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

MICHAEL S. GOODMAN,

Plaintiff,

REPORT AND
RECOMMENDATION

v.

02-C-520-C

JO ANNE B. BARNHART, Commissioner
of Social Security,

Defendant.

REPORT

This is an appeal of an adverse decision of the Commissioner of Social Security brought pursuant to 42 U.S.C. § 405(g). Plaintiff Michael S. Goodman, proceeding *pro se*, seeks judicial review of the Commissioner's determination that he is not entitled to a period of disability or disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 416(i), 423. Plaintiff contends that he has been unable to work since December 1, 1999 because of chronic depression and side effects from medication he takes for his depression. Plaintiff was represented by counsel at the administrative level. An administrative law judge found after a hearing that plaintiff is not disabled under the Act because he can perform a significant number of simple, routine, unskilled light jobs despite his severe impairment. This decision became the final decision of the Commissioner when the Appeals Council denied plaintiff's request for review.

Plaintiff contends that the ALJ erred by favoring the testimony of a non-examining neutral medical expert, Timothy Lynch, over that of his treating psychiatrist, Dr. Sheldon. In addition, plaintiff contends that the ALJ did not adequately evaluate his functional limitations and their impact on his ability to work. Having carefully reviewed the entire administrative record, I conclude that the ALJ properly weighed the various medical opinions and the evidence of record and reached a decision that is supported by substantial evidence.

From the administrative record, I find the following facts.

FACTS

I. Background and Medical Evidence

Plaintiff was born in March 1955, making him 46 years old at the time of the ALJ's decision. He had a bachelor's degree in geography and a graduate degree in Ibero-American studies. From 1989-1999, he had been employed as a Spanish language translator for Cuna Mutual, an insurance company. Thereafter, plaintiff held a series of administrative jobs that each lasted for only one or two months. Plaintiff was unmarried, had no children and lived alone in an apartment.

Plaintiff was treated sporadically for depression in 1989 and 1995. From January to May 1997, he participated in a study of the drug Paxil for the treatment of social phobia. After the study, he continued to take Paxil as prescribed by Dr. James Jefferson. In March 1998, plaintiff began being treated by Dr. Jeffrey Marcus. Plaintiff reported that his

symptoms of generalized anxiety and depression had improved significantly on the Paxil, although he still had significant anxiety when interacting with others. He also reported problems with interpersonal relationships, noting that he avoided dating or intimate relationships. Dr. Marcus continued to treat plaintiff with medication for depression and anxiety, and encouraged him to see a psychotherapist about his issues of intimacy and social anxiety.

On November 16, 1998, Dr. Edwin Sheldon began treating plaintiff. He noted that plaintiff had reported feeling "professionally stagnated" in his job. Plaintiff reported that his job had changed in the past year and he was now a "glorified gopher" running errands and doing special projects. Dr. Sheldon diagnosed a dysthymic disorder and a generalized anxiety disorder. He continued plaintiff on his medications and recommended that he continue to see a psychotherapist.

Plaintiff had no significant problems until August 1999. At a visit with Dr. Sheldon on August 31, 1999, plaintiff reported that he had had a difficult summer. He said that both his social phobia and depressive symptoms had worsened, and he was feeling more anxious and frustrated at work. His problems peaked during the time period from August 1-16, when his employer had forced him to take a medical leave and undergo an evaluation to determine whether he was fit to perform his job. According to plaintiff, he had been cleared to return to work and his symptoms had since subsided. Dr. Sheldon indicated that plaintiff was fit to carry out his work assignments.

On October 18, 1999, plaintiff reported that he was feeling better and doing much better. His problems at work had "settled down" since the summer. Plaintiff reported that his mood was good, his anxiety was controlled, he was sleeping well and his current medications were "working extremely well."

Plaintiff saw Dr. Sheldon on February 24, 2000, after having been dismissed by his employer. Plaintiff reported that he had been successful in getting his unemployment reestablished and had retained an attorney about appealing his job termination. Plaintiff reported that his anxiety was pretty well controlled and his mood was stable. Plaintiff reported that he was using his time by exercising, walking more, resting more, looking for other types of work and planning for the future.

From January to May 2000, plaintiff received services from the Wisconsin Division of Vocational Rehabilitation. On January 10, 2000, plaintiff told his counselor that his position as a translator at Cuna had been eliminated but he was seeking to obtain a different job there. He was also exploring the possibility of doing independent translation work over the Internet. On another occasion, plaintiff indicated that he was interested in ministry work. On May 5, 2000, plaintiff reported that he did not envision himself as a pastor but wanted to work in some other capacity.

