunity Development Center for nearly a year because the job did not require her to read.

Dr. Hurlburt observed that plaintiff was clean and neatly dressed. She was cooperative and tried hard on the testing. Dr. Hurlburt detected no psychomotor abnormalities. Plaintiff was alert, oriented and cooperative. Her thought process was lucid, organized and clear, with good transitions. Plaintiff's memory seemed adequate, although Dr. Hurlburt noted apparent depression. Dr. Hurlburt diagnosed plaintiff with post traumatic stress disorder with major depression that was recurrent, severe and sometimes psychotic and panic attacks. He assigned a GAF score of 40 - 50, indicating serious symptoms. Dr. Hurlburt noted that plaintiff likely was unable to manage her own finances because of her "current level of turmoil." AR 235.

In December 2002, Robert Hodes, Ph.D., reviewed plaintiff's records for the state agency. AR 252-61. In considering the "B" criteria of the listings for mental impairments, Dr. Hodes opined that plaintiff had mild restrictions of activities of daily living; moderate difficulties in maintaining social functioning; mild difficulties in maintaining concentration, persistence or pace; and one or two episodes of decompensation. Dr. Hodes completed a mental residual functional capacity questionnaire on which he opined that plaintiff was not significantly limited in her ability to understand, remember, and carry out simple work instructions. She could

perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances. She could complete a normal workday and workweek. Dr. Hodes thought plaintiff would be moderately limited in her ability to work with others, interact appropriately with the public, accept instructions and respond appropriately to criticism from supervisors and respond to changes in the work setting. AR 260. Dr. Hodes's overall conclusion was that plaintiff was not disabled.

On December 13, 2002, plaintiff saw Nancy Charlier, M.D., a psychiatrist for Portage County Social Services. AR 224-225. Dr. Charlier noted that plaintiff's mother, Linda Antill, was present at plaintiff's request and Antill answered many of the questions posed to plaintiff. According to Antill, plaintiff had problems with anger. Dr. Charlier noted that plaintiff's mother "seemed to have decided that Bonnie has certain conditions & disorders," including "chemical imbalance," dyslexia and post traumatic stress disorder stemming from plaintiff's having been sexually abused as a child. Plaintiff reporting suffering panic attacks when she saw her ex-boyfriend. Dr. Charlier was unable to obtain many details because plaintiff and her mother "kept jumping around on various topics." Dr. Charlier noted that plaintiff had completed a form on which she indicated a history of using alcohol, Adderall and Valium, although plaintiff told Dr. Charlier that she was not using any substances at the present time. Dr. Charlier made a notation to ask plaintiff about her substance use when her mother was not present. Plaintiff reported having a depressed mood, decreased energy, feelings of hopelessness and helplessness, and decreased appetite. According to plaintiff, recently she had lost more than 50 pounds. She denied having problems with sleep.

On mental status evaluation, plaintiff was alert and oriented in all spheres with no abnormal speech. Dr. Charlier noted that plaintiff's mood was mildly anxious when describing her panic attacks but otherwise was mildly sad. Plaintiff's thought process was logical, coherent and goal directed and her thought content was free from suicidal ideation, paranoia, grandiosity, hallucinations or irritability. Dr. Charlier noted that plaintiff's memory and concentration were both grossly intact despite the interruptions from plaintiff's mother and her insight was limited though not impaired. Dr. Charlier observed that plaintiff was neatly dressed and groomed. In Dr. Charlier's view, plaintiff probably was suffering from a major depressive disorder and possibly an anxiety disorder. She assigned plaintiff a GAF score of 55, indicating moderate symptoms or moderate difficulty in social, occupational or school functioning. Dr. Charlier recommended that plaintiff take Effexor for her depressive and anxiety symptoms, but plaintiff's mother kept objecting. Dr. Charlier indicated that she would schedule a meeting to discuss the issue with plaintiff only.

At a December 19 follow up visit, plaintiff agreed to try Effexor. Plaintiff reported feeling more hopeful. On February 13, 2003, Dr. Charlier noted that plaintiff's symptoms were responding to the medication; Dr. Charlier observed that plaintiff looked cheerful and energetic. AR 221. At a counseling session with Pray the same day, plaintiff reported doing much better with her anger issues and that the Effexor was helping her in general. AR 220.

On January 29, 2003, Pray wrote a ninety-day review, countersigned by Terry Kaddatz, Psy.D. Pray reported that he had seen plaintiff four times for assessment and therapy, and that plaintiff presented with a variety of problems related to depression, anxiety, learning disabilities, post traumatic stress disorder, panic disorder, and poly-substance dependence. According to

Pray, plaintiff had a variety of problems with daily functioning arising from her emotional difficulties , planning problems and vocational abilities. In Pray's view, plaintiff did not appear capable of handling full time work responsibility. AR 219.

In January 2003, Pray also completed a mental assessment form. AR 262-67. He noted that he had seen plaintiff five times. Pray listed several diagnoses, including major depressive disorder, panic disorder, post traumatic stress disorder and poly-substance dependance. Assessing the "B" criteria of the listings of mental impairments, Pray found that plaintiff's impairments were of listing-level severity, insofar as she had "marked" restrictions in daily living and social functioning; "constant" difficulties in concentration, persistence and pace; and "continual" episodes of deterioration or decompensation. Pray indicated that plaintiff's ability to perform various demands of unskilled work was severely impaired and that she was likely to miss work more than three times a month. AR 265-66.

In April 2003, Roger Rattan, Ph.D., a state agency consultant, reviewed the records for the state agency and confirmed as written Dr. Hodes's December 2002 opinion that plaintiff was not disabled. AR 252-61.

In September 2003, Pray completed a supplemental report in which he noted that he had seen plaintiff one more time after he had filed his previous report. Pray explained that he had arrived at his January 2003 opinion concerning plaintiff's functional limitations from conversations in which plaintiff and her mother reported that plaintiff had problems working because of difficulties concentrating and processing directions. Based upon these statements, Pray said, he had formed the clinical impression that work situations were very stressful and plaintiff "clearly could not function in a normal, efficient manner." AR 269-70.

III. Hearing Testimony

On January 14, 2004, plaintiff, represented by counsel, received her SSA administrative hearing. Plaintiff testified that her last employment had been at the Occupational Development Center, where she had worked almost a year as a general laborer binding books. Plaintiff reported that her supervisor had been very nice and had helped her organize her job and remember what to do. Plaintiff reported that she was able to perform jobs at ODC that required her to perform more than two steps, and that she had met her employer's expectations. Plaintiff testified that she had been fired for missing one day of work, after which she obtained unemployment benefits.

Plaintiff testified that she was really depressed, although she was not sure when this depression had become so bad as to prevent her from working. Plaintiff reported that she experienced panic attacks that caused her to "phase out" and not know what was going around her, only to realize that she was "on the floor, shaking in a corner." AR 286. Plaintiff reported that she had few friends and had not seen any friends for a year. She went to bed around midnight and arose at 3 or 4 p.m. the next day. She mostly just "sat around" because she really didn't like being around people. She watched movies and listened to CDs. She went grocery shopping once a month and did a few chores around the house. Plaintiff had gotten back together with her boyfriend, and the two of them lived with her mother and sister. She said she had not used drugs for the past nine months to a year. Plaintiff still was taking Effexor.

James F. Hobart, Ph.D., testified as a medical expert. AR 304-14. Dr. Hobart considered the specific listings of affective disorder, anxiety disorder, and substance addiction disorder. AR 305. In considering the "B" criteria, Dr. Hobart opined that plaintiff had moderate restrictions

of activities of daily living; marked restriction of social functioning; mild difficulty in maintaining concentration, persistence, and pace; and one episode of decompensation. AR 306-08.

Dr. Hobart opined that plaintiff would not have any difficulty understanding instructions. AR 308. With respect to social functioning, Dr. Hobart reported that plaintiff's limitations were rather marked; he drew this conclusion from plaintiff's testimony that she had only one friend whom she hadn't seen for a year and that she tended to isolate herself. AR 306-07. Dr. Hobart clarified that he did not think that plaintiff "should" avoid the general public; he simply was noting that she chose to do so. Dr. Hobart stated that based on plaintiff's testimony regarding her poor tolerance of criticism and perception that others were criticizing her, her ability to interact with supervisors and co-workers would be "problematic." AR 309.

Plaintiff's lawyer asked Dr. Hobart if he thought that plaintiff was likely to miss days from work as a result of her mental condition. Dr. Hobart replied:

> I suspect that there are going to be days when she is not wanting to get out of bed and go to work, and she will likely miss work because of that. To what extent, that's a kind of a voluntary thing or there's a decision that she has to make every day when she, when an alarm goes off or whatever. She's, she reports sleeping 15 hours a day. That's an excessive amount of sleep. At some point in that time, she makes a decision not to get out of bed. To what extent that is, it's unlikely that if that's a consistent level of functioning, that it's totally due to a major depressive recurrent diagnosis.

AR 310. Plaintiff's counsel rephrased the question, asking: "Is she likely to miss 3 or more days or partial days a month under what you reviewed of the records and her testimony today?" Dr. Hobart replied: "Given her current level of functioning, it's probably likely that she will miss that or more." AR 310-311.

Richard Willette testified as a vocational expert. Before asking Willette about the requirements of specific jobs, the ALJ told Willette that if his testimony differed from information contained in the Dictionary of Occupational Titles, then Willette should say so. The ALJ asked Willette whether a hypothetical person of plaintiff's age, education and work experience who was available for only simple, routine, repetitive and low stress work could perform any of plaintiff's past work, and if not, to state whether other work existed in the economy for such an individual.

