IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO
Judge R. Brooke Jackson

Civil Action No. 16-cv-01341-RBJ

RYAN MICHAEL SPICKARD,

Plaintiff,

v.

NANCY A. BERRYHILL,[*] Acting Commissioner of the Social Security Administration,

Defendant.

ORDER REVERSING AND REMANDING THE COMMISSIONER'S DECISION

This matter is before the Court on review of the Social Security Administration Commissioner's decision denying claimant Ryan M. Spickard's application for Supplemental Security Income ("SSI") under Title XVI of the Social Security Act. Jurisdiction is proper under 42 U.S.C. § 405(g). For the reasons explained below, the Court reverses and remands the Commissioner's decision.

STANDARD OF REVIEW

This appeal is based upon the administrative record and the parties' briefs. In reviewing a final decision by the Commissioner, the District Court examines the record and determines whether it contains substantial evidence to support the Commissioner's decision and whether the Commissioner applied the correct legal standards. *Winfrey v. Chater*, 92 F.3d 1017, 1019 (10th

[*] In accordance with Rule 25(d) of the Federal Rules of Civil Procedure, Nancy A. Berryhill is substituted for Carolyn W. Colvin as the Acting Commissioner of the Social Security Administration.

Cir. 1996). A decision is not based on substantial evidence if it is "overwhelmed by other evidence in the record." *Bernal v. Bowen*, 851 F.2d 297, 299 (10th Cir. 1988). Substantial evidence requires "more than a scintilla, but less than a preponderance." *Wall v. Astrue*, 561 F.3d 1048, 1052 (10th Cir. 2009). Evidence is not substantial if it "constitutes mere conclusion." *Musgrave v. Sullivan*, 966 F.2d 1371, 1374 (10th Cir. 1992). Reversal may also be appropriate if the Commissioner applies an incorrect legal standard or fails to demonstrate that the correct legal standards have been followed. *Winfrey*, 92 F.3d at 1019.

BACKGROUND

Mr. Spickard was born in 1979 and is now 38 years old. *See* R. 170. He is a high school dropout, quitting after tenth grade when he began to display symptoms of a psychological disorder. R. 175, 217, 285. After leaving high school he worked brief stints in a restaurant and a hospital, but he was unable to hold a job because of his mental health issues. R. 180, 217, 277. He has not worked in the twenty years since then. R. 164–65, 175.

In 2001 Mr. Spickard was hospitalized for a psychotic experience and was diagnosed with schizophrenia, which doctors later characterized more precisely as schizoaffective disorder. R. 217, 281. Not long afterward he was found to be disabled and was awarded Supplemental Security Income benefits. *See* R. 170, 276. To help manage his symptoms, he began self-medicating by smoking marijuana regularly in addition to taking his prescription medications. R. 286.

In roughly January 2009 Mr. Spickard stopped taking his medications—including, at one time or another, Abilify, Ativan, Celexa, Geodon, Lamictal, Paxil, Prozac, Risperdal, Xanax, Zoloft, and Zyprexa—because he found them ineffective and did not think they were worth their

negative side effects. *See* R. 218, 285, 297, 375–76, 384. Later that year, in October 2009, he attempted suicide and was admitted to a hospital. R. 373, 376. He was discharged within days and prescribed Valium, but he stopped taking it after about a month because he developed a tolerance to its effects. R. 368, 382. A few months later he readmitted himself to the hospital after suffering severe panic attacks. R. 368. He began to take Zoloft around this time, but discontinued all medication again at some point in 2010. *See* R. 285, 366.

Still off his medications, Mr. Spickard was incarcerated on charges of arson, burglary, and trespass in October 2011. R. 284, 286. His disability benefits were terminated at this time due to his incarceration status. *See* R. 172. In March 2012 he was evaluated by a psychologist and was found incompetent to stand trial. R. 291. He was reevaluated in June 2012 and was again found mentally incompetent. R. 400. He was then committed to a psychiatric hospital, apparently released, and readmitted in August 2012. *See* R. 387, 395. There he participated in structured group therapy and began taking the antipsychotic drug Latuda. R. 389–90. After a month of treatment he was found competent to stand trial and was discharged from the hospital. R. 394, 402.

Mr. Spickard has been compliant with his mental health treatment since then. *See* R. 292–346. He has not used marijuana since he got arrested in 2011. R. 47. He now lives with his father and spends most of his time just "sitting at home." R. 43, 186.

A. Procedural History.

On April 25, 2013 Mr. Spickard reapplied for Supplemental Security Income, alleging disability beginning March 1, 2001. R. 170. The claim was initially denied on July 16, 2013. R. 82. Mr. Spickard requested a hearing, which was held in front of Administrative Law Judge

("ALJ") Patricia E. Hartman on May 29, 2014. R. 36. The ALJ issued a decision denying benefits on August 1, 2014. R. 23–31. The Appeals Council denied Mr. Spickard's request for review on March 30, 2016, rendering the ALJ's determination the final decision of the Commissioner for purposes of judicial review. R. 1. Mr. Spickard then filed a timely appeal in this Court.

B. The ALJ's Decision.

The ALJ issued an unfavorable decision after evaluating the evidence according to the Social Security Administration's standard five-step process. First, she found that Mr. Spickard had not engaged in substantial gainful activity since April 25, 2013, his application date. R. 25. At step two, the ALJ found that Mr. Spickard had the severe impairments of schizoaffective disorder, posttraumatic stress disorder ("PTSD"), and cannabis dependence.[1] R. 25. At step three, the ALJ concluded that Mr. Spickard did not have an impairment or combination of impairments that met or medically equaled the severity of one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1. R. 25–26.

The ALJ then found that Mr. Spickard retained the residual functional capacity ("RFC") to perform a full range of work at all exertional levels subject to the following nonexertional restrictions: he is limited to unskilled work involving simple, routine, and repetitive tasks; he cannot work at unprotected heights or with dangerous unprotected machinery; he cannot work at

[1] The ALJ's reference to cannabis dependence is confusing because Mr. Spickard stopped using the drug a year and a half before he applied for Supplemental Security Income, *see* R. 47, and his treatment notes last mention his addiction in remission two years before the ALJ rendered her decision, *see* R. 293–310, 317–45. In any event, this outdated diagnosis seems to have had no bearing on the ALJ's conclusion that Mr. Spickard was not disabled. *See* R. 25–31.

a production-rate pace (e.g., on an assembly line); and he can occasionally interact with supervisors and coworkers, but he cannot interact with the public as part of his job. R. 26–29.

At step four, the ALJ concluded that Mr. Spickard had no past relevant work. R. 30. At step five, she determined that there were jobs that existed in significant numbers in the national economy Mr. Spickard could perform. R. 30. Accordingly, the ALJ concluded that Mr. Spickard was not disabled. R. 31.

DISCUSSION

In essence, Mr. Spickard contends that the ALJ improperly weighed Dr. Wanstrath's and Dr. Rosenblum's opinions and erroneously found his subjective complaints not fully credible. The Court will address each issue in turn.

A. Weighing Opinions.

The ALJ gave "great weight" to Dr. Wanstrath's opinion and only "partial weight" to Dr. Rosenblum's opinion. R. 26, 29. Mr. Spickard takes issue with the ALJ's evaluation of these two opinions on the grounds that the ALJ misapplied the relevant legal standards and failed to base her assessment in substantial evidence.

Both psychologists are acceptable medical sources, so their opinions must be weighed with regard to the following six factors:

- The examining relationship between the individual and the "acceptable medical source";
- The treatment relationship between the individual and a treating source, including its length, nature, and extent as well as frequency of examination;
- The degree to which the "acceptable medical source" presents an explanation and relevant evidence to support an opinion, particularly medical signs and laboratory findings;
- How consistent the medical opinion is with the record as a whole;

- Whether the opinion is from an "acceptable medical source" who is a specialist and is about medical issues related to his or her area of specialty; and
- Any other factors brought to our attention, or of which we are aware, which tend to support or contradict the opinion.

Social Security Ruling (SSR) 06-03p, 2006 WL 2329939, at *3 (Aug. 9, 2006) (summarizing 20 C.F.R. § 416.927(c)).

Under the *Chenery* doctrine, the Court may not accept a *post hoc* rationalization for the ALJ's decision that is not clear from the decision itself. *Grogan v. Barnhart*, 399 F.3d 1257, 1263 (10th Cir. 2005). It follows from this principle that "[a]lthough the ALJ's decision need not include an *explicit discussion* of each factor, the record must reflect that the ALJ *considered* every factor in the weight calculation." *Andersen v. Astrue*, 319 F. App'x 712, 718 (10th Cir. 2009) (unpublished) (citation omitted). "The decision must articulate the ALJ's reasoning such that later reviewers can identify both the weight that was actually assigned to the opinion and the reasons for that weight." *Id.* at 719. In reviewing the decision, the Court may not reweigh the evidence or displace the ALJ's choice between two fairly conflicting views. *Oldham v. Astrue*, 509 F.3d 1254, 1257–58 (10th Cir. 2007).