On April 20, 2000, plaintiff told Dr. Sheldon that he was "getting used to not working." He was in the process of suing his former employer and looking for work. He

reported that his mood was okay, his anxiety was controlled and he was happy with his medication regimen.

On May 19, 2000, Dr. Sheldon completed a psychiatric questionnaire in connection with plaintiff's claim for disability benefits. Dr. Sheldon indicated that plaintiff had an atypical depressive illness and a generalized anxiety disorder. Dr. Sheldon indicated that plaintiff had depressive symptoms that were "more or less with him all the time," and that they could intensify with no particular pattern. He described plaintiff as chronically anxious, restless, fidgety and scattered in thought. On another section of the form, he indicated that plaintiff's concentration and short term memory could be spotty when plaintiff was "very anxious." He indicated that plaintiff's dress and grooming were poor "by conventional social standards." He described him as a "loner," but indicated that plaintiff appeared to keep himself busy. According to Dr. Sheldon, plaintiff could relate to others when he was not anxious or depressed. He indicated that when plaintiff was anxious or depressed, he lost interest in activities and personal grooming.

Pat Patterson, a psychotherapist whom plaintiff had seen approximately six times, completed a questionnaire on June 30, 2000. Patterson indicated that plaintiff arrived for all scheduled appointments 10-15 minutes late, appeared disheveled, frequently answered questions by asking questions, withheld information, and was suspicious of and had difficulty getting along with others. She rated plaintiff's ability to concentrate and pay

attention as within normal limits. She stated that plaintiff had been asked to leave at least two jobs because of "poor interpersonal skills."

On August 18, 2000, plaintiff began seeing Dr. Peter Weiss for psychotherapy related to his job loss and unemployment situation. On October 13, 2000, Dr. Weiss indicated that plaintiff had improved regarding his job crisis but that his other goals were unclear. At a visit with Dr. Sheldon on October 27, 2000, plaintiff reported that he had a new job with the Department of Workforce Development but that he was getting to work late. Plaintiff told Dr. Sheldon that he had been "using the excuse" that his medication was the reason for his tardiness. Dr. Sheldon indicated that the medication was not the reason plaintiff was late, although it might affect the speed with which he worked.

On January 25, 2001, plaintiff reported that he was doing "quite well" in spite of losing his job at the Department of Workforce Development. He indicated that he had tried a job with the Postal Service but could not work fast enough to run the machines. Plaintiff was on unemployment and looking for other jobs. He was sleeping well and his mood was stable. On June 7, 2001, plaintiff reported that he had a new job at the Department of Corrections that he liked. Dr. Sheldon reported that plaintiff was "pleased with himself" and was doing quite well.

On June 25, 2001, an attorney called Dr. Sheldon and reported that plaintiff's landlord was trying to evict him because he was collecting and "hoarding" things in his apartment. At a visit with Dr. Sheldon on August 16, 2001, plaintiff reported that he was

feeling extremely hopeless and "everything seems to be falling apart." Dr. Sheldon observed that plaintiff's mood was "more depressed today than I have seen it in some time. His [obsessive compulsive disorder] symptoms are much worse." Plaintiff reported that he continued in his struggle with his landlord. Dr. Sheldon indicated that plaintiff was "clearly suffering from a hoarding disorder as outlined by the public defender who intervened for him on the housing and found it absolutely filled with things that the patient has been unable to release or let go." AR 270. Plaintiff reported that he had lost his job with the Department of Corrections at the end of June. According to plaintiff, he had not been allowed enough time to learn the job and the environment was hostile. Dr. Sheldon also noted that plaintiff was experiencing some "posttraumatic aspects" from losing his job with Cuna, noting that the loss had "impacted his self-concept quite intensely and has also given him a lot of flashbacks." *Id*.

At a follow-up on September 27, 2001, plaintiff reported that he was "not too bad," although he had not found a new job. Dr. Sheldon noted that the issues with his previous employer "appear to be over," although plaintiff continued "to push the idea that he now meets the criteria for a PTSD diagnosis secondary to the treatment he got" from his employer. AR 267. Plaintiff reported that his mood was good and his obsessive-compulsive symptoms were less severe.

On December 20, 2001, plaintiff reported that his mood was better and that he was feeling focused and energetic, although his sleeping pattern was variable. Plaintiff told Dr. Sheldon he was "doing really quite well" on the current medication program.

