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

DANIEL T. SHEA,

Plaintiff,

v.

WILLIAM A. HALTER, Acting Commissioner of Social Security,

Defendant.

REPORT AND RECOMMENDATION

00-C-721-C

REPORT

This is an action for judicial review of an adverse decision of the Commissioner of Social Security pursuant to 42 U.S.C. § 405(g).[1] Plaintiff Daniel Shea challenges a decision of the Commissioner denying his application for disability insurance benefits and supplemental security income under the Social Security Act, 42 U.S.C. §§ 416(i), 423(d) and 1382. Because the record contains substantial evidence to support the Commissioner's determination that there is a significant number of jobs in the national economy that plaintiff is able to perform despite his impairments, I recommend that this court affirm the Commissioner's decision.

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[1] On January 20, 2001, William A. Halter became the Acting Commissioner of Social Security. In accordance with Fed. R. Civ. P. 25(d)(1) and the last sentence of 42 U.S.C. § 405(g), William A. Halter is automatically substituted for Kenneth S. Apfel as the defendant in this case.

The following facts are drawn from the administrative record:

Facts

I. Procedural History

Plaintiff applied for disability insurance benefits and supplemental security income in January 1994, alleging that he had been disabled since March 31, 1991, as a result of major depression, a panic disorder and alcoholism. The Social Security Administration denied his applications initially and upon reconsideration. At plaintiff's request, a hearing was held before an administrative law judge on August 19, 1995. At the beginning of the hearing, the ALJ advised plaintiff that he had a right to be represented by a lawyer but plaintiff indicated that he wanted to go forward *pro se*. The ALJ heard testimony from plaintiff and a vocational expert.

On April 25, 1996, the ALJ issued a decision finding that plaintiff was not disabled because he was capable of performing a significant number of light jobs. On February 19, 1997, the Appeals Council denied plaintiff's request for review, making the ALJ's decision the final decision of the Commissioner.

II. Vocational and Medical Evidence

Plaintiff graduated from high school and college and completed three years of graduate school. He has past relevant work experience as a research assistant, counselor, data processor and traffic controller. At the time of the administrative hearing, plaintiff was

42 years old. He had not engaged in any substantial gainful activity since being fired from his job as a counselor on March 31, 1991 for poor job performance.

Plaintiff has a history of alcohol dependence and depression dating to the 1980s. In December 1982, while attending graduate school, plaintiff was admitted to the DePaul Rehabilitation Hospital in Milwaukee for detoxification and inpatient counseling. He was diagnosed with alcohol dependence syndrome and an adjustment reaction with anxiety and depression. In March 1986, he was hospitalized at Milwaukee Psychiatric Hospital for alcohol problems.

In early 1989, plaintiff was hospitalized for five days at Trinity Hospital after being admitted for an acute anxiety attack; however, records from this hospitalization are not part of the administrative record. Apparently, plaintiff was diagnosed with endogenous depression and treated with antidepressants. About one and a half months later, plaintiff was hospitalized and counseled for alcohol dependency at Elmbrook Memorial Hospital. At the time of admission, plaintiff was also abusing prescription drugs (Xanax and Ativan). Plaintiff was diagnosed with chemical dependency and major depression and Prozac was prescribed.

Later that year, in October 1989, plaintiff was admitted to the University of Wisconsin hospital for complaints of suicidal ideation and alcohol-related hallucinations. Plaintiff reported that he had been depressed and drinking heavily for about one month after breaking up with his girlfriend. He reported problems with insomnia, loss of appetite, loss

of concentration and fatigue. Also, plaintiff complained of having panic attacks lasting five to 15 minutes; according to plaintiff, he had begun staying at home to avoid having an attack in public. Plaintiff was diagnosed with a major depressive episode, alcohol abuse and a panic disorder. He was advised to continue taking Prozac and attend outpatient drug and alcohol treatment.

In April and again in September 1991, plaintiff sought outpatient treatment for anxiety. Plaintiff reported stress from a recent breakup with his girlfriend and the death of his father. Plaintiff complained of waking during the night, nervousness and loss of appetite and concentration. He reported that he had little social support and was not doing things that he used to do. He was prescribed Xanax and Elavil and referred to the student counseling center. Later that year, plaintiff was again hospitalized for alcohol detoxification.

In January 1992, plaintiff saw a psychiatrist for complaints of "free floating anxiety" that had progressed to panic attacks during the past two weeks. Plaintiff reported that this was a recurrence of symptoms that he had had two years earlier. He was diagnosed with recurrent panic attacks without mania. Prozac and Serax were prescribed. Later that year, plaintiff was sentenced to nine years in prison for forgery. The prison psychiatrist changed plaintiff's medication from Prozac to Imipramine.

On August 27, 1992, plaintiff was evaluated by Debra Anderson, a Department of Corrections psychologist, for evaluation of plaintiff's treatment needs in light of his complaint of panic attacks. Anderson noted that plaintiff had been in school all of his adult

life, supporting himself with part-time jobs. She diagnosed plaintiff with alcohol dependence, a personality disorder with antisocial features and panic attacks by history. Anderson noted that plaintiff also complained of a lot of anxiety and depression, although she attributed these to his alcohol dependence and difficulty achieving goals "rather than representing a clinical depression per se." AR 178. In follow-up visits with the psychiatrist, plaintiff was noted to be "cooperative and courteous" and fully competent. On October 28, 1992, plaintiff requested that his medication be stopped.

Plaintiff participated in alcohol and drug treatment from November 1993 to January 1994. On February 10, 1994, plaintiff's social worker, Jim Jaworski, completed a questionnaire on which he indicated that during treatment plaintiff was punctual, had appropriate hygiene, showed no problems with concentration, memory or attention and was cooperative. Jaworski indicated that plaintiff had said that his alcoholism had had a negative impact on his relationships and employment and that his depression had made it difficult for him to complete his education and cope with everyday activities. Jaworski told the state disability agency that he was "surprised" to receive a disability questionnaire because he believed plaintiff was very capable of working. According to Jaworski, plaintiff had stated that he intended to return to school to get his doctorate degree.

On March 31, 1994, Dr. Henry Kaplan completed a Psychiatric Review Technique Form and Mental Residual Functional Capacity Assessment of plaintiff at the request of the Social Security Administration. Dr. Kaplan concluded that plaintiff suffered from severe

impairments, namely dysthymia and a history of substance addiction, but that the impairments were not severe enough to meet a listed impairment. Rating the severity of plaintiff's impairments, Dr. Kaplan found that plaintiff had a slight restriction in his activities of daily living, moderate restriction in maintaining social function, never experienced deficiencies of concentration, persistence or pace and "once or twice" had experienced an episode of deterioration or decompensation in work or a work-like setting. Dr. Kaplan concluded that plaintiff's ability to perform work tasks was not significantly limited in any way with the exception of the ability to get along with coworkers or peers, which Dr. Kaplan found was moderately limited.

At the request of the Social Security Administration, plaintiff was evaluated by psychologist Linda Ingison on June 9, 1994. Plaintiff reported having problems with depression, alcohol dependence and panic attacks. He reported that his symptoms included insomnia with early morning awakening, occasional nightmares, weight loss, social avoidance and memory and concentration problems. He stated that his panic attacks occurred approximately twice a week and lasted for about one-half hour, during which time plaintiff experienced having sweaty palms, an increased heart rate, dizziness and weak knees. Plaintiff reported that he had been abstinent from alcohol for the past 27 months and was planning on returning to school to finish his graduate degree.

At the time of the examination, plaintiff was on an electronic monitoring program, working part-time for a temporary service and trying to find employment. He lived alone

in an apartment where he cleaned, did laundry and cooked when he felt hungry. Overall, plaintiff denied having problems with his normal activities of daily living. He denied having problems getting along with others but added that he did not have friends and that he had begun avoiding people because of his depression. Plaintiff said his interests included guitar, swimming, movies and occasional concerts but that he had not engaged in any of these activities for at least a month.

After conducting a mental status examination, Ingison concluded that plaintiff met the criteria for a major depressive episode, panic disorder without agoraphobia and past history of alcohol abuse. She gave him a score of 55 on the Global Assessment of Functioning Scale, indicating that plaintiff was having moderate difficulty in social, occupational or school functioning. *See Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (4th ed. 1994) at 32. Ingison found that plaintiff would be able to follow instructions and respond to coworkers and supervisors adequately in a work setting. She noted that although his concentration and attention appeared adequate throughout the examination, "he might have some difficulties with pacing or stress in the work place and might respond with either anxiety or depressive symptoms." AR 216.

In January 1995, plaintiff saw Larry Mandt, a clinical psychologist. Plaintiff told Mandt that he was having problems completing written work and he wanted someone to look into it. Specifically, plaintiff was preparing to take the Graduate Record Exam (GRE) and was having a difficult time completing sample sections of the test within the allotted

time period. Plaintiff was looking for an answer as to why he took so much time to complete the tests. Mandt diagnosed plaintiff with Attention Deficit Hyperactivity Disorder (ADHD) and referred him to Dr. Kessler, a psychiatrist, for medication.

After conducting an initial evaluation of plaintiff, Dr. Kessler diagnosed plaintiff with ADHD, residual type, and prescribed Klonopin and later Nardil and Ritalin. Dr. Kessler also diagnosed plaintiff with a dysthymia disorder. Despite these diagnoses, Dr. Kessler assigned plaintiff a rating of 70 on the GAF scale, which indicates that plaintiff may have had some mild symptoms but was generally functioning pretty well. *See* DSM-IV, at 32. Neither Dr. Kessler nor Mandt completed a residual functional capacity evaluation of plaintiff. Dr. Mandt told the state agency that he had only seen the plaintiff once or twice and was not familiar enough with him to complete the form; Dr. Kessler never received the form because he had left the practice group to whom the form was sent.

On June 13, 1995, plaintiff saw Dr. Kenneth Yuska for complaints of pain in his back and right elbow that he developed at his job as a machinist. Physical examination was largely normal except for some aching and tightness in the thoracic spine. Dr. Yuska diagnosed plaintiff with a thoracic strain and lateral epicondylitis in the right elbow and prescribed Ultram. He advised plaintiff to treat his back pain by employing good posture at work and beginning an exercise program. Dr. Yuska recommended a brace for the elbow and suggested that plaintiff attempt to use various tools and machines at work in order to avoid repetitive movements.

III. Hearing Testimony

At the administrative hearing, plaintiff testified that he was disabled as a result of depression, anxiety and a past history of alcohol dependency. Also, plaintiff indicated that he had suffered from attention deficit disorder, tennis elbow and back pain. Plaintiff indicated that his mental impairments made it difficult for him to concentrate, particularly in stressful situations, and that his physical conditions precluded him from standing for long periods of time or performing repetitive tasks with his upper extremities.

Les Goldsmith testified as a vocational expert at the hearing. The ALJ asked Goldsmith to assume a hypothetical claimant with plaintiff's age, education and background and who had the following limitations: could not work in an inherently stressful environment; had to work on his own versus in a close knit work community; could not perform continuous repetitive movements with either arm; had to sit for a significant amount of time each workday; and who had to perform work that was routine and repetitive. Goldsmith testified that such an individual could perform the job of gatekeeper or security guard, of which there were approximately 5,000 jobs in the state of Wisconsin and 500,000 jobs nationwide. In response to Goldsmith's testimony, plaintiff testified that he would not be able to perform the job of gatekeeper or security guard because of his difficulty dealing with stress and his concentration problems.

IV. The ALJ's Decision

In order to be eligible for disability insurance benefits under Title II of the Social Security Act, plaintiff had to show that he was disabled on or before his last insured date of September 30, 1994. On April 25, 1996, the ALJ issued a decision in which he concluded that plaintiff was not disabled as that term is defined in the Social Security Act. After reviewing the medical evidence, the ALJ concluded that plaintiff suffered from severe impairments, namely depression, anxiety disorder, tennis elbow and thoracic strain, but that none of the impairments either individually or in combination met or equaled the criteria of any listed impairment. The ALJ found that because "[b]y all reports" plaintiff had been abstinent for several years, his alcohol dependence was "severe" only insofar as it described his past history.

The ALJ found insufficient medical documentation to support plaintiff's contention that he was severely impaired as a result of Attention Deficit Hyperactivity Disorder. Specifically, the ALJ noted that the professionals who diagnosed plaintiff with ADHD did so entirely on the basis of plaintiff's own description of his symptoms and without any clinical observations or psychological testing. The ALJ implied that Mandt and Dr. Kessler had made the diagnosis at plaintiff's begging, noting that Mandt was "willing" to diagnose plaintiff's condition as ADHD after plaintiff had "demanded" to know why he took so much time taking the Graduate Record Exam and after plaintiff had indicated that he was "90 % sure after looking at ADHD information" that this was his problem. AR 22. Also, the ALJ

noted that Mandt had declined to complete a residual functional capacity assessment on the ground that he had had limited contact with the plaintiff.

Next, the ALJ assessed plaintiff's residual functional capacity. After considering plaintiff's subjective complaints of pain and the other evidence in the record, the ALJ concluded that plaintiff had the residual functional capacity for light, non-stressful, routine work that allowed for a significant amount of sitting on the job, did not require continuous repetitive movements with either arm and did not require plaintiff to work as part of a close-knit team. After concluding that plaintiff had no past relevant work, the ALJ found that there were jobs in the economy that plaintiff could perform. Specifically, the ALJ found that plaintiff could perform the job of security guard or gatekeeper, of which there were 5,000 jobs in Wisconsin and 500,000 nationally.

The ALJ made the following findings:

1. The claimant met the disability insured status requirements of the Act on March 31, 1991, the date the claimant stated he became unable to twork, and continued to meet them only through September 30, 1994.

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

3. The medical evidence establishes that the claimant has severe impairments due to depression, anxiety disorder, tennis elbow, thoracic strain, and past history of alcohol dependence.

4. The claimant does not have an impairment or combination of impairments that meets or equals the requirements of any impairment listed in Appendix 1, Subpart P of Regulations No. 4.

5. The claimant has the residual functional capacity for a full range of light work with the specific limitations set forth in the preceding rationale.

6. The claimant's testimony was credible except with regard to the disabling severity of his pain.

7. The claimant has no past relevant work.

8. Despite his impairments, the claimant has the residual functional capacity to perform other jobs that exist in significant numbers in the national economy.

9. The claimant was not "disabled" as defined in the Social Security Act, at any time through the date of this decision, 20 CFR 404.1520(f) and 416.920(f).

Analysis

I. Statutory and Legal Framework

Under 42 U.S.C. § 405(g), the Commissioner's findings are conclusive if they are supported by "substantial evidence." *See Stevenson v. Chater*, 105 F.3d 1151, 1153 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1390 (7th Cir. 1997). "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). The court is limited to determining whether the ALJ could reasonably find on the basis of the evidence contained in the record at the time that plaintiff could perform light or sedentary work. *See id.*

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 explain why uncontradicted evidence is rejected. *Rohan v. Chater*, 98 F.3d 966, 971 (7th Cir. 1996) (citing *Carlson v. Shalala*, 999 F.2d 180, 181 (7th Cir. 1993)). 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).

This court also reviews the ALJ's findings for errors of law. *Fenn v. Shalala*, 884 F. Supp. 267, 269 (N.D. Ill. 1995). When the Commissioner commits an error of law, reversal is warranted irrespective of the volume of evidence supporting the factual findings. *Herr v. Sullivan*, 912 F.2d 178, 180 (7th Cir. 1990) (citation omitted).

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

> (1) whether the claimant is currently employed;
>
> (2) whether the claimant has a severe impairment;
>
> (3) whether the claimant's impairment meets or equals one of the impairments listed by the SSA, *see* 20 C.F.R. § 404, Subpt. P, App. 1;
>
> (4) whether the claimant can perform his past work; and
>
> (5) whether the claimant is capable of performing work in the national economy.

See 20 C.F.R. §§ 404.1520, 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*, 105 F.3d at 1154; *Brewer*, 103 F.3d at 1391.

II. Review of ALJ's Decision

Plaintiff contends that the ALJ failed to account for all of his medical impairments and failed to consider the combined effect of those impairments on his ability to work. Specifically, plaintiff contends that the ALJ ignored evidence in the record that indicates that he suffers from Attention Deficit Hyperactivity Disorder, endogenous depression and dysthymia. Plaintiff contends that the ALJ should have found that these impairments are severe and that they preclude him from working.

Plaintiff argues that the ALJ should have found that his ADHD, dysthymia and endogenous depression were severe impairments because the medical records show that he was diagnosed with and treated for these disorders. First, I note that the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) published by the American Psychiatric Association does not recognize a mental disorder called "endogenous depression." More importantly, however, the fact that a disorder has been diagnosed and medication prescribed for it does not automatically establish the existence of a severe impairment under the social security regulations. A physical or mental impairment must be established by "medical evidence consisting of signs, symptoms, and laboratory findings, not only by [the claimant's] statement of symptoms." 20 C.F.R. §§ 404.1508; 416.908. However, a claimant is not required to bring forward evidence of the cause of his disability or to provide a specific diagnosis in order to demonstrate a physical or mental impairment. *See Sparks v. Bowen*, 807 F.2d 616, 617 (7th Cir. 1986). The claimant is required only to show that he has an

objectively verifiable medical abnormality that could reasonably be expected to bring about his symptoms. *See id*. at 617-18. In order to be found disabled, a claimant must show that the functional limitations resulting from his impairment are so severe as to prevent him from performing any work.

Thus, even if the ALJ erred in concluding that plaintiff had not established that he was severely impaired as a result of ADHD, dysthymia or endogenous depression, remand is not necessary if the ALJ nonetheless accounted for all of plaintiff's alleged functional limitations in his decision. Here, plaintiff has not alleged that he has functional limitations more severe than those found by the ALJ; instead, he claims error solely on the basis of the ALJ's failure to account for various diagnoses that appear in the medical records. On its own, this is an insufficient basis on which to reverse the ALJ's decision.

Aside from the diagnoses themselves, plaintiff points to no evidence in the record that contradicts the ALJ's conclusion that plaintiff's mental impairments did not prevent him from performing any work. In reaching his conclusion, the ALJ relied on the report of the consultative examiner who concluded that plaintiff would have little difficulty with instructions on a typical work task, was capable of responding adequately to supervisors and coworkers and had adequate concentration and attention but might have some difficulties with pacing or stress in the work place; the report of the state agency physician who opined that plaintiff was not significantly limited in his ability to perform job-related tasks with the exception of the ability to get along with coworkers, which the examiner rated as

"moderately limited; and the report from the social worker Jaworski, who opined that plaintiff had the physical and mental capacity to be gainfully employed. Additionally, the ALJ gave plaintiff the benefit of the doubt and credited plaintiff's complaints of concentration problems, finding that plaintiff could only perform work that was routine and repetitive. Although plaintiff testified at the hearing that he did not think he would be able to perform the jobs of security guard or gatekeeper because of the potential for stressful situations to arise (like a long line of cars waiting for clearance to pass through the gate, for example) the vocational expert limited the jobs that he identified to those that were "inherently not highly stressful." AR 45. Thus, it was proper for the ALJ to conclude that, despite plaintiff's worst-case-scenario hypotheses, he was capable of performing the job of gatekeeper or security guard as such jobs were generally performed in the national economy.

Even the medical records from Mandt and Dr. Kessler, who diagnosed plaintiff with ADHD, do not indicate that plaintiff had functional limitations more severe than those found by the ALJ. As the ALJ noted, plaintiff's stated reason for seeing Mandt was because he had problems completing written work and he wanted someone to look into it. Specifically, plaintiff reported that he was studying to take the Graduate Record Exam (GRE) and was having a difficult time completing sample sections of the test within the allotted time period. Although plaintiff also voiced general concerns about being distracted easily and forgetting things often, he did not report that any of these symptoms were having any negative effect on him at his job as a machinist. Likewise, plaintiff did not report any

work-related difficulties during his visits with Dr. Kessler. As noted in the facts, Dr. Kessler assigned plaintiff a rating of 70 on the GAF scale, indicating that plaintiff may have had some mild symptoms but was generally functioning pretty well. The record simply does not support plaintiff's contention that he had "marked" difficulties with dysthymia, impulsiveness, inattention, restlessness and hyperactivity. To the contrary, the records from his visits with Mandt and Dr. Kessler indicate that plaintiff's inattention difficulties related primarily to his ability to perform well in a high-stress, test-taking situation; they do not indicate that plaintiff was unable to perform routine, unskilled, repetitive work. Thus, even though the ALJ may have taken some liberties with the record in suggesting that plaintiff duped Mandt and Dr. Kessler into diagnosing and treating him for ADHD, his ultimate conclusion that the ADHD was not a severe impairment is supported by substantial evidence.

In sum, substantial evidence in the record supports the ALJ's conclusion that plaintiff's functional limitations were not so severe as to prevent him from performing any work in the national economy and therefore plaintiff was not disabled. In reaching this conclusion, the ALJ not only thoroughly evaluated all of the medical evidence in the record, but he credited most of plaintiff's testimony concerning his limitations. In the absence of evidence to show that plaintiff had functional limitations that precluded him from working, the ALJ's failure to find that plaintiff suffered from dysthymia, endogenous depression or Attention Deficit Hyperactivity Disorder was immaterial.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B) and for the reasons stated above, I respectfully recommend that this court AFFIRM the decision of the Commissioner pursuant to sentence four of 42 U.S.C. § 405(g).

Dated this 26th day of April, 2001.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge