UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

ANA MARIE HANSON, Plaintiff, v. MICHAEL J. ASTRUE, Commissioner of Social Security, Defendant.	Case No. EDCV 08-1031 JC MEMORANDUM OPINION

I. SUMMARY

On August 7, 2008, plaintiff Ana Marie Hanson ("plaintiff") filed a Complaint seeking review of the Commissioner of Social Security's denial of plaintiff's application for benefits. The parties have filed a consent to proceed before a United States Magistrate Judge.

This matter is before the Court on the parties' cross motions for summary judgment, respectively ("Plaintiff's Motion") and ("Defendant's Motion"). The Court has taken both motions under submission without oral argument. See Fed. R. Civ. P. 78; L.R. 7-15; August 11, 2008 Case Management Order, ¶ 5.

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Based on the record as a whole and the applicable law, the decision of the Commissioner is AFFIRMED. The findings of the Administrative Law Judge ("ALJ") are supported by substantial evidence and are free from material error.[1]

II. BACKGROUND AND SUMMARY OF ADMINISTRATIVE DECISION

On September 15, 2005, plaintiff filed an application for Disability Insurance Benefits. (Administrative Record ("AR") 86-90). Plaintiff asserted that she became disabled on April 7, 2004, due to depression with anxiety, panic attacks, stress, paranoia, obsessive behavior, jumpiness/shakiness, difficulty in balancing with swaying while walking, agoraphobia, sleeping problems, restlessness and fatigue. (AR 100). The ALJ examined the medical record and heard testimony from plaintiff and a vocational expert on June 28, 2007. (AR 22-52).

On September 13, 2007, the ALJ determined that plaintiff was not disabled through the date of the decision. (AR 14-21). Specifically, the ALJ found: (1) plaintiff suffered from the following severe impairment: a depressive disorder, not otherwise specified (AR 16); (2) plaintiff did not suffer from an impairment or combination of impairments that met or medically equaled one of the listed impairments (AR 16-17); (3) plaintiff could perform a full range of work at all exertional levels with moderate non-exertional limitations[2] (AR 18); and (4) plaintiff could perform her past relevant work (AR 21).

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[1]The harmless error rule applies to the review of administrative decisions regarding disability. See Batson v. Commissioner of Social Security Administration, 359 F.3d 1190, 1196 (9th Cir. 2004) (applying harmless error standard); see also Stout v. Commissioner, Social Security Administration, 454 F.3d 1050, 1054-56 (9th Cir. 2006) (discussing contours of application of harmless error standard in social security cases).

[2]The ALJ determined that plaintiff has moderate limitations in carrying out detailed tasks, maintaining attention and concentration for extended periods, and responding appropriately to changes in a work setting, with no episodes of decompensation of extended duration. (AR 18).

On May 30, 2008, the Appeals Council denied plaintiff's application for review. (AR 1-3).

III. APPLICABLE LEGAL STANDARDS

A. Sequential Evaluation Process

To qualify for disability benefits, a claimant must show that she is unable to engage in any substantial gainful activity by reason of a 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 at least twelve months. Burch v. Barnhart, 400 F.3d 676, 679 (9th Cir. 2005) (citing 42 U.S.C. § 423(d)(1)(A)). The impairment must render the claimant incapable of performing the work she previously performed and incapable of performing any other substantial gainful employment that exists in the national economy. Tackett v. Apfel, 180 F.3d 1094, 1098 (9th Cir. 1999) (citing 42 U.S.C. § 423(d)(2)(A)).

In assessing whether a claimant is disabled, an ALJ is to follow a five-step sequential evaluation process:

(1) Is the claimant presently engaged in substantial gainful activity? If so, the claimant is not disabled. If not, proceed to step two.

(2) Is the claimant's alleged impairment sufficiently severe to limit her ability to work? If not, the claimant is not disabled. If so, proceed to step three.

(3) Does the claimant's impairment, or combination of impairments, meet or equal an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1? If so, the claimant is disabled. If not, proceed to step four.

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(4) Does the claimant possess the residual functional capacity to perform her past relevant work?[3] If so, the claimant is not disabled. If not, proceed to step five.

(5) Does the claimant's residual functional capacity, when considered with the claimant's age, education, and work experience, allow her to adjust to other work that exists in significant numbers in the national economy? If so, the claimant is not disabled. If not, the claimant is disabled.

Stout v. Commissioner, Social Security Administration, 454 F.3d 1050, 1052 (9th Cir. 2006) (citing 20 C.F.R. §§ 404.1520, 416.920).

The claimant has the burden of proof at steps one through four, and the Commissioner has the burden of proof at step five. Bustamante v. Massanari, 262 F.3d 949, 953-54 (9th Cir. 2001) (citing Tackett); see also Burch, 400 F.3d at 679 (claimant carries initial burden of proving disability).