Willette responded that a person with those characteristics would not be able to perform any of plaintiff's past work but could perform jobs including information clerk (1,232 jobs), order clerk (2,086 jobs) and assembler (9,280). Willette testified that if an additional limitation was added requiring only limited contact with coworkers and the public, then this would eliminate the jobs of information clerk and order clerk, along with half of the assembler jobs. Willette testified that no jobs in the economy would be available to a person who was absent three or more times a month. AR 320.

IV. The ALJ's Decision

On February 26, 2004, the ALJ issued a decision finding plaintiff not disabled. The ALJ was palpably skeptical of plaintiff's claim, fixating on bits and pieces of evidence that, in the ALJ's view, revealed plaintiff to be incredible. For example, the ALJ noted that although plaintiff had testified that she had received treatment sporadically since 1990, the earliest report in the record documenting treatment for any mental condition was from plaintiff's hospital admission

on October 14, 2002, 12 days after plaintiff filed for disability benefits. The ALJ also doubted the reports that plaintiff twice had attempted suicide, noting that these alleged attempts were not documented and that one doctor noted that it was not known if the attempts were serious "vs. manipulation." As for the October 14, 2002 hospital admission, the ALJ noted that plaintiff was not thought to be "acutely" suicidal and that hospital staff described her as having "a very exaggerated manner as if embellishing her history" and an unclear agenda.

The ALJ deemed it significant that there were no medical records documenting the extensive abuse-related injuries plaintiff reported to Dr. Hurlburt, including nine miscarriages, a crushed eye socket and cracked pelvis. In addition, noted the ALJ, plaintiff had not mentioned these injuries to her therapist, Pray. The ALJ noted that plaintiff had told Dr. Hurlburt that she "had been in learning disorder classes and placed in a specific alternative school because of profound reading problems." However, noted the ALJ, school records showed that plaintiff was found to have no severe deficits in any area, was removed from special education programming in 1998, and thereafter dropped out of school. The ALJ pointed out that I.Q. testing showed plaintiff to be of average to high average intelligence.

The ALJ questioned the validity of plaintiff's claim in light of reports that plaintiff's mother often accompanied her to appointments and "did most of the talking." The ALJ pointed to notes indicating that plaintiff's mother wanted her daughter to have a diagnosis but didn't want her on medications. Without explanation, the ALJ also noted that plaintiff's mother's "income was from W-2," that she had cancer with a poor prognosis, and used a wheelchair.

Finally, the ALJ found that: plaintiff had made inconsistent statements about her alcohol and drug use and about why she had lost her last job; plaintiff had been convicted of shoplifting, obstruction of justice and driving without a license; and plaintiff had applied for and received unemployment benefits in the past. Needless to say in light of all this, the ALJ found that plaintiff and her mother were not credible witnesses.

The ALJ rejected Pray's opinion that plaintiff had profound mental limitations that rendered her unable to work. The ALJ noted that Pray was a social worker, not a doctor and that his opinion was "clearly based at least in part on misinformation." He noted that plaintiff's report to Pray that she had had nine major panic attacks in a week was "dubious" and uncorroborated.

The ALJ rejected Dr. Hurlburt's diagnosis of panic attacks and depression based on post-traumatic stress disorder, finding that this diagnosis was based on plaintiff's questionable reports of extreme physical abuse and vivid hallucinations.

Declaring that he had "considerable doubts" as to the validity of *any* mental diagnosis, the ALJ nonetheless accepted the reports of the state agency physicians, who concluded that plaintiff had severe affective and anxiety disorders that were not of listing-level severity. The ALJ found these reports "much more persuasive" than the report from Pray, who the ALJ found had been "clearly misled." The ALJ acknowledged that Dr. Hobart had testified at the hearing that plaintiff might have marked limitations of social functioning. However, the ALJ rejected this finding, noting that it was based on the erroneous assumption that plaintiff's testimony was credible and accurate.

The ALJ concluded that plaintiff retained the residual functional capacity to perform simple, routine, repetitive, low-stress work activity at any exertional level. In view of plaintiff's limited work history, the ALJ accepted that plaintiff could not perform any of her past relevant work and did not have any transferable skills. However, relying on the testimony of the vocational expert, the ALJ found that plaintiff could perform numerous jobs existing in Wisconsin, including 1,230 information jobs, 2,000 order clerk jobs and 9,000 assembly jobs.

ANALYSIS

I. Standard of Review

The commissioner's findings of fact are "conclusive" so long as they are supported by "substantial evidence." 42 U.S.C. § 405(g). Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971). When reviewing the commissioner's findings under § 405(g), the court cannot reconsider facts, reweigh the evidence, decide questions of credibility, or otherwise substitute its own judgment for that of the ALJ regarding what the outcome should be. *Clifford v. Apfel*, 227 F.3d 863, 869 (7th Cir. 2000). Thus, where conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled, the responsibility for that decision falls on the commissioner. *Edwards v. Sullivan*, 985 F.2d 334, 336 (7th Cir. 1993). Nevertheless, the court must conduct a "critical review of the evidence" before affirming the commissioner's decision, *id.*, and the decision cannot stand if it lacks evidentiary support or "is so poorly articulated as to prevent meaningful review." *Steele v. Barnhart*, 290 F.3d 936, 940 (7th Cir.