1. Dr. Wanstrath's opinion.

On July 15, 2013 Dr. Wanstrath completed a Mental RFC Assessment for Mr. Spickard. R. 76–77. After reviewing several medical records, Dr. Wanstrath concluded that Mr. Spickard was only "moderately" limited in his ability (1) 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; (2) to accept instructions and

respond appropriately to criticism from supervisors; and (3) to maintain socially appropriate behavior and adhere to basic standard of neatness and cleanliness. *Id.*

The ALJ recited Dr. Wanstrath's opinion and then afforded it "great weight" because the opinion was "consistent with the record as a whole" and Dr. Wanstrath had a thorough understanding of the Social Security Administration's disability programs and their evidentiary requirements, though he never examined Mr. Spickard in person. R. 26, 29. The ALJ thus appears to have applied the appropriate factors in weighing Dr. Wanstrath's opinion.

However, there is insubstantial evidence for the view that Dr. Wanstrath's opinion is consistent with the record as a whole. The ALJ cites as relevant evidence: (1) that Mr. Spickard engaged in "normal daily activities"; (2) that he "can function fairly well when he is compliant with treatment"; and (3) that he received "treatment that has been essentially routine and/or conservative in nature, with no indication of any need for more frequent or aggressive treatment." R. 28–29.

To the extent that the ALJ relied on Mr. Spickard's "normal" daily activities, her decision is flawed because she failed to articulate any reason that this evidence might support Dr. Wanstrath's opinion. The ALJ instead simply labeled Mr. Spickard's daily activities as "normal" and listed them as follows:

> [T]he claimant reported attending to his own personal needs and hygiene, preparing meals, performing household chores, yard work including mowing the lawn, and household repairs such as fixing the yard fence. He can handle finances, go out to eat, and go to movies, fishing, playing frisbee golf, and daily walks. He spends time on his computer engaging in role-playing and computer games. He enjoys art, writing, reading, and comics, and takes care of his dog.

R. 28–29. But Mr. Spickard's taking care of chores, leaving the house for specific purposes, and enjoying solitary hobbies have no obvious connection with the symptoms of his schizoaffective

disorder or PTSD. In fact, Social Security Administration guidance explains that there may be no connection at all because "[i]ndividuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function well." SSR 85-15, 1985 WL 56857, at *6 (1985).

At most, Mr. Spickard's activities outside his home might call into question his level of anxiety, but the ALJ seriously exaggerates the nature of these activities. Mr. Spickard eats at a restaurant "[m]aybe once or twice a year"; he ventures out to the movies "[m]aybe once a year"; he goes fishing with his father "[a] couple of times a year"; and he mentioned playing Frisbee golf with his mother once. *See* R. 51–52, 324. These are not daily activities by any stretch of the imagination. And while Mr. Spickard regularly goes on short walks, he does so at the recommendation of his treatment provider. *See* R. 303, 319. By contrast, the record repeatedly notes that he spends most of his time at home to avoid the stresses of the outside world. *See, e.g.*, R. 303, 305, 307, 319, 322, 324.

Moreover, the record as a whole contradicts the ALJ's conclusions about the effectiveness and aggressiveness of Mr. Spickard's treatment. In particular, the treatment records Dr. Wanstrath did not have the chance to review undercut his opinion that Mr. Spickard's functioning is not more restricted. These records comprise the only medical evidence on file for most of the year leading up to the ALJ's decision, so they are highly probative and are worth examining in detail.

On August 22, 2013, one month after Dr. Wanstrath issued his opinion, Mr. Spickard's treatment notes indicated that he experienced some "minor" visual hallucinations for the first time since he was unmedicated in 2012. *Compare* R. 332, *with* R. 287–310. His psychiatric

nurse practitioner also noted that Mr. Spickard had been having more anxiety since he started driving his father to appointments. R. 332. Although the nurse previously advised Mr. Spickard to try decreasing his intake of the antianxiety drug clonazepam, she recommended resuming his full dosage. R. 331–33.

At the next appointment the nurse wrote that Mr. Spickard had to decrease his intake of Latuda because he was "more agitated" on a higher dose. R. 330. She also noted that Mr. Spickard's mother "[t]hinks meds are keeping [him] fairly stable as long as there isn't too much stress in his life." R. 330.

A month and a half later Mr. Spickard reported feeling "a little more comfortable driving," but he had "some severe depression" and his anxiety was "sometimes 'very bad.'" R. 328. He was now experiencing some auditory hallucinations as well when he felt anxious, another return of symptoms that he had not experienced since 2012. *Compare* R. 328, *with* R. 287–310. He also reported his anxiety worsening after taking his medication every day at 2 p.m. and he described having nightmares and flashbacks from being in jail, seemingly a symptom of his PTSD. *See* R. 328. The nurse increased his clonazepam dosage from twice a day to three times a day and prescribed prazosin for his nightmares. R. 327.

Mr. Spickard continued to report heightened anxiety in the late afternoon and evening a month later so the nurse again strengthened his prescription, this time by adding the antianxiety drug buspirone to avoid increasing his already strong clonazepam prescription. R. 325–26. She also doubled his prazosin dosage. *See id.*

At the following appointment Mr. Spickard continued to report nightmares, prompting the psychiatric nurse practitioner to more than double his prazosin prescription once again. *See*

R. 323–24. Mr. Spickard found the buspirone ineffective at low doses but he became dizzy at higher doses, so the nurse discontinued this prescription. *See id.* Mr. Spickard also reported that he was still experiencing visual and auditory hallucinations but they were not "intrusive" and he could tell that they were not real. R. 324.

Six weeks later Mr. Spickard's nurse noted that despite his medications he "has had more anxiety and depression." R. 322. His mother attended the appointment and expressed her view that Mr. Spickard "has been regressing and not staying steady." *Id.* Even the heightened dose of prazosin had not helped Mr. Spickard's nightmares and his mother complained that he was "getting off track" with sleep—staying up late and sleeping in during the day. *Id.* The nurse increased his citalopram prescription "to address depression and anxiety" and discontinued prazosin since it was not effective. R. 321.

The following treatment notes indicated that Mr. Spickard "became more agitated, anxious and unable to sleep" a week into the increase in citalopram, but he dutifully continued taking the high dose anyway. R. 319. The nurse instructed Mr. Spickard to wean off the drug and begin switching over to paroxetine (Paxil) for his depression and anxiety, which he had used previously and was "[w]illing to try again." R. 319–20.

In the last notes on file Mr. Spickard's mother complained that he "is up all night and sleeps in the day." R. 317. The nurse explained that Mr. Spickard had developed a bad habit, and she recommended adding Seroquel XR for "his depression, continued hallucinations and sleep problems." R. 317–18. Mr. Spickard refused this drug in the past, but he reluctantly agreed to try it. R. 317.

These treatment notes directly refute the ALJ's understanding of the record. Instead of showing effective, conservative treatment with mild side effects, R. 28–29, the record reflects symptoms of depression, anxiety, hallucinations, and sleeplessness persisting in spite of increasingly aggressive treatment. The ALJ overlooks this conclusion by picking through the record selectively. She summarizes Mr. Spickard's treatment history in three stages by writing that his October 2012 treatment notes "show no complaints that would suggest a need for change in dosage or frequency," the following records through July 2013 indicate that Mr. Spickard had "only moderate symptoms" for half a year, and the remaining records from August 2013 to April 2014 include mental status examinations that were "fairly normal" because, among other things, Mr. Spickard was "neatly groomed," held "direct eye contact," and used "normal speech." R. 28. But between October 2012 and April 2014 Mr. Spickard's prescription increased twelve times, *see* R. 298, 300, 302, 304, 306, 318, 320, 321, 323, 325, 327, 331; his brief period of "only moderate symptoms" included "'lots' of panic and depression," "[f]eel[ing] so anxious" he wanted to "[h]it [his] head against a wall," "crying . . . because he felt so awful," "panic attacks daily," and "[s]leeping 12 hours at night and napping for 2 in [the] day," followed by "no improvement in energy or motivation," R. 299, 301, 303, 307, 309; and, as discussed above, treatment notes beginning in August 2013 show symptoms relapsing and resisting treatment, *see* R. 317–32.

The ALJ may not pick and choose evidence from medical records in this manner, "using only those parts that are favorable to a finding of nondisability." *Robinson v. Barnhart*, 366 F.3d 1078, 1083 (10th Cir. 2004). Rather, to find support in substantial evidence the ALJ's discussion must address the evidence supporting her decision as well as "significantly probative evidence

[she] rejects." *Clifton v. Chater*, 79 F.3d 1007, 1010 (10th Cir. 1996). Therefore, on remand the ALJ should reevaluate whether Dr. Wanstrath's opinion is truly consistent with the record as a whole in light of the discussion above.[2] The ALJ should also use this opportunity to consider medical records from the relevant time period that were not available when she issued her decision. *See* R. 386–427.

2. Dr. Rosenblum's opinion.

On May 23, 2014, ten months after Dr. Wanstrath gave his opinion, Dr. Rosenblum prepared a report summarizing the results of his examination of Mr. Spickard and his opinion about Mr. Spickard's limitations. R. 348–57. In Dr. Rosenblum's opinion, Mr. Spickard's mental health issues severely impair his ability to complete a normal workday without unreasonable rest periods, maintain attention and concentration for extended periods, get along with supervisors and coworkers, respond appropriately to changes in the workplace, and carry out instructions. R. 349. The ALJ afforded Dr. Rosenblum's opinion only "partial weight" for two overarching reasons.

First, the ALJ judged Dr. Rosenblum's opinion to be inconsistent with the record as a whole. R. 29. She explained that Mr. Spickard's subjective reports to Dr. Rosenblum "appear exaggerated" because "progress notes from treating providers do not show such level of complaints" and these prior treatment records "do not support the GAF score of 40 which the claimant portrayed during the examination." R. 29.

[2] Of course, "[t]he regulations contemplate a briefer explanation if the decision is fully favorable and the opinion in question is of marginal importance to that decision." *Andersen*, 319 F. App'x at 719 n.3 (citing SSR 96-2p, 1996 WL 374188, at *5 (July 2, 1996)).

Although the ALJ correctly applied the law in considering the consistency of Dr. Rosenblum's opinion with Mr. Spickard's medical record, she erred in concluding that the opinion was inconsistent with the record. At the outset, the ALJ's discussion of the record misrepresents Mr. Spickard's treatment history for the reasons described above, tainting her evaluation of Dr. Rosenblum's opinion as well. *See supra* Part A.1.

The specific reasons given for finding Dr. Rosenblum's opinion inconsistent with the record do not withstand scrutiny either. Contrary to the ALJ's conclusion, Dr. Rosenblum's tests do appear to reflect a level of complaints similar to the progress notes from Mr. Spickard's treatment providers. For example, on an anxiety test Mr. Spickard reported to Dr. Rosenblum that most or all of the time he "feel[s] more nervous and anxious than usual," "feel[s] afraid for no reason at all," and "get[s] upset easily or feel[s] panicky." R. 354. While these check-the-box responses were more specific than some of his treatment notes, his psychiatric nurse practitioner similarly noted that Mr. Spickard had said he "[f]eels so anxious [he] wants to 'Hit my head against a wall'" and that he had "panic attacks daily." R. 299, 301. Likewise, Mr. Spickard's depression test indicated that he did not "get real satisfaction out of anything anymore" and that he had "to push [himself] very hard to do anything," R. 356, while he told his regular provider he was sleeping for 14 hours a day because he was "not feeling motivated or having the energy to do much," R. 303. Mr. Spickard's complaints to Dr. Rosenblum thus appear to be largely consistent with his complaints to his regular treatment provider.

The ALJ's other reason for finding inconsistency here—that prior treatment records do not prospectively support Dr. Rosenblum's finding a GAF score of 40 in May 2014—does not make sense. Mr. Spickard's medical records include GAF scores of 35-40, 40, 40-45, 45, 50, 55,

and 60. *See, e.g.*, 219, 281, 294, 302, 338, 368, 377. As discussed above, Mr. Spickard's most recent treatment notes observe him "regressing" and document persistent depression, anxiety, hallucinations, and insomnia despite increasingly aggressive treatment. *See* R. 317–32. Although these records did not assign Mr. Spickard a GAF score, that does not mean they preclude a score on the low end of Mr. Spickard's historical range. If anything, the changes detailed in these records indicate that the last GAF score of 60 that Mr. Spickard received in 2013 may have been stale by the time the ALJ issued her decision in mid-2014.

Second, the ALJ gave Dr. Rosenblum's opinion little weight because it "has an implied bias as this examination was at the request of the claimant's representative." R. 29. But this logic runs afoul of the Social Security Administration's regulations. The ALJ cannot rationally accept "the reports of [a psychologist] employed and paid by the government for the purpose of defending against a disability claim" when she is not willing to accept the same from a psychologist employed by a claimant for the purpose of supporting a disability claim. *Frey v. Bowen*, 816 F.2d 508, 513 (10th Cir. 1987) (quoting *Turner v. Heckler*, 754 F.2d 326, 329 (10th Cir. 1985)). The reason an acceptable medical source offers an opinion thus cannot be considered a factor "which tend[s] to support or contradict the medical opinion" or else ALJs would have to systematically discount the opinions of the agency's medical and psychological consultants—like Dr. Wanstrath. *See* 20 C.F.R. § 416.927(c)(6). And because a claimant bears the burden of establishing his or her RFC, such a rule would disadvantage all claimants who seek to provide more evidence of their disabilities, undermining the Social Security Administration's nonadversarial decisionmaking process. *See* 20 C.F.R. § 416.1400(b). This consideration is therefore prohibited by law.

Additionally, the ALJ's decision does not indicate that she considered the fact that Dr. Rosenblum actually examined Mr. Spickard, which would tend to warrant giving more weight to Dr. Rosenblum's opinion relative to that of Dr. Wanstrath. *See* 20 C.F.R. § 416.927(c)(1); *see also Robinson*, 366 F.3d at 1084 ("The opinion of an examining physician is generally entitled to less weight than that of a treating physician, and the opinion of an agency physician who has never seen the claimant is entitled to the least weight of all."); *Allison v. Heckler*, 711 F.2d 145, 147–48 (10th Cir. 1983) ("The general rule is that the written reports of medical advisors who have not personally examined the claimant deserve little weight in the overall evaluation of disability." (internal quotation marks omitted)).

Last, the decision does not reflect that the ALJ considered that Dr. Rosenblum "present[ed] relevant evidence" from psychological tests to support his opinion, which would also warrant giving his opinion more weight. 20 C.F.R. § 416.927(c)(3).

On remand the ALJ should reevaluate whether Dr. Rosenblum's opinion is consistent with the record as a whole in light of the discussion above. The ALJ should also make sure to apply the factors listed in 20 C.F.R. § 416.927(c)—and only those factors—in weighing Dr. Rosenblum's opinion, and her decision should reflect that she considered every relevant factor in calculating the weight she gives this opinion.

B. Subjective Symptom Evaluation.

When assessing a claimant's subjective complaints, an ALJ must consider the objective medical evidence that may correlate with these symptoms, opinions from acceptable medical sources, and other relevant evidence, including: (1) the claimant's daily activities; (2) the location, duration, frequency, and intensity of symptoms; (3) precipitating and aggravating

factors; (4) the type, dosage, effectiveness, and side effects of any medication taken; (5) treatment other than medication; (6) any measures used to relieve symptoms; and (7) any other factors concerning functional limitations. 20 C.F.R. § 416.929(c). This credibility determination "does not require a formalistic factor-by-factor recitation of the evidence . . . [s]o long as the ALJ sets forth the specific evidence [she] relies on in evaluating the claimant's credibility." *Qualls v. Apfel*, 206 F.3d 1368, 1372 (10th Cir. 2000).

Following these guidelines, the ALJ found Mr. Spickard's subjective complaints concerning the intensity, persistence, and limiting effects of his schizoaffective disorder and PTSD not entirely credible. She based this determination on Mr. Spickard's activities of daily living, the effectiveness of medication in treating his symptoms, and Dr. Wanstrath's and Dr. Rosenblum's opinions about his limitations. R. 28–29. But for the reasons provided above, this explanation does not justify the ALJ's credibility determination. Specifically, the ALJ's analysis of Mr. Spickard's daily activities, his medical treatment, and the two psychologists' opinions is not supported by substantial evidence. *See supra* Part A. Furthermore, the ALJ failed to "explain why the specific evidence . . . led [her] to conclude claimant's subjective complaints were not credible." *Hardman v. Barnhart*, 362 F.3d 676, 679 (10th Cir. 2004) (quoting *Kepler v. Chater*, 68 F.3d 387, 391 (10th Cir. 1995)). In other words, "the link between the evidence and credibility determination is missing." *Kepler*, 68 F.3d at 391.

On remand, the ALJ's subjective symptom evaluation should be "closely and affirmatively linked" to substantial evidence in the record by correcting the inaccurate description of Mr. Spickard's daily activities and medical treatment, properly evaluating the

medical opinions of record, and explicitly connecting the discussion of this evidence to his reported symptoms.

ORDER

For the reasons described above, the Court REVERSES and REMANDS the Commissioner's decision denying claimant Ryan M. Spickard's application for Supplemental Security Income.

DATED this 20th day of July, 2017.

BY THE COURT:

R. Brooke Jackson
United States District Judge