B. Standard of Review

Pursuant to 42 U.S.C. section 405(g), a court may set aside a denial of benefits only if it is not supported by substantial evidence or if it is based on legal error. Robbins v. Social Security Administration, 466 F.3d 880, 882 (9th Cir. 2006) (citing Flaten v. Secretary of Health & Human Services, 44 F.3d 1453, 1457 (9th Cir. 1995)). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971) (citations and quotations omitted). It is more than a mere scintilla but less than a preponderance. Robbins, 466 F.3d at 882 (citing Young v. Sullivan, 911 F.2d 180, 183 (9th Cir. 1990)).

To determine whether substantial evidence supports a finding, a court must "'consider the record as a whole, weighing both evidence that supports and

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[3]Residual functional capacity is "what [one] can still do despite [ones] limitations" and represents an "assessment based upon all of the relevant evidence." 20 C.F.R. § 404.1545(a).

evidence that detracts from the [Commissioner's] conclusion.'" Aukland v. Massanari, 257 F.3d 1033, 1035 (9th Cir. 2001) (quoting Penny v. Sullivan, 2 F.3d 953, 956 (9th Cir. 1993)). If the evidence can reasonably support either affirming or reversing the ALJ's conclusion, a court may not substitute its judgment for that of the ALJ. Robbins, 466 F.3d at 882 (citing Flaten, 44 F.3d at 1457).

IV. DISCUSSION

A. The ALJ Did Not Fail Adequately to Develop the Record

Plaintiff contends that the ALJ failed adequately to develop the record by obtaining updated medical records from Dr. Ruby Jan Sia, an internal medicine physician, who was plaintiff's treating physician. (Plaintiff's Motion at 5). This Court disagrees.

1. Applicable Law

An ALJ has an affirmative duty to assist the claimant in developing the record at every step of the sequential evaluation process. Bustamante, 262 F.3d at 954; see also Webb v. Barnhart, 433 F.3d 683, 687 (9th Cir. 2005) (ALJ has special duty fully and fairly to develop record and to assure that claimant's interests are considered). "The ALJ's duty to develop the record fully is [] heightened where the claimant may be mentally ill and thus unable to protect her own interests." Tonapetyan v. Halter, 242 F.3d 1144, 1150 (9th Cir. 2001) (citation omitted). The ALJ's duty is triggered "when there is ambiguous evidence or when the record is inadequate to allow for proper evaluation of the evidence." Mayes v. Massanari, 276 F.3d 453, 459-60 (9th Cir. 2001) (citation omitted).

2. Analysis

In this case, the ALJ's duty to develop the record further was not triggered. Plaintiff does not argue that the evidence of plaintiff's impairments is ambiguous, or that the record as a whole was inadequate to allow for proper evaluation of the evidence. Even if it was, after the hearing the ALJ subpoenaed additional medical

records plaintiff identified as missing, and held the record open until he received a response. (AR 50-51, 213). The ALJ also permitted plaintiff to submit any additional evidence of her own while the record remained open.[4] (AR 51). Plaintiff, however, did not provide any additional information. This was sufficient to satisfy the ALJ's duty fully and fairly to develop the record. See Tidwell v. Apfel, 161 F.3d 599, 602 (9th Cir 1998) (ALJ satisfied duty fully and fairly to develop record by keeping record open after hearing to allow supplementation of record); see also Smolen v. Chater, 80 F.3d 1273, 1288 (9th Cir. 1996) (ALJ may discharge duty fully and fairly to develop record in several ways, including: subpoenaing claimant's physicians, submitting questions to claimant's physicians, and continuing hearing to augment record).

The ALJ was not required further to develop the record by re-contacting Dr. Sia. Accordingly, a remand or reversal on this basis is not warranted.

B. The ALJ Properly Evaluated Medical Opinion Evidence

Plaintiff contends that the ALJ failed to discuss some of the opinions and conclusions expressed in examination notes and a disability report from Dr. Sia, and therefore erroneously ignored probative medical opinion evidence. (Plaintiff's Motion at 2). Specifically, plaintiff alleges that the ALJ ignored Dr. Sia's opinions that plaintiff (1) "suffers from depression and anxiety;" (2) "has trouble with concentration;" (3) is "socially withdrawn;" (4) "wakes up at night;" and (5) was "disabled from December 28, 2005 to April 30, 2006." (Plaintiff's Motion at 2). This Court concludes that the ALJ did not materially err in his consideration of Dr. Sia's opinions.

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[4]The ALJ told plaintiff at the end of the administrative hearing that he would keep the record open pending a response to his subpoena, and that, "in the meantime, if you have any other additional records on your own that you want to submit, you better get them to me before that time . . . ." (AR 51).

1. Pertinent Facts

a. Statements of Plaintiff's Treating Physician

Dr. Sia treated plaintiff for high blood pressure, anxiety, and depression from March 5, 2004, through the date of the administrative hearing. (AR 85, 103, 153-75). Dr. Sia's progress notes for June 15, 2005, reflect that plaintiff suffered from "severe anxiety." (AR 168). In a December 28, 2005, Physician's Supplementary Certificate, Dr. Sia diagnosed plaintiff with "depression and anxiety," noted that plaintiff experienced trouble with concentration, and estimated that plaintiff would be able to work on April 30, 2006. (AR 161). Dr. Sia's progress notes for December 28, 2005, reflect that plaintiff was "still socially withdrawing." (AR 159). Subsequent progress notes in January and March 2006 reflect that plaintiff "[woke] up every night," continued to experience difficulty with concentration, and suffered from anxiety and depression. (AR 154, 156).

b. Consultative Examining Psychiatrist Opinions

On September 26, 2005, Dr. Ernest A. Bagner, III, a consultative psychiatrist, conducted a psychiatric evaluation of plaintiff. (AR 176). Dr. Bagner noted in connection with a mental status examination that plaintiff was "alert and oriented to person and place," and demonstrated "no evidence of auditory or visual hallucinations or paranoid delusions." (AR 176). In his functional assessment, Dr. Bagner noted that plaintiff had difficulty with concentration and memory, had difficulty sleeping, and had a diminished interest in doing daily activities. (AR 176). Dr Bagner further indicated that plaintiff was "able to carry out simple three-part commands, but had some difficulty in doing so." (AR 176). Dr. Bagner diagnosed plaintiff with "depressive disorder not otherwise specified," opined that she was then unable to work, and concluded that she could return to work in two months, *i.e.*, on November 26, 2005. (AR 176).

Approximately a month later, on October 22, 2005, Dr. Jobst Singer, a consultative psychiatrist, conducted a psychiatric evaluation of plaintiff. (AR 177-

80). Plaintiff complained of depression, but denied experiencing auditory or visual hallucinations. (AR 179). After examining plaintiff, Dr. Singer found "[plaintiff's] ability to understand, remember and perform instructions [was] unimpaired for simple tasks and mildly impaired for complex tasks." (AR 179). Dr. Singer observed "no psychiatric factors . . . that would significantly interfere with [plaintiff's] ability to complete a normal day of work" other than plaintiff's reported "anxiety episodes." (AR 179-80). Dr. Singer also noted that plaintiff's ability to interact with coworkers, the public, and supervisors was "not impaired." (AR 180). Dr. Singer diagnosed plaintiff with depression not otherwise specified. (AR 177).

c. Consultative Reviewing Psychiatrist Opinions

On November 9, 2005, a reviewing psychiatrist, Dr. K.D. Gregg, completed a psychiatric review technique form for the period of April 7, 2004 to November 5, 2005. (AR 181-94). Dr. Gregg opined that plaintiff had mild restrictions in her activities of daily living, mild difficulties in maintaining social function and in maintaining concentration, persistence or pace, and that she had had no episodes of decompensation of extended duration. (AR 191).

On March 9, 2006, Dr. H. Amado, a state agency psychiatrist, completed a Psychiatric Review Technique form.[5] (AR 199–212). Dr. Amado opined: Plaintiff had a severe affective disorder and anxiety-related disorder. (AR 199). She suffered no limitations in activities of daily living, mild difficulties in social

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[5]In a mental residual functional capacity assessment also completed on March 9, 2006, Dr. Amado opined that plaintiff was moderately limited in her ability to (i) understand, remember and carry out detailed instructions; (ii) maintain attention and concentration for extended periods; (iii) respond appropriately to changes in a work setting, and (iv) "complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods." (AR 195-96).

functioning, moderate difficulties in concentration, persistence or pace, and no episodes of decompensation.[6] (AR 209).[7]

d. The ALJ's Decision

In his September 13, 2007, decision, the ALJ thoroughly summarized the medical opinions and evaluations regarding plaintiff's mental impairments provided by plaintiff's primary care physician (Dr. Sia), plaintiff's therapist (Debra Nystrom), the examining physicians, and the reviewing physicians, together with the "entire record," which also included statements submitted by plaintiff and her daughter, as well as testimony of plaintiff and the vocational expert at the administrative hearing. (AR 14-21). The ALJ expressly referred to Dr. Sia's treatment of plaintiff, stating:

> The [plaintiff] was treated for high blood pressure and depression by her treating physician, an internal medicine doctor (Exhibit 1F) [AR 153-75]. He [sic] prescribed Prozac, Klonopin, and Xanax. The blood pressure was under control as evidenced by the normal readings [citations omitted].

(AR 20).

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[6]Dr. Amado noted that there were restricted medical source statement-like psych-related statements by plaintiff's primary care doctor, presumably Dr. Sia. (AR 211). Dr. Amado discounted such restrictions, noting that the primary care doctor was a "non-psych source" and had opined as to a matter reserved to the Commissioner. (AR 211).

[7]The record also contains extensive records from plaintiff's therapist, Debra Nystrom, whom plaintiff saw from March 206 to at least July 2007. (AR 213-55). As the ALJ noted, such records indicate that plaintiff received routine outpatient treatment for a depressive disorder. (AR 20). A mental status examination apparently completed in March 2006, reflects that plaintiff was oriented in four spheres, that her thoughts were congruent, and that there were no perceptual disturbances such as hallucinations. (AR 250-53). Her thought processes and speech were normal, and there were no behavioral disturbances. Id. Her insight and judgment were intact. Id. Her motor activity was described as placid, her concentration and memory were said to be impaired, and her mood as depressed. Id. As the ALJ noted, the therapist's notes reflect that plaintiff's condition gradually improved, with the therapist giving her repeatedly favorable assessments. (AR 21) (citing Exhibit 7F at 18, 22-24, 28 and 31 [AR 230, 234-36, 240, 243]).

2. Pertinent Law

In Social Security cases, courts employ a hierarchy of deference to medical opinions depending on the nature of the services provided. Courts distinguish among the opinions of three types of physicians: those who treat the claimant ("treating physicians") and two categories of "nontreating physicians," namely those who examine but do not treat the claimant ("examining physicians") and those who neither examine nor treat the claimant ("nonexamining physicians"). Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1996) (footnote reference omitted). A treating physician's opinion is entitled to more weight than an examining physician's opinion, and an examining physician's opinion is entitled to more weight than a nonexamining physician's opinion.[8] See id. In general, the opinion of a treating physician is entitled to greater weight than that of a non-treating physician because the treating physician "is employed to cure and has a greater opportunity to know and observe the patient as an individual." Morgan v. Commissioner of Social Security Administration, 169 F.3d 595, 600 (9th Cir. 1999) (citing Sprague v. Bowen, 812 F.2d 1226, 1230 (9th Cir. 1987)).

The treating physician's opinion is not, however, necessarily conclusive as to either a physical condition or the ultimate issue of disability. Magallanes v. Bowen, 881 F.2d 747, 751 (9th Cir. 1989) (citing Rodriguez v. Bowen, 876 F.2d 759, 761-62 & n.7 (9th Cir. 1989)). Where a treating physician's opinion is not contradicted by another doctor, it may be rejected only for clear and convincing reasons. Orn v. Astrue, 495 F.3d 625, 632 (9th Cir. 2007) (citation and internal quotations omitted). The ALJ can reject the opinion of a treating physician in favor of a conflicting opinion of another examining physician if the ALJ makes findings setting forth specific, legitimate reasons for doing so that are based on

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[8] Cf. Le v. Astrue, 529 F.3d 1200, 1201-02 (9th Cir. 2008) (not necessary or practical to draw bright line distinguishing treating physicians from non-treating physicians; relationship is better viewed as series of points on a continuum reflecting the duration of the treatment relationship and frequency and nature of the contact) (citation omitted).

substantial evidence in the record. Id. (citation and internal quotations omitted); Thomas v. Barnhart, 278 F.3d 947, 957 (9th Cir. 2002) (ALJ can meet burden by setting out detailed and thorough summary of facts and conflicting clinical evidence, stating his interpretation thereof, and making findings) (citations and quotations omitted); Magallanes, 881 F.2d at 751, 755 (same; ALJ need not recite "magic words" to reject a treating physician opinion – court may draw specific and legitimate inferences from ALJ's opinion). "The ALJ must do more than offer his conclusions." Embrey v. Bowen, 849 F.2d 418, 421-22 (9th Cir. 1988). "He must set forth his own interpretations and explain why they, rather than the [physician's], are correct." Id. "Broad and vague" reasons for rejecting the treating physician's opinion do not suffice. McAllister v. Sullivan, 888 F.2d 599, 602 (9th Cir. 1989).

3. Analysis

Although the ALJ in this case did not discuss every piece of evidence in the record, the ALJ was not required to do so. See Howard ex rel. Wolff v. Barnhart, 341 F.3d 1006, 1012 (9th Cir. 2003) (citations omitted). Here, the ALJ accounted for all significant probative evidence of plaintiff's impairment and limitations. Reddick v. Chater, 157 F.3d 715, 722-23 (9th Cir. 1998) (ALJ must "fully account[] for the context of materials or all parts of the testimony and reports"). The ALJ stated that he carefully considered "the entire record" and "opinion evidence" in accordance with administration regulations. (AR 18). He expressly found that plaintiff has the severe impairment of "depressive disorder," and noted that Dr. Sia was treating plaintiff for "depression." (AR 16, 20). The ALJ also thoroughly discussed plaintiff's limitations related to depression, anxiety, concentration and social functioning in his analysis of medical records from the

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examining psychiatrists.[9] Simply because the ALJ did not discuss cumulative opinions from Dr. Sia's progress notes regarding the same limitations does not mean he failed to consider that evidence. See Black v. Apfel, 143 F.3d 383, 386 (8th Cir. 1998) ("An ALJ's failure to cite specific evidence does not indicate that such evidence was not considered[.]").

Further, the ALJ was not required to discuss Dr. Sia's December 28, 2005 opinion that plaintiff could not return to work until after April 2006. There is nothing inconsistent between Dr. Sia's opinion in this regard, and the ALJ's residual functional capacity assessment. Specifically, accepting Dr. Sia's assessment in this regard would not establish that plaintiff was entitled to receive Disability Insurance Benefits because an inability to work for four months falls well short of establishing a disability for a continuous twelve-month period as is required.[10] Dr. Sia's December 28, 2005 opinion, which estimated that plaintiff could not work until after April 2006, neither met the durational requirements applicable to social security disability cases, nor revealed any additional functional limitations not already accounted for in the ALJ's residual functional capacity determination.[11]

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[9]Plaintiff also faults the ALJ for not expressly addressing Dr. Sia's note that plaintiff "[woke] up at night." (Plaintiff's Motion at 2). Although Dr. Sia's progress notes prior to April 2006 so reflect, plaintiff points to no evidence that she experienced this symptom or functional limitations resulting therefrom (at least none which are not already accounted for in the ALJ's residual functional capacity assessment) for a continuous twelve-month period.

[10]See Burch, 400 F.3d at 679 (To justify payment of social security disability benefits, mental impairment must be expected to last "for a continuous period of not less than 12 months.") (citing 42 U.S.C. § 423(d)(1)(A)).

[11]Dr. Bagner concluded that plaintiff would be unable to work for the two-month period between September 26, 2005 and November 26, 2005. (AR 176). Even assuming that plaintiff was disabled from September 26, 2005 to April 30, 2006, this seven-month period of alleged disability would still fall short of the twelve-month continuous period necessary to receive disability benefits.

Accordingly, it was unnecessary for the ALJ specifically to address Dr. Sia's estimate regarding the duration of plaintiff's mental inability to work.[12]

In light of the foregoing, a remand or reversal on this basis is not warranted.

C. The ALJ Posed a Complete Hypothetical Question to the Vocational Expert.

Plaintiff alleges that a reversal or remand is appropriate because the ALJ mischaracterized the severity of plaintiff's mental limitations in the hypothetical question he posed to the vocational expert. This Court disagrees.

1. Pertinent Facts

The ALJ determined that plaintiff had "the residual functional capacity to perform a full range of work at all exertional levels but with moderate limitations in carrying out detailed tasks, maintaining attention and concentration for extended periods, and responding appropriately to changes in a work setting." (AR 18). This finding was based on the state agency psychiatrist's mental residual functional capacity assessment in which such psychiatrist opined that plaintiff had such "moderate[]" limitations. (AR 20, 195-98).

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[12]Even assuming that the ALJ had rejected Dr. Sia's opinion in this regard, the ALJ's failure expressly to do so would not require reversal or remand since the four-month period in issue does not meet the durational time requirement to receive benefits. In short, an ALJ must provide an explanation only when he rejects "significant probative evidence." See Vincent v. Heckler, 739 F.2d 1393, 1394-95 (9th Cir. 1984) (citation omitted). Dr. Sia's opinion that plaintiff was unable to work for a four-month period does not meet that standard. In any event, the record contains sufficient evidence from other examining sources which would support a rejection of Dr. Sia's opinion of disability – even for four months. As noted above, Dr. Bagner opined that plaintiff could return to work in November 2005. Dr. Singer observed "no psychiatric factors . . . that would significantly interfere with [plaintiff's] ability to complete a normal day of work" other than plaintiff's reported "anxiety episodes." (AR 179-80). Dr. Amado, found plaintiff was only moderately limited in her ability to "complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods." (AR 195-96). Further, as noted by the ALJ, records from plaintiff's therapist likewise support the ALJ's conclusion that plaintiff was not disabled. (AR 20-21) (citing Exhibit 7F [AR 213-55)].

In his decision, the ALJ stated that plaintiff was able to perform her past relevant work as the president of a construction company and as a construction laborer (as those jobs are normally performed) based on the testimony of the vocational expert. In the hypothetical question posed to the vocational expert at the administrative hearing, the ALJ defined "moderate" limitation as follows: "Moderate limitation in any area means the individual is still able to function satisfactorily in that area." (AR 44).

2. Pertinent Law

A hypothetical question posed by an ALJ to a vocational expert must set out all the limitations and restrictions of the particular claimant. Light v. Social Security Administration, 119 F.3d 789, 793 (9th Cir.), as amended (1997) (citing Andrews v. Shalala, 53 F.3d 1035, 1044 (9th Cir. 1995)); Embrey, 849 F.2d at 422 ("Hypothetical questions posed to the vocational expert must set out *all* the limitations and restrictions of the particular claimant . . . .") (emphasis in original; citation omitted). However, an ALJ's hypothetical question need not include limitations not supported by substantial evidence in the record. Osenbrock v. Apfel, 240 F.3d 1157, 1163-64 (9th Cir. 2001) (citation omitted).

3. Analysis

Plaintiff does not dispute that the ALJ included all of plaintiff's mental limitations in the hypothetical question posed to the vocational expert. (Plaintiff's Motion at 8). Plaintiff argues, however, that the ALJ erroneously defined "moderately limited" to mean that an individual could still "function satisfactorily" with respect to a particular mental activity. (Plaintiff's Motion at 6-8). Plaintiff argues that "moderately limited" mental functioning actually represents a "very significant" limitation on a plaintiff's mental activity, and thus the hypothetical posed to the vocational expert was incomplete. (Plaintiff's Motion at 7-8).

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While plaintiff claims that the ALJ made an arbitrary attempt to change the definition of the term "moderately limited," the fact is that the hypothetical question posed by the ALJ to the vocational expert was based upon the limitations set forth in the state agency psychiatrist's mental residual functional capacity assessment (AR 195-98), which was accepted by the ALJ. (AR 20). Plaintiff presents no legal support for his novel definition of "moderately limited." Cf. Serna v. Astrue, 2008 WL 5179033, at *3 (C.D. Cal. Dec. 9, 2008) (Social Security regulations do not provide standard definition of "moderate"; noting that Eighth Circuit upheld ALJ's finding that claimant who had moderate limitation in ability to respond appropriately to work pressures in usual work setting would still be able satisfactorily to function in area) (citing LaCroix v. Barnhart, 465 F.3d 881, 888 (8th Cir. 2006)); Arriola v. Astrue, 2008 WL 4926961, at *4 (C.D. Cal. Nov. 14, 2008) (noting that ALJ's definition of the term "moderate" was consistent with 2006 edition of SSA Form HA-1152, which defines moderate limitation as follows: "There is more than a slight limitation in this area but the individual is still able to function satisfactorily.").

As the ALJ identified all the limitations that he found to exist which were supported by substantial evidence in the medical record, he did not pose an incomplete hypothetical question to the vocational expert. Accordingly, a remand or reversal on this basis is not warranted.[13]

D. The ALJ Properly Considered Lay Witness Evidence

Plaintiff contends that the ALJ failed properly to consider statements provided by plaintiff's daughter, MaryAnn Galvan, and failed to provide sufficient

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[13]Defendant correctly notes that vocational expert testimony is not required at step four. See Crane v. Shalala, 76 F.3d 251, 255 (9th Cir. 1996) (determination at step four that claimant could return to past relevant work need not be supported by vocational testimony). Here, however, the ALJ expressly relied upon the testimony of the vocational expert in concluding that plaintiff could return to his past relevant work. (AR 21).

reasons for disregarding her statements. (Plaintiff's Motion at 8-10). This Court disagrees.

1. Pertinent Facts

In a "Function Report – Adult – Third Party" form dated February 22, 2006, plaintiff's daughter provided information about plaintiff's daily activities, personal care, meals, house and yard work, getting around, shopping, money handling, hobbies and interests, social activities, and information about her abilities. (AR 124-31). Plaintiff's daughter stated that: (i) she saw plaintiff two or three times a week to visit, go shopping or attend church; (ii) plaintiff's medications made it difficult for her to sleep at night and made her drowsy in the daytime; (iii) plaintiff needed medication reminders; (iv) plaintiff's memory failed and at times she was unable to count money correctly; (v) plaintiff had difficulty remembering what people told her or events, had difficulty completing tasks and maintaining concentration, and had trouble remembering details; (vi) plaintiff did not handle stress well; (vii) plaintiff had increasingly "paranoid behavior;" and (viii) plaintiff "tend[ed] to 'blank out'." (AR 124-31).

2. Pertinent Law

Lay testimony as to a claimant's symptoms is competent evidence that an ALJ must take into account, unless he expressly determines to disregard such testimony and gives reasons germane to each witness for doing so. Stout, 454 F.3d at 1056 (citations omitted); Lewis v. Apfel, 236 F.3d 503, 511 (9th Cir. 2001); see also Robbins, 466 F.3d at 885 (ALJ required to account for all lay witness testimony in discussion of findings) (citation omitted); Regennitter v. Commissioner of Social Security Administration, 166 F.3d 1294, 1298 (9th Cir. 1999) (testimony by lay witness who has observed claimant is important source of information about claimant's impairments); Nguyen v. Chater, 100 F.3d 1462, 1467 (9th Cir. 1996) (lay witness testimony as to claimant's symptoms or how impairment affects ability to work is competent evidence and therefore cannot be

disregarded without comment) (citations omitted); Sprague v. Bowen, 812 F.2d 1226, 1232 (9th Cir. 1987) (ALJ must consider observations of non-medical sources, *e.g.*, lay witnesses, as to how impairment affects claimant's ability to work). The standards discussed in these authorities appear equally applicable to written statements. Cf. Schneider v. Commissioner of Social Security Administration, 223 F.3d 968, 974-75 (9th Cir. 2000) (ALJ erred in failing to consider letters submitted by claimant's friends and ex-employers in evaluating severity of claimant's functional limitations).

In cases in which "the ALJ's error lies in a failure to properly discuss competent lay testimony favorable to the claimant, a reviewing court cannot consider the error harmless unless it can confidently conclude that no reasonable ALJ, when fully crediting the testimony, could have reached a different disability determination." Robbins, 466 F.3d at 885 (quoting Stout, 454 F.3d at 1055-56).

3. Analysis

To the extent the ALJ erroneously failed to discuss particular statements made by plaintiff's daughter, any error was harmless. The ALJ expressly noted in his decision that he had considered the lay evidence. (AR 19). The ALJ was not required to discuss every detail of the daughter's statement. See Black, 143 F.3d at 386. In addition, as discussed below, the ALJ properly rejected aspects of the daughter's statements that were inconsistent with substantial other evidence. See Vincent v. Heckler, 739 F.2d 1393, 1394-95 (9th Cir. 1984) (ALJ did not err by omitting from hearing decision discussion of "lay testimony that conflicted with the available medical evidence.") (citation omitted). Further, to the extent the ALJ failed expressly to address other statements from plaintiff's daughter that simply corroborated limitations the ALJ already accounted for in his decision, any error

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was harmless.[14] See Zerba v. Commissioner of Social Security Administration, 279 Fed. Appx. 438, 440 (9th Cir. 2008) (failure to address husband's cumulative lay testimony harmless error); Rohrer v. Astrue, 279 Fed. Appx. 437, 437 (9th Cir. 2008) (rejecting claimant's contention that ALJ improperly rejected lay witness statement of claimant's girlfriend where such statement was cumulative of statements by claimant which ALJ accepted).[15]

Moreover, the ALJ found plaintiff's daughter's statements "not entirely credible." (AR 19). The ALJ explained that while plaintiff's daughter believed plaintiff "should not go out alone," she nonetheless stated that plaintiff "shops, cooks, cleans, does the laundry and is able to take care of her own personal hygiene." (AR 19, 124-27). The daughter's statements were also contradicted by plaintiff's own statements that she engaged in such activities, as well as "watching television, reading, walking, going to church and socializing." (AR 19, 116-23). The ALJ found the daughter's claims that plaintiff "is paranoid" and "has had stressful nervous breakdowns" to be "inconsistent with [plaintiff's] presentation at psychiatric examinations" which, as discussed above, reflect, in part, "no evidence of . . . [plaintiff's] paranoia . . . ." (AR 19, 176-80).

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[14]To the extent the ALJ failed to consider plaintiff's daughter's statements that "plaintiff's sleeping habits ha[d] changed drastically" due to medication, any such error is harmless. Stout, 454 F.3d at 1056; see also Robbins, 466 F.3d at 885. Plaintiff fails to demonstrate how plaintiff's changed sleeping habits impaired her ability to work beyond what was already accounted for in the ALJ's residual functional capacity assessment. Moreover, in light of the substance of the daughter's statements, plaintiff's own statements, and the medical evidence in the record, this Court can confidently conclude that no reasonable ALJ, even fully crediting those statements from plaintiff's daughter which were not expressly addressed by the ALJ, could have reached a different disability determination. Plaintiff's claim that the ALJ failed to consider plaintiff's "black outs" is unsupported by the daughter's own statements that plaintiff sporadically "blank[s] out." (AR 131). In any event, for the same reasons, any error in failing to mention the evidence is harmless.

[15]The Court may cite unpublished Ninth Circuit opinions issued on or after January 1, 2007. See U.S. Ct. App. 9th Cir. Rule 36-3(b); Fed. R. App. P. 32.1(a).

As the ALJ expressly considered and partially rejected plaintiff's daughter's statements based upon germane reasons which are supported by the record, a remand or reversal on this basis is not warranted.

E. The ALJ Properly Assessed Plaintiff's Credibility

Plaintiff asserts that the ALJ failed properly to evaluate plaintiff's credibility. This Court disagrees.

1. Pertinent Law

An ALJ is not required to believe every allegation of disabling pain or other non-exertional impairment. Orn, 495 F.3d at 635 (citing Fair v. Bowen, 885 F.2d 597, 603 (9th Cir. 1989)). If the record establishes the existence of a medically determinable impairment that could reasonably give rise to symptoms assertedly suffered by a claimant, an ALJ must make a finding as to the credibility of the claimant's statements about the symptoms and their functional effect. Robbins, 466 F.3d 880 at 883 (citations omitted). Where the record includes objective medical evidence that the claimant suffers from an impairment that could reasonably produce the symptoms of which the claimant complains, an adverse credibility finding must be based on clear and convincing reasons. Carmickle v. Commissioner, Social Security Administration, 533 F.3d 1155, 1160 (9th Cir. 2008) (citations omitted). The only time this standard does not apply is when there is affirmative evidence of malingering. Id. The ALJ's credibility findings "must be sufficiently specific to allow a reviewing court to conclude the ALJ rejected the claimant's testimony on permissible grounds and did not arbitrarily discredit the claimant's testimony." Moisa v. Barnhart, 367 F.3d 882, 885 (9th Cir. 2004). The ALJ must "specifically identify the testimony [the ALJ] finds not to be credible and must explain what evidence undermines the testimony." Holohan v. Massanari, 246 F.3d 1195, 1208 (9th Cir. 2001).

To find the claimant not credible, an ALJ must rely on (1) reasons unrelated to the subjective testimony (*e.g.*, reputation for dishonesty); (2) internal

contradictions in the testimony; or (3) conflicts between the claimant's testimony and the claimant's conduct (*e.g.*, engaging in daily activities inconsistent with the alleged symptoms, maintaining work inconsistent with the alleged symptoms, failing, without adequate explanation, to take medication, to seek treatment or to follow prescribed course of treatment). Lingenfelter v. Astrue, 504 F.3d 1028, 1035-40 (9th Cir. 2007); Orn, 495 F.3d at 636; Robbins, 466 F.3d at 883; Burch, 400 F.3d at 680-81; SSR 96-7p. Although an ALJ may not disregard a claimant's testimony solely because it is not substantiated affirmatively by objective medical evidence, the lack of medical evidence is a factor that the ALJ can consider in his credibility assessment. Burch, 400 F.3d at 681.

Questions of credibility and resolutions of conflicts in the testimony are functions solely of the Commissioner. Greger v. Barnhart, 464 F.3d 968, 972 (9th Cir. 2006). If the ALJ's interpretation of the claimant's testimony is reasonable and is supported by substantial evidence, it is not the court's role to "second-guess" it. Rollins v. Massanari, 261 F.3d 853, 857 (9th Cir. 2001).

2. Analysis

The ALJ presented clear and convincing reasons for discounting plaintiff's statements regarding her subjective symptoms, and thus did not materially err in his assessment of plaintiff's credibility.

First, in assessing credibility, the ALJ may properly rely on inconsistencies between plaintiff's statements and her conduct. See Thomas, 278 F.3d at 958-59 (inconsistency between the claimant's testimony and the claimant's conduct supported rejection of the claimant's credibility); Verduzco v. Apfel, 188 F.3d 1087, 1090 (9th Cir. 1999) (inconsistencies between claimant's testimony and actions cited as clear and convincing reason for rejecting claimant's testimony). Here, the ALJ found plaintiff's allegations regarding the severity of her symptoms and related limitations "not entirely credible" because plaintiff engaged in

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significant activities of daily living inconsistent with such allegedly severe limitations.[16] (AR 19).

Second, an ALJ may discredit a plaintiff's subjective symptom testimony due, in part, to the absence of supporting objective medical evidence. Burch, 400 F.3d at 681; Rollins, 261 F.3d at 857 ("While subjective pain testimony cannot be rejected on the sole ground that it is not fully corroborated by objective medical evidence, the medical evidence is still a relevant factor in determining the severity of the claimant's pain and its disabling effects.") (citation omitted). Here, the ALJ reasonably concluded that plaintiff's subjective symptom allegations were "inconsistent with [plaintiff's] presentation at the psychiatric examinations . . . ."[17] (AR 19).

The foregoing reasons, by themselves, constituted clear and convincing reasons which provide a sufficient basis upon which to reject plaintiff's testimony and statements. As the ALJ made specific findings stating clear and convincing reasons supported by substantial evidence for disbelieving plaintiff, the ALJ's

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[16]The ALJ noted that plaintiff "shops, cooks, cleans, does the laundry, drives[,] takes care of personal hygiene needs" and engages in other activities such as "watching television, reading, walking, going to church, and socializing." (AR 19).

[17]Reports from examining Drs. Bagner and Singer reflect the following:

> [Plaintiff] was alert and oriented to person, place, and time. There was no evidence of auditory or visual hallucinations or paranoid delusions. Memory and concentration were not markedly impaired. Speech was normal, affect stable and thought processes were clear. There was no paranoia and the claimant specifically denied hallucinations. The claimant was able to complete the mental status examination and follow instructions without difficulty. Her ability to carry out simple tasks was unimpaired and only mildly impaired in complex tasks. No psychiatric factors were identified that would significantly interfere with the claimant's ability to complete a normal work day other than the reported anxiety episodes, which were not observed during the examination.

(AR 19, 176-80).

credibility determination was not materially erroneous. Accordingly, a remand or reversal on this basis is not warranted.

V. CONCLUSION

For the foregoing reasons, the decision of the Commissioner of Social Security is affirmed.

LET JUDGMENT BE ENTERED ACCORDINGLY.

DATED: September 16, 2009

/s/
Honorable Jacqueline Chooljian
UNITED STATES MAGISTRATE JUDGE