On January 25, 2002, Dr. Sheldon completed a Mental Impairment Questionnaire and an Affective Disorder form regarding plaintiff. He indicated that plaintiff struggled with an obsessive-compulsive disorder and an acute and chronic dysthymic disorder that "comes and goes" affecting his memory, appetite and sleep pattern. Dr. Sheldon indicated that plaintiff had various symptoms, including hoarding behaviors; flashbacks, fears and somatic reactions to his former work place; problems with concentration, staying on task and sustaining effort; and sleep disturbances. He opined that plaintiff's condition resulted in marked restrictions of activities of daily life, social functioning and concentration, persistence or pace, and repeated episodes of deterioration or decompensation. In addition, he opined that plaintiff would miss work more than three times a month because of his impairments. He gave plaintiff a current score of 50 and a past year score of 45 on the Global Assessment of Functioning Scale, indicating that plaintiff had serious symptoms or limitations in social or occupational functioning. He stated that plaintiff had reported no side effects from his medications.

II. Plaintiff's Statements and Testimony

On June 17, 2000, plaintiff completed a Daily Activities Questionnaire for the purposes of his application for Social Security benefits. Plaintiff reported that on a typical day, he worked at various hobbies, read extensively, watched television, slept or rested, listened to the radio, handled correspondence, attended a lecture or cultural event or visited with friends. He stated that he performed household chores that included cooking, cleaning, laundry, trash removal, picking up mail, making his bed and "weeding out" old or unneeded items. He left home daily, going to lectures or cultural events, parks, meetings with friends, doctor's appointments and an occasional movie. He stated that the amount of time he slept had increased, and that he now slept largely during the day time and remained awake at night and into the early morning hours. He stated that he drove, read, performed grooming, talked on the phone and handled finances at least daily; visited with friends, attended church activities and went out to eat weekly; and performed volunteer activities for public radio and television monthly. He stated that he had lost his job at Cuna as a result of an "increased insistence" on the part of his employer that he "arrive at work strictly on time, and that I adapt to, and completely follow, an increasingly complex and ever-changing set of work rules." AR 60. He stated that he became unable to meet his employer's expectations because of his progressively worsening depression and the side effects of anti-depressants.

At the administrative hearing on February 6, 2002, plaintiff testified that he first started seeing a doctor for depression in January 1997 because he was feeling more

withdrawn, socially isolated, pessimistic, lethargic and apathetic. Plaintiff testified that his symptoms were a "deepening" of a process that had begun 20 to 25 years earlier. Plaintiff testified that his symptoms included weight loss; an increasingly erratic sleep pattern; fidgeting and nervous tics, such as head nodding and shaking; decreased energy; feelings of guilt and passive thoughts of suicide. Plaintiff testified that he spent the whole day in bed approximately two days each week. He testified that he left the house about two or three times a week; bathed two or three times a week; had few friends; cried about three times a week; and became easily distracted. He testified that he read a fair amount and watched a lot of television. Plaintiff testified that Dr. Sheldon had not told him that he should not work.

Plaintiff testified that he had represented himself as available and able to work for the purposes of unemployment compensation, and that he had been awarded such benefits. He testified that he was advised by an attorney to file for unemployment compensation and that he had never been told that he could not receive Social Security disability and unemployment compensation at the same time.

Plaintiff testified that his job at Cuna ended because of his tardiness and failure to follow management instructions. He testified that the company underwent a change in corporate culture in 1999; prior to that time, he had had more personal autonomy and flexibility at his job. He testified that he had also received complaints about his personal hygiene.

Plaintiff testified that he had been fired from his last job as a program assistant with the Department of Corrections because he was not learning the job fast enough, his attendance needed improvement and other employees had complained about his personal hygiene. Plaintiff speculated that the "hygiene" issue was his body odor and perspiration, which he attributed partly to his nervousness. He testified that he lost his job at the Postal Service because he was unable to successfully complete the training, which required him to complete computer-based exercises that became progressively more difficult. Plaintiff testified that he was discharged from his job at the Department of Workforce Development because of tardiness and his failure to master customer service skills quickly enough.

III. Third Party Statements

Laurie See, a friend of plaintiff's for 19 years, completed an Activities Questionnaire on June 27, 2000, in connection with plaintiff's benefits application. She testified that he was unkempt in appearance, often wearing tattered or dirty clothing, and needed to be reminded to shower at times. She stated that he spent a lot of time sleeping or resting in bed and devoted little time to household chores or visiting with friends. She stated that plaintiff had several unusual hobbies, including collecting and importing books, maps and flags, and that he was a "fanatic" about Cuba. She reported that plaintiff also had a habit of broaching inappropriate topics such as sexual fetishes. See reported that plaintiff had difficulty dealing with authority figures, relating to groups and keeping appointments. She stated that

although many of her descriptions of plaintiff had applied for much of the 19 years that she had known him, she had observed a drastic deterioration in plaintiff's appearance and his ability to function in the past year.

III. Medical Expert Testimony

Psychologist Timothy Lynch, Ph. D., testified as a neutral medical expert at the administrative hearing. Lynch opined that plaintiff had symptoms of an affective disorder and an anxiety disorder, but not on an ongoing and continuous basis. Lynch reviewed the medical records and found that, with the exception of August 1-16, 1999, plaintiff's symptoms were not severe and were well-controlled with medication. According to Lynch, plaintiff's condition was episodic in nature and was sometimes severe, but was not incapacitating except for the time period in August 1999. Lynch testified that plaintiff's impairments resulted in mild to moderate restrictions of activities of daily living; moderate restrictions in social functioning; and mild restrictions in his ability to concentrate and attend. He opined that he had insufficient evidence to determine the frequency with which plaintiff experienced decompensation or deterioration in the workplace.

In response to cross-examination by plaintiff's attorney, Lynch testified that plaintiff's testimony, if considered by itself, established that plaintiff had marked functional limitations. He testified that if plaintiff had lost three jobs within a year because of an inability to grasp things or personal hygiene, that would indicate that plaintiff had repeated

episodes of workplace deterioration. He testified that an individual with dysthymia and mild anxiety would not be likely to miss work several times a month, but an individual with major depression would. Lynch testified that a person with major depression would not have the ability to articulate "with the kind of memory and attention" like plaintiff demonstrated at the hearing. He indicated that plaintiff probably had a bout of major depression in August 1999, but there was no evidence to suggest that it had recurred.

IV. Vocational Evidence

Gregory Wisnieski testified as a vocational expert. Wisniewski testified that plaintiff had transferable skills including his ability to translate different languages and knowledge of computers, operations and keyboards. He testified that an individual of plaintiff's age, education and work experience who could meet the exertional demands of light work but was limited to simple, routine, repetitive, low stress work with limited contact with the public and coworkers could perform the jobs of file clerk, billing clerk, traffic clerk and mail clerk. Wisniewski testified that there were approximately 19,000 such jobs available in the economy. He testified that no jobs would be available for an individual who would be absent from work more than three times a month.

V. Legal Framework and the ALJ's Decision

Under the Social Security Act, a disability is 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's regulations establish a 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 his or her past work? and

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

See 20 C.F.R. § 416.920.

In seeking benefits the initial burden is on the claimant to prove that a severe impairment prevents him from performing past relevant work. If he can show this, the burden shifts to the Commissioner to show that plaintiff 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). Although the Commissioner must carefully consider opinions from medical sources when conducting the five-step sequential inquiry, final responsibility for deciding whether a claimant is disabled is reserved for the Commissioner. 20 C.F.R. § 404.1527(e).

In his written decision, the ALJ conducted a five-step evaluation. At step one, he found for the purposes of his decision that plaintiff had not engaged in substantial gainful activity after his alleged onset date of December 1, 1999, even though plaintiff had worked after that date. At step two, the ALJ accepted for the purposes of his decision that plaintiff's history of an affective disorder with anxiety or mild social phobia constituted a "severe" impairment, although he expressed his skepticism that the medical evidence supported such a finding. He noted that although Dr. Sheldon had reported "profound and marked" limitations that he attributed to acute and chronic depression including social withdrawal, obsession and suicidal thoughts, these limitations were not corroborated by the treatment notes. The ALJ opined that "if Dr. Sheldon's limitations are to be considered credible, they reflect short-term acute psychological problems which did not last for any period meeting the twelve month durational requirement of the Social Security Act." In fact, noted the ALJ, plaintiff had been working as recently as June 2001.

At step three, the ALJ found that plaintiff's impairment did not meet or equal an impairment listed in Appendix 1, Subpart P, Regulations No. 4. He noted that the agency

consulting physicians and Lynch, the medical expert, found that plaintiff had only mild or moderate functional limitations. (To meet a listing, plaintiff had to have "marked" limitations.) The ALJ noted that if plaintiff's testimony was credited, it might support more serious limitations. However, the ALJ found that "this testimony lacks credibility and is notably inconsistent with most of the treatment records." AR 15.

At step four, he found that plaintiff had the residual functional capacity to perform work at the light exertional level that was simple, routine, repetitive and low stress and that involved only limited contact with the public and co-workers, and that plaintiff was unable to perform his past relevant work. At step five, he relied on the vocational expert's testimony and found that there were approximately 19,000 clerking jobs within the state of Wisconsin that plaintiff could perform despite his limitations.

The ALJ made the following specific findings:

1. The claimant met the disability insured status requirements of the Act on December 1, 1999, the date the claimant stated he became unable to work, and continues to meet them through December 31, 2005.

2. The claimant has not engaged in substantial gainful activity since his alleged onset of disability.

3. The medical evidence establishes that the claimant has "severe" adjustment disorder with complaints of social phobia, but that he does not have an impairment or combination of impairments listed in, or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4.

4. The claimant's allegations of total disability lack a reasonable medical basis and are not credible.

5. The claimant has the residual functional capacity to perform light work activities not requiring that he lift any more than twenty pounds or ten pounds with frequency. He is capable of sitting or standing as much as six hours each during an eight hour day and can perform simple, routine, repetitive, low stress work involving only limited contact with the public and co-workers (20 CFR § 404.1545).

6. The claimant is unable to perform his past relevant work as a self-employed truck driver.

7. The claimant's residual functional capacity for the full range of light work is reduced by the limitations cited above.

8. The claimant is approximately 47 years old, which is defined as a younger individual (20 CFR § 404.1563).

9. The claimant has a high school and collegiate education (20 CFR § 404.1564).

10. The claimant has acquired work skills in languages and computer skills which he demonstrated in past work, and which could be applied to meet the requirements of other skilled work (20 CFR § 404.1568).

11. Based on an exertional capacity for light work, and the claimant's age, education, and work experience, section 404.1569 and Rule 202.22, Table No. 2, Appendix 2, Subpart P, Regulations No. 4 would direct a conclusion of "not disabled."

12. Although the claimant's additional nonexertional limitations do not allow him to perform the full range of light work, using the above-cited rule as a framework for decisionmaking, there are a significant number of jobs in the national economy which he could perform. Examples of such jobs include file clerk, traffic clerk, mail clerk, and other clerking jobs. These job classifications provide approximately 18,800 jobs within the state of Wisconsin.

13. The claimant was not under a "disability," as defined in the Social Security Act, at any time through the date of this decision (20 CFR § 404.1520(f)).

ANALYSIS

I. Standard of Review

Under 42 U.S.C. § 405(g), the Commissioner's findings are conclusive if they are supported by "substantial evidence." *See Stevenson*, 105 F.3d at 1153; *Brewer*, 103 F.3d at 1390. "Substantial evidence is more than a mere scintilla. It is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Stevenson*, 105 F.3d at 1153 (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938), as quoted in *Richardson v. Perales*, 402 U.S. 389, 401 (1971)) (other citations omitted). A standard this low could allow for different supportable conclusions in a given claimant's case. That being so, this court cannot in its review 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. *See Brewer*, 103 F.3d at 1390 (citations omitted); *Kapusta v. Sullivan*, 900 F.2d 94, 96 (7th Cir. 1990).

Although the ALJ's reasonable resolution of evidentiary inconsistencies is not subject to review, *see Brewer*, 103 F.3d at 1390, and the ALJ's written opinion need not evaluate every piece of testimony and evidence submitted, the ALJ "must at least minimally discuss a claimant's evidence that contradicts the Commissioner's position." *Godbey v. Apfel*, 238 F.3d 803, 808 (7th Cir. 2001). The ALJ's opinion must adequately articulate how the evidence was weighed so that this court may trace the path of his or her reasoning. *Id*. For example, ignoring an entire line of evidence would fail this standard. *Diaz v. Chater*, 55 F.3d

300, 307 (7th Cir. 1995). However, as with any fact finder, the ALJ is entitled to choose between competing opinions. *Luna v. Shalala*, 22 F.3d 687, 690 (7th Cir. 1994). Most importantly, "the ALJ must build an accurate and logical bridge from the evidence to his conclusion." *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir. 2000). In addition, the court reviews the ALJ's decision to ensure that no errors of law occurred. *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir. 2001).

II. Dr. Sheldon

Plaintiff contends the ALJ erred by affording more weight to the opinion of Lynch, the neutral medical expert who never examined him, than to the opinion of Dr. Sheldon, plaintiff's treating psychiatrist of more than two years. The Commissioner's regulations set forth a variety of factors an ALJ must consider in assessing conflicting medical opinion evidence. These include whether a physician is a treating or examining physician; the length, nature, and extent of the treatment relationship; the physician's specialty; and the consistency and supportability of the physician's opinion. 20 C.F.R. §§ 404.1527(a)-(d), 416.927(a)-(d). Pursuant to 20 C.F.R. § 404.1527, the ALJ is to give controlling weight to the opinion of a treating physician if that opinion "is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record." When evaluating a conflict between the opinions of treating and consulting physicians, "the ALJ must take into account the treating

physician's ability to observe the claimant over a longer period." *Stephens v. Heckler*, 766 F.2d 284 (7th Cir. 1985). However, "while the treating physician's opinion is important, it is not the final word on a claimant's disability." *Reynolds v. Bowen*, 844 F.2d 451 (7th Cir. 1988). As the Court of Appeals for the Seventh Circuit has noted:

> The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability. The regular physician also may lack an appreciation of how one case compares with other related cases. A consulting physician may bring both impartiality and expertise.

Stephens, 766 F.2d at 289. "[I]n the end, 'it is up to the ALJ to decide which doctor to believe--the treating physician who has experience and knowledge of the case, but may be biased, or . . . the consulting physician, who may bring expertise and knowledge of similar cases--subject only to the requirement that the ALJ's decision be supported by substantial evidence.'" *Books v. Chater*, 91 F.3d 972, 979 (7th Cir. 1996) (quoting *Micus v. Bowen*, 979 F.2d 602, 608 (7th Cir. 1992)).

Applying these principles leads to the conclusion that the ALJ did not err in favoring Lynch's opinion over that of Dr. Sheldon. In particular, the record supports the ALJ's conclusion that the treatment notes in the record were inconsistent with Dr. Sheldon's opinion that plaintiff had marked limitations resulting from acute and chronic depression. As the ALJ noted, Dr. Sheldon described plaintiff in December 2001 as being "focused and energetic" and he reported on September 27, 2001 that his mood was "good." The ALJ also noted that earlier treatment records indicated that plaintiff was able to engage in group

activities despite his social phobia; that although plaintiff had episodes of depression, they "did not last long;" and that plaintiff had reported to one physician that he had no problems with sleep, appetite or concentration. While these records preceded the date of plaintiff's alleged onset of disability, they were relevant insofar as they tended to undermine Dr. Sheldon's finding that plaintiff had chronic symptoms of depression.

In light of the discrepancy between Dr. Sheldon's opinion and his treatment notes, many of which I have reviewed in detail in the Facts section of this report, it was not unreasonable for the ALJ to discount Dr. Sheldon's opinion in favor of Lynch's. Lynch provided a thorough, cohesive discussion of his rationale at the hearing, pointing to various treatment notes that suggested that plaintiff was not severely impaired by his anxiety and depression. Furthermore, Lynch's opinion that plaintiff did not suffer from marked limitations except during one brief time period was shared by the state agency physicians. As the cases cited above make clear, Dr. Sheldon's status as plaintiff's treating physician did not mean that the ALJ was required to give his opinion controlling weight where it was inconsistent with this other substantial evidence in the record. As the finder of fact, it was up to the ALJ to weigh the competing medical opinions, and here the record supports his conclusion that Lynch's opinion was better supported than Dr. Sheldon's.

III. Credibility Determination

Lynch testified that if fully credited, plaintiff's testimony at the hearing suggested that he had marked functional limitations, which in turn would mean that plaintiff satisfied the criteria for a listed mental impairment. Thus, the next issue this court must consider is whether the ALJ made a proper credibility determination when he rejected plaintiff's testimony. In evaluating the credibility of statements supporting a Social Security application, an ALJ must comply with Social Security Ruling 96-7p. *Brindisi v. Barnhart*, 315 F.3d 783, 787 (7th Cir. 2003). That ruling sets forth a two-step process that the ALJ must follow when evaluating an individual's own description of his or her impairments. According to the ruling, the first question the ALJ must answer is whether there is "an underlying medically determinable physical or mental impairment(s)–i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques–that could reasonably be expected to produce the individual's pain or other symptoms." Soc. Sec. Ruling 96-7p, 1996 WL 374186, *1 (1996). If the record does not allow the ALJ to make such a finding, then that ends the inquiry, for a finding of disability cannot be made solely on the basis of symptoms, even if they appear genuine. *Id*.