2002). When the ALJ denies benefits, she must build a logical and accurate bridge from the evidence to his conclusion. *Zurawski v. Halter*, 245 F.3d 881, 887 (7th Cir. 2001).

II. Credibility Determination

There is no doubt that the record contains substantial evidence to support plaintiff's claim that she is disabled. Pray, Dr. Hurlburt and Dr. Hobart all offered opinions that, if accepted, indicate that plaintiff suffers from severe mental impairments that prevent her from working. In the case of Pray, he stated explicitly that plaintiff is unable to work. Although Dr. Hurlburt did not offer an opinion on this subject, his conclusion that plaintiff is incapable of managing her own funds and his GAF score of 40 - 50 tend to support a finding of disability. And Dr. Hobart's conclusion that plaintiff is likely to miss three or more days of work a month given her current state of functioning equates to such a finding.

Plaintiff makes various arguments why the ALJ erred in rejecting these opinions. However, with the exception of Dr. Hobart, plaintiff does not deny that the ALJ rejected all of these opinions, at least in part, on the ground that they were founded on plaintiff's subjective complaints and reports, which the ALJ determined were not credible. It is well-settled that an ALJ may disregard a medical opinion premised on the claimant's self-reported symptoms if the ALJ has reason to doubt the claimant's credibility. *See, e.g.*, *Diaz v. Chater*, 55 F.3d 300, 307 (7th Cir. 1995) (ALJ could reject portion of physician's report based upon plaintiff's own statements of functional restrictions where ALJ found plaintiff's subjective statements not credible); *Mastro v. Apfel*, 270 F.3d 171, 177-78 (4th Cir. 2001) (affirming ALJ's disregard of

treating physician's opinion because it "was based largely upon the claimant's self-reported symptoms" and was not supported by the objective medical evidence); *Morgan v. Commissioner of the Social Security Administration*, 169 F.3d 595, 602 (9th Cir. 1999) (physician's opinion of disability premised to large extent on claimant's own accounts of symptoms and limitations may be disregarded where those complaints have been properly discounted). Accordingly, if the ALJ properly discounted plaintiff's subjective statements, it follows that he could reject any medical opinions based on those statements.

An ALJ's credibility determination is given special deference because the ALJ is in the best position to see and hear the witness and to determine credibility. *Shramek v. Apfel*, 226 F.3d 809, 812 (7th Cir. 2000) (citation omitted). In general, an ALJ's credibility determination will be upheld unless it is "patently wrong." *Prochaska v. Barnhart*, 454 F.3d 731, 738 (7th Cir. 2006) (citation omitted); *Sims v. Barnhart*, 442 F.3d 536, 538 (7th Cir. 2006) ("Credibility determinations can rarely be disturbed by a reviewing court, lacking as it does the opportunity to observe the claimant testifying."). However, the ALJ still must build an accurate and logical bridge between the evidence and the result. *Shramek*, 226 F.3d at 811.

Although the ALJ did not come right out and say it, the essence of his credibility finding was that plaintiff and her mother–who did not testify at the hearing but who made statements to various health providers about plaintiff's condition–were dishonest people who exaggerated plaintiff's symptoms in a willful attempt to obtain social security benefits to which they knew plaintiff was not entitled. The ALJ listed numerous reasons to support this conclusion and his rationale is discernible from his decision. Unfortunately, many of the ALJ's reasons are based on misstatements of the record or on specious logic.

For example, the ALJ suggested that plaintiff had lied when she testified that she had received treatment sporadically since 1990. The ALJ noted that the earliest report in the record documenting treatment for any mental condition was from plaintiff's hospital admission on October 14, 2002. However, Pray noted on his mental impairment questionnaire that plaintiff had been seen in the past by him and other staff at Portage County Health and Human Services, including Dr. Richard Williams and Irene Tyler, a family social worker. Indeed, Pray indicated on his report that plaintiff's complete records could be forwarded; the ALJ, however, never sought to obtain these records. Pray's report corroborates plaintiff's assertion that she had received treatment in the past and contradicts the ALJ's suggestion that plaintiff had not accurately reported her mental health treatment history. Pray's report of having seen plaintiff in the past also contradicts the ALJ's finding that plaintiff had seen Pray only five times.

Another example: the ALJ suggested that plaintiff had been untruthful when she told Dr. Hurlburt that she had been "in learning disorder classes and placed in a specific alternative school because of profound reading problems." The ALJ contrasted plaintiff's statement with school records that plaintiff had been removed from the learning disability program in June 1998 after it was found that she had no severe deficits in any area. However, plaintiff never told Dr. Hurlburt that she attended the alternative school *because* of her reading problems or for her learning disability, as the ALJ inferred. Rather, plaintiff told Dr. Hurlburt that "she was in learning disability classes . . . in junior high and in grade school. She then attended a special alternative school and had people read the test to her so that she could do them." AR 231. Nothing in this statement suggests that plaintiff was claiming to have been continued in learning disability courses beyond eighth grade.

A third example: the ALJ noted that I.Q. testing showed plaintiff to have an average to high average intelligence, appearing to suggest that this evidence contradicted plaintiff's claim that she had difficulty reading. However, a person can have a reading disability yet still have a high I.Q. Indeed, Dr. Hurlburt, who administered the I.Q. test, observed that the discrepancy between plaintiff's verbal score and performance score suggested a learning disability in the area of reading. The record does not support the ALJ's implication that plaintiff's relatively high I.Q. undermined her claim to have a reading disability.

A fourth example: the ALJ asserted that plaintiff had made inconsistent statements concerning her drug and alcohol use. The record does not support this assertion. The ALJ appears to have relied heavily on plaintiff's having denied any significant use when she was interviewed by Dr. Charlier. However, Dr. Charlier noted that plaintiff's mother was present during the interview; the doctor made a note reminding herself to talk to plaintiff again about her AODA issues when her mother was not there. Dr. Charlier's notes suggest that she suspected plaintiff might be withholding information due to her mother's presence (which also would contradict the ALJ's suspicion that plaintiff and her mother were colluding to fabricate an alarming record). Further, Dr. Charlier noted that plaintiff had completed a form acknowledging past heavy use of alcohol, Adderall and Valium. Overall, the record shows that plaintiff was consistent in her statements regarding her drug and alcohol use, including her claim to have stopped using those substances after her inpatient admission in October 2002.

A fifth concern would be the ALJ's remarks about plaintiff's mother, Linda Antill. In addition to noting that Antill often accompanied plaintiff to appointments and did "most of the

talking," the ALJ also deemed it noteworthy that Antill's income was from W-2 (Wisconsin's welfare program), that she had been noted to have cancer with a poor prognosis and that she had attended one visit in a wheelchair. Why did the ALJ think these facts were relevant to his determination? Was he insinuating that Antill was a "welfare queen" coaching her daughter as they conned their way through the system? If so, the ALJ should have been more candid so that this issue could be addressed openly. After all, there is ground for suspicion: some records suggest that Antill seemed intent on having her daughter diagnosed with a mental impairment and qualified for SSI benefits. One could infer Antill's financial interest in plaintiff's claim because Antill was living with plaintiff shortly after plaintiff filed her application.

However, the ALJ's suggestion that Antill's W-2 status and her physical condition were additional reasons to suspect a plot is speculative and boorish. Further, even if Antill had selfish motives for assisting her daughter, it does not necessarily follow that the ALJ should mistrust plaintiff and the opinions and evaluations derived from plaintiff's reports. Notably, although both Pray and Dr. Hurlburt consulted Antill for information, it is clear from their notes and reports that their opinions were also based upon information from plaintiff.

This litany of miscues by the ALJ might be viewed as grounds for remand and reconsideration. However, remand is warranted only if there is a reasonable possibility of a different outcome. *Keys v. Barnhart*, 347 F.3d 990, 994 (7th Cir. 2003) (doctrine of harmless error applies to judicial review of administrative decisions). Having carefully considered the record and the ALJ's rationale, I am convinced that such is not the case here. That's because the record also contains sufficient valid support for the ALJ's credibility determination.

First, the ALJ correctly noted Dr. Kipnis's observation that plaintiff was a "difficult historian" who related in a very exaggerated manner as if embellishing her history. Although plaintiff suggests that her propensity to exaggerate is consistent with her mental illness, none of the mental health providers who evaluated plaintiff endorsed this symptom. Accordingly, it was not unreasonable for the ALJ to draw an adverse inference from this evidence.

Second, the ALJ cited to the absence of corroboration of the severe injuries that plaintiff told Dr. Hurlburt she had suffered at the hands of her boyfriend, including a crushed eye socket that resulted in the loss of half of her vision and a cracked pelvis that sometimes caused her to limp. Plaintiff responds that "many times physical abuse is not reported," but she does not argue that *she* did not report these incidents: how plaintiff would know she had a cracked pelvis if she had not been x-rayed? The ALJ also observed that plaintiff apparently never mentioned these alleged injuries to Pray, her therapist, who noted that plaintiff was in good physical health and that her only limitations were psychological in nature.[2]

Third, the ALJ noted plaintiff's contradictory explanations as to why she lost her job at ODC. Plaintiff (and her mother) told Pray that she lost her job because of mental problems, including her inability to concentrate and follow instructions. However, plaintiff testified and indicated on a form that she had been terminated for unexcused absences. AR 91. Although

[2] A noteworthy document not mentioned by the ALJ was a "Report of Contact" reporting an April 2003 telephone conversation between Antil and the disability examiner, in which Antil stated that if plaintiff wore her glasses she could see faces, read well and use the computer without problems, and that her vision blurred only occasionally when her eyes got tired. AR 107. This report is inconsistent with plaintiff's statement to Dr. Hurlburt that she had lost "half her vision." (Such an inconsistency also undermines the ALJ's implicit suspicion that Antil and plaintiff had coordinated a fraudulent application).

plaintiff attempts to argue that unexcused absences and mental problems are "one in the same," plaintiff testified at the hearing that she was able to perform more than two-step tasks at ODC and to meet her employer's expectations. Further, when plaintiff filed her application for SSI, she indicated that she could not work because of problems reading, not because of problems concentrating. AR 72. Overall, the evidence supports the ALJ's conclusion on this issue.

Fourth, the ALJ questioned plaintiff's credibility because she had applied for unemployment benefits, which required plaintiff to represent that she was ready, able and willing to work. Plaintiff argues that such application would be inconsistent with her disability claim only if the claims overlapped, but she is silent on whether there actually was an overlap. There was: plaintiff testified at the hearing that she applied for unemployment after she had been fired from ODC. This was the same date on which plaintiff alleged she first became disabled. Under these circumstances, it was proper for the ALJ to consider plaintiff's UC claim as a factor adversely affecting her credibility. *Schmidt v. Barnhart*, 395 F.3d 737, 747 (7th Cir. 2005).

Fifth, the ALJ relied on plaintiff's criminal convictions for shoplifting, obstruction of justice and driving without a license.[3] Although plaintiff's criminal record alone would not have been an adequate basis on which to find her incredible, it was not improper for the ALJ to consider such convictions as part of the totality of circumstances when determining credibility.

[3] The ALJ also noted that although plaintiff denied having been convicted of a felony, SSA reports showed that a record appeared on the prisoner update processing system database. I cannot find that report in the administrative record. To the extent the ALJ is suggesting that plaintiff might have lied about a felony conviction, I have ignored that suggestion.

Having considered both the proper and improper factors on which the ALJ based his credibility determination, I conclude that this court should uphold the ALJ's determination that plaintiff was not a credible witness. Obviously it would have been better if the ALJ had been less *Javertian* when compiling his list of reasons why he didn't believe plaintiff. Even so, after stripping away the improper and questionable considerations, enough valid reasons remain to provide substantial support for the ALJ's credibility determination. *Cf. Herron v. Shalala*, 19 F.3d 329, 336 (7th Cir. 1994) ("Because we have concluded that the inconsistencies in Herron's testimony do not exist, and the ALJ has not provided us with any other reason for rejecting Herron's testimony, we are left without a basis to uphold the ALJ's credibility determination."); *Ribaudo v. Barnhart*, 458 F.3d 580, 585 (7th Cir. 2006) (remanding after finding that "[e]ach of the ALJ's reasons for his adverse credibility finding is flawed"). It makes no sense to remand this case if this court would uphold it even without the questionable findings made by the ALJ.

Apart from attacking the reasoning underlying the ALJ's credibility finding, plaintiff argues that this determination is erroneous as a matter of law because the ALJ failed to consider the specific factors outlined in 20 C.F.R. § 404.1529 and Social Security Ruling 96-7p, including plaintiff's limited daily activities and the potential side effects from medications. *See Brindisi v. Barnhart*, 315 F.3d 783, 787 (7th Cir. 2003) (ALJ's must comply with SSR 96-7p). But after the ALJ concluded that plaintiff was not a believable witness, he did not have to accept her testimony as an accurate account of her daily activities. As for medication side effects, plaintiff has not argued that she suffers from any. Accordingly, even if the ALJ technically erred by failing to address the SSR 96-7p factors, this error was harmless.

III. The Medical Opinions

Plaintiff argues that the ALJ committed reversible error when he "ignored" Dr. Hobart's testimony that plaintiff likely would miss 3+ days of work each month. In discussing Dr. Hobart's testimony, the ALJ noted only that "the medical expert's testimony suggested that the claimant could have even marked limitations of social functioning, although he stated that he had based that opinion on the assumption that the claimant's testimony was credible and accurate." The ALJ noted that he did not agree with the assumption that plaintiff was credible.

The ALJ did not specifically address Dr. Hobart's testimony concerning plaintiff's absences. Dr. Hobart's testimony is significant, because the VE testified that a person who misses at least three days of work each month is not employable. But the ALJ's omission does not augur remand. An ALJ is not required to provide a written evaluation of every piece of evidence; he need only "minimally articulate" his reasoning so as to "make a bridge" between the evidence and his conclusions. *Rice v. Barnhart*, 384 F.3d 363, 371 (7th Cir. 2004). Given the overall tenor of the ALJ's decision and his explanation why he was rejecting Dr. Hobart's opinion regarding plaintiff's social functioning, it is clear from the ALJ's decision that he was rejecting any and every opinion of Dr. Hobart's to the extent that it was based on plaintiff's self-reported symptoms.

Plaintiff argues that Dr. Hobart's testimony was not based solely upon plaintiff's testimony but also on his observations of plaintiff at the hearing and the medical reports in the file. Plaintiff is incorrect, at least regarding the monthly absences. Although Dr. Hobart observed plaintiff testify and reviewed the record, it is clear from his testimony that his opinion

regarding absences was founded largely upon plaintiff's testimony at the hearing about her current level of functioning, particularly her report of sleeping 15 hours a day. Because the ALJ deemed incredible plaintiff's self-reports concerning her functioning, it was not improper for him to reject Dr. Hobart's testimony.

Plaintiff accuses the ALJ of "playing doctor," arguing that absent medical evidence to the contrary, the ALJ's decision to reject Dr. Hobart's conclusion on this point merely reflected the ALJ's lay opinion. *Rohan v. Chater*, 98 F.3d 966, 970-71 (7th Cir. 1995) (ALJ's conclusion that plaintiff's ability to engage in small machine repair/resale business was inconsistent with depression was inadequate ground for rejecting treating physician's opinion). But as the commissioner points out, the ALJ also cited to state agency psychologists' opinions that plaintiff was not significantly limited in her ability to complete a normal workweek. The ALJ's reliance on this contradictory evidence from professionals distinguishes this case from *Rohan* and the other cases cited by plaintiff. The ALJ explained that he found the opinions of the state agency physicians "much more persuasive" than the restrictive opinion provided by Dr. Hobart, insofar as Dr. Hobart had based his opinion on plaintiff's self-reported functioning level. This was an adequate reason to reject Dr. Hobart's opinion. Further, contrary to plaintiff's contention, the ALJ explained his rationale sufficiently to permit informed review.

Next, plaintiff argues that the ALJ misapplied the regulations when he discounted Pray's opinion on the ground that Pray was not a physician or psychological doctorate. Plaintiff points out that although Pray was not an "acceptable medical source" for the purpose of establishing whether plaintiff had a medically determinable impairment, he was an "other source" whose

opinion was relevant to show the severity of plaintiff's impairments and how they affected her ability to work. 20 C.F.R. § 416.913(d)(1). The ALJ did not dismiss Pray's opinion solely on the ground that Pray was not an acceptable medical source. The ALJ also found that Pray's assessments were based on unreliable information from plaintiff and her mother, including statements about plaintiff's alleged concentration problems at work. Having concluded that the ALJ did not err by finding these statements incredible, I conclude that the ALJ did not err by rejecting Pray's opinion.

Finally, plaintiff argues that the ALJ failed to give an adequate reason for rejecting Dr. Hurlburt's report. Although plaintiff appears to concede that Dr. Hurlburt did not offer an opinion regarding plaintiff's ability to work, she points out that Dr. Hurlburt assigned plaintiff a GAF score of 40-50, suggesting significant limitations. The ALJ appeared to have acknowledged this, insofar as he took care to explain why he was not affording much weight to that report. According to the ALJ, Dr. Hurlburt's assessment was based in upon plaintiff's uncorroborated and highly suspect reports of extreme physical abuse and vivid hallucinations; therefore, his assessment was unreliable.

The ALJ's characterization of Dr. Hurlburt's report is not completely accurate. The report indicates that Dr. Hurlburt did not rely exclusively on plaintiff's alleged recent physical abuse as a basis for his conclusions. He also relied on plaintiff's report of having been sexually abused when she was five years old and her reports of having visual hallucinations of the perpetrator's face. Nonetheless, as with the other medical opinions, the ALJ could reject Dr. Hurlburt's report to the extent it was based on plaintiff's self-reporting. It is plain from Dr.

Hurlburt's report that he accepted at face value plaintiff's reports of her current functioning, including her severe panic attacks at the sight of her allegedly abusive ex-boyfriend. It also is plain, as discussed previously, that the ALJ did not believe plaintiff's account of her current functioning or of her past abuse-related injuries. Accordingly, although the ALJ may not have been entirely accurate in describing the basis for Dr. Hurlburt's diagnosis, the ALJ sufficiently articulated his reasons for rejecting Dr. Hurlburt's report to permit informed review. Applying the deferential standard of review to those reasons, I conclude that substantial evidence supports the ALJ's determination that Dr. Hurlburt's assessment of plaintiff's ability to function was entitled to little weight.

IV. Learning Disability

Plaintiff contends the ALJ erred by failing to include limitations in the residual functional capacity assessment to account for plaintiff's reading disability. Plaintiff points out that Dr. Hurlburt noted that the spread between plaintiff's verbal and performance scores on I.Q. testing suggested the possibility of a learning disorder in the area of reading. According to plaintiff, the ALJ discounted this evidence solely on the flawed assumption that it was contradicted by plaintiff's average to high average I.Q.

It would have been error for the ALJ to rely solely on plaintiff's I.Q. as a basis for rejecting her alleged reading problems. However, a review of the ALJ's decision shows that he also relied on the fact that plaintiff had been discontinued from special education services in eighth grade after school staff found that she had no severe deficits in any area. This evidence

suggests that, to the extent plaintiff has reading problems, they are not profound. Indeed, Dr. Hurlburt's testing showed only the "possibility" of a learning disability in the area of reading. Overall, the ALJ gave sufficient reasons for rejecting plaintiff's allegation of a severe reading disability.

Further, it appears that even if the ALJ should have included limitations in the residual functional capacity assessment to account for plaintiff's reading disability, such additional limitations would not affect the ultimate determination that plaintiff is not disabled. As plaintiff acknowledges, in response to the ALJ's hypothetical question, the VE identified thousands of unskilled jobs (listed in the *Dictionary of Occupational Titles* as requiring a Specific Vocational Preparation of SVP 1 or 2). SSR 00-4P (noting that unskilled work corresponds to SVP of 1-2). Because most unskilled work requires working with things, as opposed to people or data, even illiterate persons can perform such work. *See* 20 C.F.R., Pt. 404, Subpt. P, App. 2, Sec. 201.00(h)(4)(I). Indeed, according to the description of small products assembler excerpted in plaintiff's brief, that job can be performed by individuals falling into Language Development Level 1, requiring the performance of only minimal reading and writing abilities. *See Dictionary of Occupational Titles* (4th Ed., Revised 1991) Appendix C--Components of the Definition Trailer.[4]

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[4] This information can be gleaned from the job's "definition trailer," a coded series of acronyms and numbers listed at the end of the job description. Educational requirements are described in the job's "GED," which stands for "General Educational Development." The GED is broken down into three divisions: Reasoning Development, Mathematical Development and Language Development. Plaintiff appears to have confused the "R" in the definition trailer as an abbreviation for "Reading," when actually the R stands for "Reasoning Development." Reading skills are encompassed within Language Development, abbreviated in the GED as "L." *See generally*, Appendix C to the *Dictionary of Occupational Titles*.

Apart from Dr. Hurlburt's report indicating the possibility of a reading disability, plaintiff has not presented any evidence to suggest that she would not be able to perform at least the assembly jobs identified by the vocational expert. Notably, plaintiff did not ask the VE at the hearing how her alleged reading problems might affect the number of jobs he identified. The record indicates that at the time she was tested in eighth grade, plaintiff was reading at the seventh grade level. Plaintiff testified that although she had dropped out of high school, she had obtained her general equivalency diploma. In addition, plaintiff was able to perform satisfactorily at the ODC despite her alleged reading problems. In light of this evidence, I am satisfied that even if the ALJ failed to give good reasons for rejecting the evidence of plaintiff's reading disability, the outcome would not change on remand.

That said, the commissioner has probably waived any harmless error argument by failing to raise it in her brief. Accordingly, if the district court disagrees with my conclusion that the ALJ properly rejected plaintiff's allegation of a reading disability, then remand might be appropriate to the take additional evidence concerning the severity of plaintiff's alleged reading disability and the extent to which this disability would impact the jobs identified by the vocational expert.

CONCLUSION

The ALJ's unnecessarily captious opinion of plaintiff's credibility is troubling, but it does not appear to provide a basis for remand. The commissioner just as easily could have granted benefits to plaintiff, but he didn't, and that decision is entitled to substantial deference on appeal.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that this court affirm the Commissioner's decision denying plaintiff Bonnie Vreeland's application for supplemental security income.

Entered this 27th day of March, 2007.

BY THE COURT:

/s/

STEPHEN L. CROCKER
Magistrate Judge

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March 27, 2007

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Re: Vreeland v. Astrue
Case No. 06-C-466-C

Dear Counsel:

The attached Report and Recommendation has been filed with the court by the United States Magistrate Judge.

The court will delay consideration of the Report in order to give the parties an opportunity to comment on the magistrate judge's recommendations.

In accordance with the provisions set forth in the newly-updated memorandum of the Clerk of Court for this district which is also enclosed, objections to any portion of the report may be raised by either party on or before April 13, 2007, by filing a memorandum with the court with a copy to opposing counsel.

If no memorandum is received by April 13, 2007, the court will proceed to consider the magistrate judge's Report and Recommendation.

Sincerely,

/s/

Connie A. Korth
Secretary to Magistrate Judge Crocker

Enclosures
cc: Honorable Barbara B. Crabb, Chief Judge