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**UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA**

LINDA KELSCH,	)	NO. CV 14-532-E
	)	
Plaintiff,	)	
	)	
v.	)	<b>MEMORANDUM OPINION</b>
	)	
CAROLYN W. COLVIN, ACTING	)	<b>AND ORDER OF REMAND</b>
COMMISSIONER OF SOCIAL SECURITY,	)	
	)	
Defendant.	)	
	)	

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Pursuant to sentence four of 42 U.S.C. section 405(g), IT IS  
HEREBY ORDERED that Plaintiff's and Defendant's motions for summary  
judgment are denied and this matter is remanded for further  
administrative action consistent with this Opinion.

**PROCEEDINGS**

Plaintiff filed a Complaint on January 23, 2014, seeking review  
of the Commissioner's denial of social security disability benefits.  
The parties filed a consent to proceed before a United States  
Magistrate Judge on August 8, 2014.

1 Plaintiff filed a motion for summary judgment on July 9, 2014.  
2 Defendant filed a motion for summary judgment on August 8, 2014. The  
3 Court has taken both motions under submission without oral argument.  
4 See L.R. 7-15; "Order," filed January 27, 2014.

5  
6 **BACKGROUND AND SUMMARY OF ADMINISTRATIVE DECISION**  
7

8 Plaintiff asserts disability since July 24, 2009, based primarily  
9 on alleged mental problems (Administrative Record ("A.R.") 83, 151,  
10 154). An Administrative Law Judge ("ALJ") examined the medical record  
11 and heard testimony from Plaintiff and a vocational expert (A.R. 24-  
12 35, 47-75). The ALJ found Plaintiff has severe "major depressive  
13 disorder and panic disorder," but retains the residual functional  
14 capacity to perform work at all exertion levels with certain  
15 nonexertional limitations (A.R. 26-33).<sup>1</sup> In reliance on the  
16 vocational expert's testimony, the ALJ found Plaintiff can perform  
17 work as a packager and linen room attendant (A.R. 34-35; see also A.R.  
18 66-67 (vocational expert testimony)). The Appeals Council denied  
19

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20 <sup>1</sup> The ALJ found Plaintiff can:

21 perform simple, routine tasks with simple instructions;  
22 perform work involving simple decision-making; never  
23 remember or carry out detailed tasks or instructions;  
24 tolerate occasional changes in routine; work in a low  
25 stress environment defined as no fast paced-high volume  
type work;\* with frequent interaction with supervisors,  
coworkers and the general public.

26 (A.R. 28). \*The Court observes that the semi-colon appears to  
27 have been placed in error. The vocational expert testified that  
28 a person with these limitations could not perform Plaintiff's  
past relevant work because that work required frequent contact  
with the general public. See A.R. 67.

1 review (A.R. 1-3).

2  
3 **STANDARD OF REVIEW**  
4

5 Under 42 U.S.C. section 405(g), this Court reviews the  
6 Administration's decision to determine if: (1) the Administration's  
7 findings are supported by substantial evidence; and (2) the  
8 Administration used correct legal standards. See Carmickle v.  
9 Commissioner, 533 F.3d 1155, 1159 (9th Cir. 2008); Hoopai v. Astrue,  
10 499 F.3d 1071, 1074 (9th Cir. 2007); see also Brewes v. Commissioner  
11 of Social Sec. Admin., 682 F.3d 1157, 1161 (9th Cir. 2012).  
12 Substantial evidence is "such relevant evidence as a reasonable mind  
13 might accept as adequate to support a conclusion." Richardson v.  
14 Perales, 402 U.S. 389, 401 (1971) (citation and quotations omitted);  
15 see also Widmark v. Barnhart, 454 F.3d 1063, 1067 (9th Cir. 2006).  
16

17 **DISCUSSION**  
18

19 **I. Evidence Regarding Plaintiff's Alleged Mental Impairments.**  
20

21 The extensive evidence regarding Plaintiff's alleged mental  
22 impairments is partially in conflict with certain findings made by the  
23 ALJ. Therefore, the Court summarizes this evidence in some detail.  
24

25 Plaintiff took a stress leave from her job on July 24, 2009 (the  
26 alleged onset date) (A.R. 216-17). The first treatment note for  
27 anxiety at work is dated April 9, 2009, with symptoms reportedly  
28 "longstanding" (A.R. 240-41). Plaintiff's doctor diagnosed anxiety

1 disorder, prescribed Alprazolam (Xanax), and gave Plaintiff contact  
2 information for psychiatry and health education because Plaintiff was  
3 "less inclined" to take medication (A.R. 241).<sup>2</sup> Plaintiff's blood  
4 pressure was elevated due to stress (A.R. 241).

5  
6 Plaintiff returned to her doctor on April 23, 2009, claiming  
7 increased anxiety due to work stress but she reportedly did not appear  
8 anxious or depressed (A.R. 245). Plaintiff assertedly did not want  
9 medications or psychotherapy (A.R. 245). Given Plaintiff's reluctance  
10 to take medications, Plaintiff's doctor recommended acupuncture (A.R.  
11 245).

12  
13 Plaintiff next complained of work related stress on July 23, 2009  
14 (A.R. 248). She reportedly appeared anxious, exhibited a depressed  
15 mood and was diagnosed with an acute stress reaction (A.R. 248).  
16 Plaintiff again assertedly did not want any medications (A.R. 248).  
17 Plaintiff's primary doctor ordered Plaintiff off work until she could  
18 be seen by a psychiatrist (A.R. 248).

19  
20 A marriage and family therapist examined Plaintiff on July 30,  
21 2009 (A.R. 249-52). Plaintiff complained that she could not control  
22 herself at work, feels ill, cries, cannot concentrate or function, and

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23  
24 <sup>2</sup> Plaintiff reportedly had been prescribed psychotropic  
25 medication in 1985, which she discontinued after one or two doses  
26 due to a "horrible" headache (A.R. 555). Plaintiff also was  
27 prescribed Ativan as needed in January of 1998 for stress and  
28 anxiety (A.R. 548). Plaintiff refused to take Xanax when it was  
recommended in April of 2009 (A.R. 250, 550). As of January 5,  
2011, Plaintiff reportedly had never used any psychotropic  
medications except as noted herein (A.R. 555).

1 gets confused due to her workload (A.R. 250). Plaintiff had not taken  
2 the Xanax she was prescribed in April, saying she had bad reactions to  
3 medications in the past (A.R. 250). Plaintiff's mood reportedly was  
4 depressed and her memory and concentration assertedly were poor (A.R.  
5 251). The therapist diagnosed Adjustment Disorder with Depression and  
6 Anxiety, Occupational Issues, and assigned a Global Assessment of  
7 Functioning ("GAF") score of 55, which denotes moderate problems (A.R.  
8 252).<sup>3</sup>

9  
10 Psychologist Michelle Levin evaluated Plaintiff twice in  
11 September of 2009 (A.R. 216-22). Dr. Levin believed that workplace  
12 factors, namely Plaintiff's relationship with her manager and  
13 increased workload, triggered Plaintiff's diagnosed condition (Major  
14 Depressive Disorder, Single Episode, Severe without Psychotic  
15 Features, and Generalized Anxiety Disorder) (A.R. 221). Dr. Levin  
16 recommended that Plaintiff attend individual psychotherapy, see a  
17 psychiatrist to explain medication options, and be re-evaluated in six  
18 months (A.R. 221).

19  
20 Psychologist April Pavlik prepared a follow up report dated  
21 December 23, 2009 (A.R. 223-25). Dr. Pavlik found Plaintiff still  
22 moderately depressed and indicated Plaintiff should continue

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23  
24 <sup>3</sup> Clinicians use the GAF scale to rate "psychological,  
25 social, and occupational functioning on a hypothetical continuum  
26 of mental health-illness." American Psychiatric Association,  
27 Diagnostic and Statistical Manual of Mental Disorders 34 (4th ed.  
28 TR 2000) ("DSM"). A GAF of 51-60 indicates "[m]oderate symptoms  
(e.g., flat affect and circumstantial speech, occasional panic  
attacks) or moderate difficulty in social, occupational, or  
school functioning (e.g., temporarily falling behind in  
schoolwork)." Id.

1 individual therapy and remain off work until February 11, 2010 (A.R.  
2 225).<sup>4</sup>

3  
4 Psychologists Barry Halote and Allan Gerson reviewed the  
5 available record and prepared a "Permanent and Stationary Evaluation  
6 Report" dated July 12, 2010 (A.R. 282-305; see also A.R. 306-17  
7 (initial report)). Drs. Halote and Gerson evaluated Plaintiff on  
8 February 16, 2010, and again on June 1, 2010 (A.R. 282-83; see also  
9 A.R. 398-427 (initial evaluation)).<sup>5</sup> They found Plaintiff incapable of  
10 returning to her usual and customary job duties based on cumulative  
11 stress from the workplace (A.R. 283, 296-300, 303-05). Reportedly,  
12 Plaintiff had been treated individually by Dr. Swanson, and had stated

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19 <sup>4</sup> Plaintiff reported that she met with Dr. Levin for  
20 weekly psychotherapy sessions from September 2009 through the  
21 time she started meeting with Dr. Pavlik (A.R. 544, 552).  
22 Plaintiff then met with Dr. Pavlik weekly until December 2009,  
23 when insurance stopped paying for the visits (A.R. 544). There  
24 are no treatment notes in the medical record for these therapy  
25 sessions.

26 <sup>5</sup> Dr. Halote also prepared a summary of the medical  
27 record as of January 20, 2011 (A.R. 440-59). Plaintiff first  
28 complained of carpal tunnel syndrome on the left hand in June  
2001 (A.R. 447). She first reported headaches and dizziness from  
work-related stress in April 2009 (A.R. 454). Based on his  
review of the medical evidence, Dr. Halote found no reason to  
change his opinion that Plaintiff was unable to return to her  
past work (A.R. 458 (deferring judgment on non-psychological  
issues)).

1 that overall she was feeling better (A.R. 284, 296-97).<sup>6</sup> Plaintiff  
2 reported work-related anxiety and depression, as well as headaches,  
3 nausea, dizziness, loss of balance and, while at work, muscle tension  
4 and pain in her neck and shoulders, excessive sweating, weakness,  
5 shortness of breath, rapid heartbeat and chest pain (A.R. 285, 287,  
6 298, 300).

7  
8 On examination, no memory or concentration problems reportedly  
9 were evident, nor signs of significant cognitive impairment observed  
10 (A.R. 291). Psychological testing indicated, inter alia, that  
11 Plaintiff was depressed (mild levels), withdrawn, fearful, and mildly  
12 anxious (moderate, subjectively) (A.R. 292-95). Test results  
13 assertedly revealed the presence of depression, anxiety, loss of self-  
14 confidence, social isolation, anger, and difficulties with  
15 concentration (A.R. 295-96).

16  
17 Drs. Halote and Gerson diagnosed Plaintiff with Major Depressive  
18 Disorder, Single Episode, Improved, and Panic Disorder without

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25 <sup>6</sup> At the time of their initial evaluation in February of  
26 2010, Drs. Halote and Gerson said that prompt treatment was  
27 "deemed necessary" to mitigate Plaintiff's symptoms (A.R. 283).  
28 They had referred Plaintiff to Dr. Swanson for therapy in an  
individual setting and said Plaintiff had been treating with Dr.  
Swanson at the time of the second interview in June of 2010 (A.R.  
283-84).

1 Agoraphobia, with a GAF score of 64 (A.R. 301).<sup>7</sup> They concluded that  
2 Plaintiff was unable to return to her former work, and also should be  
3 restricted from working in high stress situations (A.R. 305).

4  
5 Treating psychologist Frank Swanson prepared a Psychological  
6 Evaluation dated September 30, 2010 (A.R. 370-73). Dr. Swanson  
7 indicated he first had examined Plaintiff on March 4, 2010, and most  
8 recently had examined her on September 15, 2010 (A.R. 373; but see  
9 A.R. 296 (referencing "Treatment and Progress Notes" from Dr. Swanson,  
10 "dated February 24, 2010" and "dated April 21, 2010")).<sup>8</sup> Plaintiff  
11 reportedly appeared to have fear, anxiety, distress, tearful behavior,  
12 psychomotor agitation, and accelerated speech (A.R. 370). Dr. Swanson  
13 reportedly had observed a depressed mood and anxiety during therapy  
14 (A.R. 372). "Several test instruments were used to ascertain  
15 [Plaintiff's] psychological functioning" (A.R. 371). Dr. Swanson  
16 thereby "determined" Plaintiff's helplessness, loss of motivation,  
17 loss of energy, loss of interest, sadness, intense fear, sleep

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18  
19 <sup>7</sup> A GAF score of 61-70 indicates "[s]ome mild symptoms  
20 (e.g., depressed mood and mild insomnia) or some difficulty in  
21 social, occupational, or school functioning (e.g., occasional  
22 truancy, or theft within the household) but generally functioning  
pretty well, has some meaningful interpersonal relationships."  
DSM, p. 34.

23 <sup>8</sup> As of January 5, 2011, Plaintiff reported that she had  
24 met with Dr. Swanson for weekly therapy for approximately three  
25 months (i.e., from February through April 2010), then tapered off  
26 to seeing Dr. Swanson once every three to four weeks (A.R. 544).  
27 There are no treatment notes in the medical record for any of  
28 these therapy sessions. It is not clear when Plaintiff may have  
stopped consulting Dr. Swanson. As reflected in the above  
discussion, the existing record references at least four specific  
dates on which Plaintiff was seen by Dr. Swanson, but suggests  
that many more than four therapy sessions with Dr. Swanson  
actually occurred.



1 disturbance, and increased irritability (A.R. 371). Dr. Swanson  
2 indicated that Plaintiff had diminished intellectual functioning, and  
3 that sleep deprivation and chronic physical pain, as well as  
4 ambivalence and loss of independence, self-value, and self-identity,  
5 had contributed to cognitive dysfunction (i.e., decreased  
6 concentration, attention, and memory) (A.R. 371-72). Plaintiff's  
7 social functions assertedly had improved with increased "out-door  
8 behavior," but her work functions "remained tentative" (A.R. 373).  
9 Dr. Swanson diagnosed Plaintiff with Panic Anxiety Disorder  
10 (Provisional Agoraphobia), Major Depressive Disorder, and Primary  
11 Insomnia (Provisional), assigning a present GAF score of 58 to 62, and  
12 48 to 52 for the past year, with a guarded prognosis (A.R. 373). Dr.  
13 Swanson concluded, "[i]t is unlikely that [Plaintiff] will be able to  
14 perform work activities at this time" (A.R. 372).

15  
16 On September 6, 2011, Dr. Swanson completed a form entitled  
17 "Medical Statement Concerning Depression and Anxiety, OCD, PTSD or  
18 Panic Disorder for Social Security Disability Claim" (A.R. 377-79).  
19 Dr. Swanson identified essentially the same symptoms discussed in his  
20 earlier evaluation, and indicated that Plaintiff would have "moderate"  
21 restriction of activities of daily living and "marked" difficulty  
22 maintaining social functioning (A.R. 377). He also indicated the  
23 presence of deficiencies of concentration, persistence, or pace, and  
24 repeated episodes of decompensation in work-like settings (A.R. 377).  
25 Dr. Swanson further indicated that Plaintiff would have work-related  
26 psychiatric limitations ranging from "moderate" to "marked" to  
27 "extremely" impaired (A.R. 378-79). The only ability that reportedly  
28 was "not significantly impaired" was the ability to ask simple

1 questions or request assistance (A.R. 378-79). Dr. Swanson left blank  
2 the "Comments" section of the form (A.R. 379).

3  
4 Psychiatrist David Sones reviewed the medical record (absent Dr.  
5 Swanson's September 6, 2011 evaluation) and prepared an Agreed Medical  
6 Examination in Psychiatry report dated January 5, 2011, for  
7 Plaintiff's workers compensation claim (A.R. 538-86; see also A.R.  
8 588-655 (Dr. Sones' interview notes)). Plaintiff reported her current  
9 psychological stress level as 1 out of 10, with 10 being the level of  
10 stress she experienced when she last worked (A.R. 545). Plaintiff  
11 reported suffering from anxiety and depression approximately two times  
12 per week for periods from five minutes to five hours when she worries  
13 about work or her financial situation, interrupted sleep two to three  
14 nights per week, but no disturbance in her social functioning (A.R.  
15 557-59). Plaintiff reportedly enjoyed interacting with family and  
16 friends and was not socially withdrawn (A.R. 559). Mental status  
17 examination noted no unusual findings other than an affect reflecting  
18 apprehension and frustration, a predominantly dysphoric mood, with  
19 periods in which Plaintiff became acutely anxious with trembling and  
20 an increased respiration rate, and "somewhat limited" judgment and  
21 insight (A.R. 562-64, 579). Dr. Sones gave Plaintiff a battery of  
22 tests and diagnosed Plaintiff with Adjustment Disorder with Mixed  
23 Anxiety and Depressed Mood, Chronic, and assigned a GAF score in the  
24 range of 51-60 (A.R. 564-76, 579-80, 584). Dr. Sones opined that  
25 Plaintiff's psychiatric condition would not change within the next  
26 twelve months (A.R. 582). Dr. Sones recommended that Plaintiff  
27 receive up to eight sessions per year of psychotherapy on an as-needed  
28 basis (A.R. 583). Dr. Sones opined that "[f]rom a psychiatric

1 standpoint the applicant is capable of resuming her usual and  
2 customary work duties as a commercial lines account manager for [her  
3 employer] without the need for any modifications" (A.R. 584).  
4

5 Psychiatrist Allen Chroman prepared a Psychiatric Consultation  
6 dated May 8, 2011 (A.R. 391-93). Plaintiff reportedly exhibited signs  
7 of anxiety, euthymic mood, blunted affect, but a grossly intact  
8 memory, fund of knowledge, and the ability to abstract spontaneously  
9 and appropriately (A.R. 391-92). Plaintiff reported that at times she  
10 has difficulty going outside her house (A.R. 391). Dr. Chroman  
11 diagnosed Plaintiff with Panic Disorder and assigned a current GAF  
12 score of 55 (A.R. 392). He prescribed Lexapro and Ativan (A.R. 392-  
13 93). Plaintiff reported that recently she was unable to have lunch in  
14 a restaurant and fled, secondary to panic (A.R. 396). On July 12,  
15 2011, Plaintiff reported only modest improvement with respect to her  
16 panic attacks (A.R. 397). Dr. Chroman prescribed a trial of BuSpar  
17 (A.R. 397).  
18

19 Consultative psychological examiner Curtis Edwards reviewed a  
20 portion of the medical records and prepared a Psychological Evaluation  
21 dated November 17, 2011, and an accompanying Medical Source Statement  
22 of Ability to do Work-Related Activities (Mental) (A.R. 380-89).  
23 Plaintiff reportedly complained of panic, anxiety, fear, fear of  
24 leaving the house, sleep difficulties, difficulty dealing with people,  
25 confusion and disorientation (wherein she feels dizzy, has difficulty  
26 breathing, a rapid heartbeat, and a feeling that she may die) that has  
27 caused her to get lost when she leaves home, and to lose interest in  
28 her life (A.R. 381). Plaintiff reported that her psychiatric symptoms

1 caused impairments in all areas of daily living, in that she could  
2 complete activities but lacked motivation and energy to initiate tasks  
3 (A.R. 381, 383). She also reported social isolation with few  
4 friendships (A.R. 381). Plaintiff claimed to have engaged in  
5 psychotherapy for over two years with some benefit, but did not take  
6 any prescribed medications (A.R. 382).

7  
8       Upon testing, Dr. Edwards opined that Plaintiff's attention and  
9 concentration were adequate for basic tasks that required less  
10 sustained concentration, she had deficits in several memory functions,  
11 difficulty identifying abstract problems, and "clear" discrepancies in  
12 her cognitive functioning with deficits in auditory/verbal processing,  
13 as well as working and delayed memory functioning (A.R. 383-85). Dr.  
14 Edwards further opined that Plaintiff's performance on measures of  
15 intellectual functioning was suppressed as a result of other factors,  
16 such as pain and depressed mood (A.R. 384-85). Dr. Edwards diagnosed  
17 Plaintiff with Panic Disorder without Agoraphobia and Major Depressive  
18 Disorder, Recurrent, Moderate (A.R. 386). Dr. Edwards believed that  
19 Plaintiff could function appropriately in most situations, but that  
20 Plaintiff's condition likely would interfere with sustained activity  
21 in more demanding situations (A.R. 385). He ultimately opined that  
22 Plaintiff would have moderate limitation: (1) understanding,  
23 remembering, and carrying out complex job instructions;  
24 (2) maintaining attention, concentration, persistence, and pace;  
25 (3) maintaining regular work attendance and performing work activities  
26 on a consistent basis; (4) making judgments on complex work-related  
27 decisions; and (5) responding appropriately to usual work situations  
28 and to changes in a routine work setting (A.R. 386-88). According to

1 Dr. Edwards, Plaintiff would have mild limitations relating to  
2 supervisors, coworkers, and the public, and accepting instructions  
3 from supervisors (A.R. 386, 388). Dr. Edwards opined that Plaintiff  
4 would have no limitation in performing work activities without special  
5 or additional supervision for simple job instructions, and no  
6 limitations understanding, remembering, and carrying out simple  
7 instructions (A.R. 386-87). Dr. Edwards did not opine concerning  
8 Plaintiff's social functioning.

9  
10 A CT study of Plaintiff's head from June 7, 2011 (which predated  
11 Dr. Edwards' evaluation but was not part of his record review),  
12 suggested mild volume loss, nonspecific mild periventricular white  
13 matter hypodensities which may represent chronic microvascular  
14 ischemic process, and bilateral basal ganglia hypodensities where  
15 "[d]ifferential includes prominent perivascular space versus lacunes"  
16 (A.R. 375-76).

17  
18 On February 8, 2012, Plaintiff presented with complaints of  
19 confusion (A.R. 724-28). A MRI of Plaintiff's brain from March 10,  
20 2012, showed nonspecific bilateral periventricular white matter signal  
21 changes, mild volume loss, and bilateral paranasal sinus disease (A.R.  
22 657). Plaintiff's doctors described her condition as entailing  
23 "cerebrovascular disease" (i.e., a disease of the blood vessels that  
24 supply the brain, usually caused by atherosclerosis which can lead to  
25 stroke) (A.R. 667). See Definition of Cerebrovascular Disease  
26 (available online at [http://www.medterms.com/script/main/  
27 art.asp?articlekey=40116](http://www.medterms.com/script/main/art.asp?articlekey=40116) (last visited Sept. 16, 2014)). A March 15,  
28 2012 treatment note from Neurologist Yuri Bronstein assessed Plaintiff

1 with memory loss, but stated that her cognitive testing was within the  
2 "broad spectrum of normal" (A.R. 695; see also A.R. 713-19 (treatment  
3 note from February 22, 2012, stating that Plaintiff also complained of  
4 vertigo and dizziness and ordering MRI study); A.R. 722 (March 8, 2012  
5 normal EEG study)). Dr. Bronstein recommended testing for multiple  
6 sclerosis and signs of inflammation or infection, and referred  
7 Plaintiff to neurology for a second opinion (A.R. 695).

8  
9 Dr. Roopa Bhat performed a neurological consultation on March 30,  
10 2012 (A.R. 668-72). Plaintiff complained of confusion and difficulty  
11 with recall, as well as vertigo since November 2011 (A.R. 668).  
12 Regarding Plaintiff's reported memory and concentration difficulties,  
13 Dr. Bhat believed that Plaintiff's mental status examination was  
14 normal, but could not rule out contribution of insomnia and anxiety  
15 disorder (A.R. 672). Dr. Bhat suggested neuropsychological testing  
16 (A.R. 672). Dr. Bhat also recommended further testing to evaluate  
17 Plaintiff for multiple sclerosis (A.R. 672).

18  
19 **II. The ALJ Erred in the Evaluation of the Treating Psychologist's**  
20 **Opinion.**

21  
22 Plaintiff argues, inter alia, that in determining her residual  
23 functional capacity, the ALJ improperly rejected the opinions of  
24 Plaintiff's treating psychologist, Dr. Swanson. See Plaintiff's  
25 Motion, pp. 5-7. The ALJ rejected Dr. Swanson's opinions based on:  
26 (1) the ALJ's belief that Dr. Swanson's "treatment history was quite  
27 brief . . . that [Plaintiff] initiated treatment with Dr. Swanson in  
28 March 2010 and was seen only two times"; (2) the ALJ's belief that Dr.

1 Swanson's opinions were not "formed" until one year after Dr. Swanson  
2 stopped treating Plaintiff; (3) the alleged inconsistency between Dr.  
3 Swanson's opinions and Plaintiff's reported daily activities; and  
4 (4) the asserted lack of objective support for Dr. Swanson's opinions  
5 (A.R. 33).

6  
7 A treating physician's conclusions "must be given substantial  
8 weight." Embrey v. Bowen, 849 F.2d 418, 422 (9th Cir. 1988); see  
9 Rodriguez v. Bowen, 876 F.2d 759, 762 (9th Cir. 1989) ("the ALJ must  
10 give sufficient weight to the subjective aspects of a doctor's  
11 opinion. . . . This is especially true when the opinion is that of a  
12 treating physician") (citation omitted); see also Orn v. Astrue, 495  
13 F.3d 625, 631-33 (9th Cir. 2007) (discussing deference owed to  
14 treating physician opinions). Even where the treating physician's  
15 opinions are contradicted,<sup>9</sup> as here, "if the ALJ wishes to disregard  
16 the opinion[s] of the treating physician he . . . must make findings  
17 setting forth specific, legitimate reasons for doing so that are based  
18 on substantial evidence in the record." Winans v. Bowen, 853 F.2d  
19 643, 647 (9th Cir. 1987) (citation, quotations and brackets omitted);  
20 see Rodriguez v. Bowen, 876 F.2d at 762 ("The ALJ may disregard the  
21 treating physician's opinion, but only by setting forth specific,  
22 legitimate reasons for doing so, and this decision must itself be  
23 based on substantial evidence") (citation and quotations omitted).

24 ///

25  
26  
27 <sup>9</sup> Rejection of an uncontradicted opinion of a treating  
28 Smolen v. Chater, 80 F.3d 1273, 1285 (9th Cir. 1996); Gallant v.  
Heckler, 753 F.2d 1450, 1454 (9th Cir. 1984).

1 An ALJ may discount treating physician opinions that are not  
2 adequately supported by clinical findings and objective medical  
3 evidence. See Batson v. Commissioner, 359 F.3d 1190, 1195 (9th Cir.  
4 2004); Connett v. Barnhart, 340 F.3d 871, 875 (9th Cir. 2003); Matney  
5 v. Sullivan, 981 F.2d 1016, 1019-20 (9th Cir. 1992). A limited  
6 treatment history is a proper consideration. See Benton v. Barnhart,  
7 331 F.3d 1030, 1038-39 (9th Cir. 2003) (duration of the treatment  
8 relationship and the frequency and nature of the contact deemed  
9 relevant in weighing medical opinion evidence); 20 C.F.R. §  
10 404.1527(c)(2) (factors to consider in weighing treating source  
11 opinion include the nature and length of treatment relationship, the  
12 frequency of examination, the supportability of the opinions by  
13 medical signs and laboratory findings, and the opinion's consistency  
14 with the record as a whole).

15  
16 In the present case, the ALJ rejected Dr. Swanson's opinions  
17 based in part on the ALJ's characterization of Plaintiff's treatment  
18 history as "quite brief" and as having involved Plaintiff seeing Dr.  
19 Swanson "only two times" (A.R. 33). The ALJ thereby mischaracterized  
20 the record. An ALJ's material mischaracterization of the record can  
21 warrant remand. See, e.g., Regennitter v. Commissioner, 166 F.3d  
22 1294, 1297 (9th Cir. 1999). As detailed above, the record reflects  
23 that Dr. Swanson saw Plaintiff on at least four different, specific  
24 dates. The record also contains other indications of significant  
25 treatment by Dr. Swanson over a considerable period of time. For  
26 months, Plaintiff reportedly saw Dr. Swanson "weekly," and thereafter  
27 tapered off to "approximately once every three to four weeks" (A.R.  
28 544). Drs. Halote and Gerson, whose observations also suggested that



1 Plaintiff had a more significant treatment history with Dr. Swanson  
2 than the ALJ found to exist, evidently saw treatment notes from Dr.  
3 Swanson that are not a part of the administrative record. It is  
4 unclear why Dr. Swanson's treatment notes were not made a part of the  
5 record. The record also seems to be devoid of the type of written  
6 requests the Administration often sends to treating providers in order  
7 to obtain medical records.

8  
9 "The ALJ has a special duty to fully and fairly develop the  
10 record and to assure that the claimant's interests are considered.  
11 This duty exists even when the claimant is represented by counsel."  
12 Brown v. Heckler, 713 F.2d 441, 443 (9th Cir. 1983); accord Garcia v.  
13 Commissioner, 2014 WL 4694798, at \*4 (9th Cir. Sept. 23, 2014); see  
14 also Sims v. Apfel, 530 U.S. 103, 110-11 (2000) ("Social Security  
15 proceedings are inquisitorial rather than adversarial. It is the  
16 ALJ's duty to investigate the facts and develop the arguments both for  
17 and against granting benefits. . . ."); Widmark v. Barnhart, 454 F.3d  
18 1063, 1068 (9th Cir. 2006) (while it is a claimant's duty to provide  
19 the evidence to be used in making a residual functional capacity  
20 determination, "the ALJ should not be a mere umpire during disability  
21 proceedings") (citations and internal quotations omitted); Smolen v.  
22 Chater, 80 F.3d at 1288 ("If the ALJ thought he needed to know the  
23 basis of Dr. Hoeflich's opinions in order to evaluate them, he had a  
24 duty to conduct an appropriate inquiry, for example, by subpoenaing  
25 the physicians or submitting further questions to them. He could also  
26 have continued the hearing to augment the record.") (citations  
27 omitted). An ALJ's duty to develop the record is "especially  
28 important" "in cases of mental impairments." DeLorme v. Sullivan, 924

1 F.2d 841, 849 (9th Cir. 1991).

2  
3 As mentioned above, in rejecting Dr. Swanson's opinions, the ALJ  
4 relied in part on the supposedly limited treatment history (which the  
5 ALJ mischaracterized) and an assumed lack of objective evidence  
6 supporting Dr. Swanson's opinions. The ALJ should not have done so  
7 without first attempting to develop the record fully regarding  
8 Plaintiff's treatment history with Dr. Swanson and the bases for Dr.  
9 Swanson's opinions. See, e.g., Montgomery v. Astrue, 2012 WL 4848731,  
10 at \*5 (C.D. Cal. Oct. 11, 2012) ("It is unjust to fail to fully  
11 develop the record regarding these treatment notes and then rely on  
12 the lack of supporting treatment notes to reject the opinions of the  
13 treating sources.").

14  
15 The ALJ also relied in part on an asserted inconsistency between  
16 Plaintiff's reported daily activities and Dr. Swanson's opinions that  
17 Plaintiff would be moderately to markedly restricted in her daily  
18 activities and social functioning. See A.R. 33. A material  
19 inconsistency between a treating physician's opinion and a claimant's  
20 admitted level of daily activities can furnish a specific, legitimate  
21 reason for rejecting the treating physician's opinion. See, e.g.,  
22 Rollins v. Massanari, 261 F.3d 853, 856 (9th Cir. 2001). However, the  
23 only time Dr. Swanson opined regarding Plaintiff's specific work  
24 related limitations was on September 6, 2011,<sup>10</sup> following Plaintiff's  
25 report of having experienced difficulties leaving her house beginning  
26 in September of 2010. See A.R. 373, 391, 396 (Plaintiff's reported

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27  
28 <sup>10</sup> The record is uncertain regarding precisely when Dr.  
Swanson formed the opinions he expressed on September 6, 2011.

1 difficulties); see also A.R. 381 (Plaintiff's November 17, 2011 report  
2 to Dr. Edwards of impairment in activities of daily living).

3  
4 The function reports on which the ALJ apparently relied as  
5 assertedly inconsistent with Dr. Swanson's opinions significantly  
6 predate those opinions. In a function report dated August 4, 2010  
7 (more than a year before the expression of Dr. Swanson's opinions),  
8 Plaintiff's husband reported that Plaintiff went outside daily, drove,  
9 did the shopping, helped with cleaning, paid bills, played with and  
10 helped feed the pets and took them to the veterinarian, used the  
11 internet, watched television, read, and had no problem with her  
12 personal care (A.R. 173-74, 176-77). Plaintiff's husband reportedly  
13 prepared all the meals eaten at home (A.R. 175). He said Plaintiff  
14 was able to go to lunch or dinner with friends "from time to time"  
15 (A.R. 177). Plaintiff's husband then knew of no changes in  
16 Plaintiff's social activities since her condition began (A.R. 178).  
17 He stated at that time that she got along "fine" with authority  
18 figures (including bosses) (A.R. 179).

19  
20 In a document dated August 1, 2010, Plaintiff herself similarly  
21 reported that she was able to care for her personal needs, and that  
22 she watched television, used a computer to read and do research and  
23 played interactive games, fed, exercised and played with her animals,  
24 ran errands, occasionally ate lunch with friends, visited friends in  
25 person, via telephone and via computer daily, made phone calls, filled  
26 out paperwork, did light cleaning and laundry, and a few household  
27 repairs (A.R. 181-83, 185). Plaintiff then indicated she did not have  
28 any problems getting along with others and got along "very well" with

1 authority figures (including bosses) (A.R. 186-87).  
2

3 Plaintiff reported to the Agreed Medical Examiner on January 5,  
4 2011, that her husband had taken responsibility for most household  
5 chores (A.R. 547). She then estimated spending only an hour per month  
6 doing chores, but up to six hours per day using a computer and  
7 watching television (A.R. 547). Plaintiff then reportedly could  
8 attend to her activities of daily living and could drive without  
9 assistance (A.R. 547). In a face to face interview on January 19,  
10 2011, Plaintiff was observed to have trouble talking and answering  
11 questions and was described as "very jittery and nervous" and crying  
12 (A.R. 190-91). Yet, at approximately the same time, Plaintiff  
13 evidently did not report to an agreed medical examiner "any  
14 disturbance in her social functioning" (A.R. 559).  
15

16 Plaintiff's April 3, 2012 hearing testimony, if credible,<sup>11</sup>  
17 suggested that a significant deterioration in Plaintiff's daily  
18 activities and social functioning occurred in 2011 and 2012.  
19 Plaintiff testified that she was not able to work because she could  
20 not function or deal with people (i.e., people telling her what to do,  
21 interacting with people, having deadlines and having to work with  
22 people) (A.R. 55-56). As to household activities, Plaintiff said that  
23 her husband "does it all" (A.R. 58).  
24

25 Given the ALJ's failure to develop the record fully concerning  
26 the duration and nature of Dr. Swanson's treatment and the bases for  
27

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28 <sup>11</sup> The Court recognizes that the ALJ deemed Plaintiff's  
testimony "less than fully credible" (A.R. 29).

1 Dr. Swanson's opinions, the Court is unable to conclude that the  
2 inconsistencies between Plaintiff's earlier reported activities of  
3 daily living and social functioning and Dr. Swanson's later opinions  
4 furnish a legitimate reason for rejecting Dr. Swanson's opinions.  
5 Significantly, many if not most mental impairments are progressive in  
6 nature. See Blankenship v. Bowen, 874 F.2d 1116, 1121-22 (6th Cir.  
7 1989), cited with approval in Morgan v. Sullivan, 945 F.2d 1079, 1082-  
8 83 (9th Cir. 1991).

9  
10 The Court is unable to deem the ALJ's errors to have been  
11 harmless. See Garcia v. Commissioner, 2014 WL 4694798, at \*6-7;  
12 McLeod v. Astrue, 640 F.3d 881, 888 (9th Cir. 2011); Tommasetti v.  
13 Astrue, 533 F.3d 1035, 1038 (9th Cir. 2008). Because the  
14 circumstances of this case suggest that further administrative review  
15 could remedy the ALJ's errors, remand is appropriate. McLeod v.  
16 Astrue, 640 F.3d at 888; see generally INS v. Ventura, 537 U.S. 12, 16  
17 (2002) (upon reversal of an administrative determination, the proper  
18 course is remand for additional agency investigation or explanation,  
19 except in rare circumstances).<sup>12</sup>

20 ///

21 ///

22  
23 <sup>12</sup> There are outstanding issues that must be resolved  
24 before a proper disability determination can be made in the  
25 present case. For example, it is not clear whether the ALJ would  
26 be required to find Plaintiff disabled for the entire claimed  
27 period of disability even if Dr. Swanson's opinions were fully  
28 credited. See Luna v. Astrue, 623 F.3d 1032, 1035 (9th Cir.  
2010). For at least this reason, the Ninth Circuit's decision in  
Harman v. Apfel, 211 F.3d 1172 (9th Cir.), cert. denied, 531 U.S.  
1038 (2000), does not compel a reversal for the immediate payment  
of benefits.

1 **CONCLUSION**

2  
3 For all of the foregoing reasons,<sup>13</sup> Plaintiff's and Defendant's  
4 motions for summary judgment are denied and this matter is remanded  
5 for further administrative action consistent with this Opinion.  
6

7 LET JUDGMENT BE ENTERED ACCORDINGLY.  
8

9 DATED: October 1, 2014.  
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11 \_\_\_\_\_/s/\_\_\_\_\_  
12 CHARLES F. EICK  
13 UNITED STATES MAGISTRATE JUDGE  
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24 \_\_\_\_\_  
25 <sup>13</sup> The Court has not reached any other issue raised by  
26 Plaintiff except insofar as to determine that reversal with a  
27 directive for the immediate payment of benefits would not be  
28 appropriate at this time. "[E]valuation of the record as a whole  
creates serious doubt that [Plaintiff] is in fact disabled."  
See Garrison v. Colvin, 759 F.3d 995, 1021 (9th Cir. 2014).