If, however, the medical evidence shows the existence of an underlying impairment that could be reasonably expected to produce the claimant's pain or other symptoms, the ALJ must then proceed to evaluate the "intensity, persistence, and limiting effects of the individual's symptoms to determine the extent to which the symptoms limit the individual's

ability to do basic work activities." *Id*. When conducting this evaluation, "the ALJ may not disregard subjective complaints merely because they are not fully supported by objective medical evidence." *Knight v. Chater*, 55 F.3d 309, 314 (7th Cir. 1995). "The absence of objective medical evidence is just one factor to be considered along with: (a) the claimant's daily activities; (b) the location, duration, frequency and intensity of pain; (c) precipitating and aggravating factors; (d) type, dosage, effectiveness and side effects of medication; (e) treatment other than medication; (f) any measures the claimant has used to relieve the pain or other symptoms; and (g) functional limitations and restrictions." *Id*.; see also SSR 96-7p; 20 C.F.R. § 404.1529(c). An ALJ's evaluation of a claimant's credibility must contain "specific reasons" and "must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight." SSR 96-7p.

Courts generally will not overturn an ALJ's credibility determination unless it was "patently wrong." *Zurawski v. Halter*, 245 F.3d 881, 887 (7th Cir. 2001). But reversal is warranted if the ALJ provides no explanation for the determination or his finding is based upon factual or logical errors. *Brindisi*, 315 F.3d at 787-88.

In the body of his decision, the ALJ concluded that it was "technically" unnecessary to evaluate plaintiff's subjective complaints because the record lacked evidence of any medically determinable impairment which would be expected to cause plaintiff's symptoms. In spite of this conclusion, the ALJ went on to find in both the body of his decision and the

"Findings" section that plaintiff's allegations of total disability were not credible. Had the ALJ stopped at step one and not proceeded to make a credibility finding, I would probably recommend reversal. The medical evidence demonstrates that plaintiff has been diagnosed with an anxiety disorder and dysthymia and that he has been treated for both almost continuously since 1997. These are medically determinable impairments that could reasonably be expected to cause at least some of plaintiff's reported symptoms, such as low energy or fatigue, social withdrawal, and poor concentration. *See Diagnostic and Statistical Manual of Mental Disorders* 378-80 (4th ed. 2000) (text revision). To the extent that the medical evidence may not have supported the *severity* or *persistence* of the symptoms that plaintiff alleged, that was a factor that the ALJ should have considered at step two, not step one, of the credibility assessment process. The ALJ's suggestion that there was no underlying medically determinable impairment that could reasonably be expected to produce plaintiff's symptoms is simply not supported by the record.

However, the ALJ's error at step one has no bearing on the outcome if this court can sustain his credibility finding at step two. The ALJ's credibility finding lacks the thoroughness and clarity demanded by the Commissioner's rulings and regulations. The ALJ's opinion contains no discussion of the various credibility factors set out in SSR 96-7p, such as plaintiff's medications or daily activities, and does not mention plaintiff's testimony regarding his functional limitations in any detail. In fact, the decision does not contain any succinct discussion of the reasons underlying the ALJ's credibility finding; rather, the reader

must tease those reasons out from various places in the decision. The decision leaves the impression that the ALJ glossed over the second part of the SSR 96-7p analysis because of his view that such analysis was not necessary at all. Yet, as I have just noted, the ALJ did not actually *find* that there was no evidence of any medically determinable impairment that might reasonably cause plaintiff's symptoms, and even if he had, that determination would have been wrong. So, having proceeded to evaluate plaintiff's subjective complaints, the ALJ should have paid more attention in his decision to the factors the Commissioner has deemed relevant to the credibility analysis.

In spite of these deficiencies, I conclude that this court can uphold the ALJ's credibility finding. A careful reading of the ALJ's opinion divines the following bases for his finding: 1) plaintiff's testimony regarding his symptoms was inconsistent with most of the treatment records; 2) plaintiff continued to look for work after he lost his job at Cuna and worked as recently as June 2001; 3) plaintiff stated on January 25, 2001 that he was getting used to not working; and 4) plaintiff represented himself as having no work-related limitations when he applied for unemployment compensation. When viewed independently, the last three of these reasons do not necessarily support an inference that plaintiff's testimony regarding his subjective complaints was exaggerated. Although plaintiff attempted to look for work and obtained employment after he was terminated from Cuna, the record indicates that plaintiff held these jobs for only a short time before he was terminated for reasons that were arguably related to his mental impairments. Furthermore, although a

claimant's statement that he is ready, willing and able to work for the purposes of seeking unemployment compensation may adversely affect the credibility of his claim of total disability for the same time period, it is not conclusive. *See*, *e.g.*, *Jernigan v. Sullivan,* 948 F.2d 1070, 1074 (8th Cir. 1991); *Perez v. Secretary of HEW*, 622 F.2d 1, 3 (1st Cir. 1980); *Bartell v. Cohen*, 445 F.2d 80, 82 (7th Cir. 1971) (plaintiff's attempts to find job were "relevant only to her motivation and not to whether she was, in fact, disabled"). Plaintiff testified at the hearing that his lawyer advised him to apply for unemployment compensation and did not tell him that it might preclude his simultaneous application for disability benefits. This tends to undermine the negative inference the ALJ drew from plaintiff's statements in connection with his application for unemployment benefits. Finally, plaintiff's statement that he was "getting used" to not working is hardly compelling evidence of a desire not to work.

Nonetheless, although these findings provide weak support for the ALJ's credibility determination, I cannot say that they provide *no* support. The fact that plaintiff continued to look for work and held himself out as able to work after the date he allegedly became disabled tends to undermine his claim. Furthermore, these facts take on added weight when they are viewed against the treatment notes, which played a significant role in the ALJ's conclusion that plaintiff was not as limited as a he claimed. As Lynch testified at the hearing and the ALJ found in his decision, there is little record in the treatment notes of the disabling symptoms of which plaintiff complained at the hearing. For example, Dr. Sheldon

never reported in his notes of his visits with plaintiff that plaintiff had crying spells or thoughts of suicide. Although there were times when plaintiff's symptoms as reported to Dr. Sheldon approached the severity of those of which he complained at the administrative hearing, on most occasions he told Dr. Sheldon that he was doing well on his medications and his mood was stable. Lynch testified that overall, the notes did not support a conclusion that plaintiff suffered from marked limitations for any 12-month period. Because the treatment notes consisted largely of plaintiff's own descriptions of his symptoms, the ALJ could reasonably rely on the notes and Lynch's testimony as a reason to discount the credibility of plaintiff's testimony at the hearing.

The inconsistency between plaintiff's statements to his health care providers and his testimony at the hearing regarding his functional limitations provides substantial evidence to support the ALJ's conclusion that plaintiff's testimony was not fully credible. It is worth noting that in spite of his skepticism, the ALJ credited plaintiff with having significant mental functional limitations by assigning him a rather restrictive residual functional capacity that limited him to simple, routine, repetitive, low stress work that did not require more than limited contact with co-workers and the public. This residual functional capacity tracked the opinions of the state agency physicians and Lynch, who opined that plaintiff's mental impairments imposed no more than mild to moderate limitations. As such, it was supported by substantial evidence.

IV. Other Issues

A few other aspects of the ALJ's decision deserve mention. First, the ALJ did not mention the Activities Questionnaire completed by See, which tended to support plaintiff's allegations of total disability. However, this omission was not significant because See's statements were essentially redundant of plaintiff's testimony at the hearing. *See Carlson v. Shalala*, 999 F.2d 180, 181 (7th Cir. 1993) (ALJ who explicitly addressed plaintiff's testimony did not err in failing to discuss wife's corroborative testimony) (per curiam).

Second, plaintiff contends that the ALJ erred in relying on the vocational expert's testimony regarding the number of jobs available in the economy because the VE never identified exactly where those jobs existed. It is true that the VE never testified whether the jobs existed in the regional or national economy. In his opinion, the ALJ indicated that the jobs existed in the state of Wisconsin. But even if the ALJ was wrong and the relevant economy was the national economy, that would be enough to satisfy the Commissioner's burden at Step 5. *See* 20 CFR § 404.1505(a) (defining disability as inability to do past work or any other substantial gainful activity which exists in the national economy). Furthermore, plaintiff had the opportunity to cross-examine the VE about his opinions at the administrative hearing.

Finally, the ALJ erred in the Findings section of his opinion when he found that plaintiff had past relevant work as a truck driver (he did not) and that plaintiff had an

adjustment disorder (he has an affective disorder). However, neither of these errors had any bearing on the outcome.

In sum, although the ALJ could have–and should have–written a more accurate and thorough opinion, I have found no errors consequential enough to require remand.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the Commissioner denying plaintiff Michael Goodman's application for disability insurance benefits be AFFIRMED.

Entered this 3rd day of July, 2003.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge