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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

JEFFREY D. DYKES,

Plaintiff,

v.

NANCY A. BERRYHILL, Acting
Commissioner of Social Security,

Defendant.

CASE NO. C16-5649-MAT

ORDER RE: SOCIAL SECURITY
DISABILITY APPEAL

Plaintiff Jeffrey Dykes proceeds through counsel in his appeal of a final decision of the Commissioner of the Social Security Administration (Commissioner). The Commissioner denied plaintiff's application for Supplemental Security Income (SSI) after a hearing before an Administrative Law Judge (ALJ). Having considered the ALJ's decision, the administrative record (AR), and all memoranda, this matter is REMANDED for further proceedings.

FACTS AND PROCEDURAL HISTORY

Plaintiff was born on XXXX, 1966.¹ He reached the tenth grade of high school, attending special education classes, did not obtain his GED, and worked in a variety of different jobs. (AR 36-37, 71-72, 584-86.)

¹ Dates of birth must be redacted to the year. Fed. R. Civ. P. 5.2(a)(2) and LCR 5.2(a)(1).

1 Plaintiff protectively filed his SSI application on October 5, 2009, alleging disability as of
2 October 1, 2001. (AR 154.) The application was denied initially and on reconsideration.

3 On June 16, 2011, ALJ Catherine Lazuran held a hearing, taking testimony from plaintiff
4 and a vocational expert (VE). (AR 31-81.) In a decision dated August 26, 2011, ALJ Lazuran
5 denied plaintiff's claim. (AR 604-13.) Plaintiff timely appealed and the Appeals Council denied
6 review (AR 619), making the ALJ's decision the final decision of the Commissioner.

7 Plaintiff requested review in this Court and the parties stipulated to a remand. (AR 624-
8 41.) The Appeals Council vacated the decision and remanded to an ALJ. (AR 643-45.) Among
9 other issues identified, the Appeals Council indicated any evidence relied on from any prior
10 claim(s) for disability benefits must be made part of the record and proffered to the claimant.²

11 ALJ Jo Hoenninger held a hearing on January 22, 2015, taking testimony from plaintiff.
12 (AR 892-949.) In another hearing on October 29, 2015, the ALJ took testimony from a VE. (AR
13 580-600.) ALJ Hoenninger, in a decision dated December 10, 2015, concluded plaintiff had not
14 been under a disability since the October 5, 2009 application date. (AR 503-24.) *See* 20 C.F.R. §
15 416.335 (SSI is not payable prior to the month following the month of the application.)

16 Plaintiff timely appealed. The Appeals Council denied plaintiff's request for review on
17 May 18, 2016 (AR 486-88), and plaintiff appealed to this Court.

18 **JURISDICTION**

19 The Court has jurisdiction to review the ALJ's decision pursuant to 42 U.S.C. § 405(g).

20 **DISCUSSION**

21 The Commissioner follows a five-step sequential evaluation process for determining
22 whether a claimant is disabled. *See* 20 C.F.R. §§ 404.1520, 416.920 (2000). At step one, it must
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² A previous SSI claim was denied in January 2007 and is administratively final. (AR 504.)

1 be determined whether the claimant is gainfully employed. The ALJ found plaintiff had not
2 engaged in substantial gainful activity since the October 5, 2009 application date. At step two, it
3 must be determined whether a claimant suffers from a severe impairment. The ALJ found severe
4 plaintiff's degenerative disc disease with lumbar strain, chronic obstructive pulmonary disease
5 (COPD), and major depressive disorder with psychotic features. Step three asks whether a
6 claimant's impairments meet or equal the criteria of a listed impairment. The ALJ found plaintiff's
7 impairments did not meet or equal a listing.

8 If a claimant's impairments do not meet or equal a listing, the Commissioner must assess
9 residual functional capacity (RFC) and determine at step four whether the claimant has
10 demonstrated an inability to perform past relevant work. The ALJ found plaintiff able to perform
11 medium work, with the following limitations: lift, carry, push, and/or pull up to thirty pounds
12 occasionally and up to twenty pounds frequently; stand and/or walk one hour at a time, up to five
13 hours total in an eight-hour workday; sit without limitation; frequently stoop, kneel, crouch, and
14 crawl; understand and remember simple, but not detailed instructions; sufficient concentration,
15 persistence, and pace to complete simple, routine tasks in two-hour increments for normal workday
16 and workweek; would likely need additional supervision and encouragement during the first few
17 weeks of a job, but not thereafter; and should not work around the general public, but can work
18 around a small number of coworkers. The ALJ found insufficient information to make a finding
19 about past relevant work at step four.

20 If a claimant demonstrates an inability to perform past relevant work, or has no past
21 relevant work, the burden shifts to the Commissioner to demonstrate at step five that the claimant
22 retains the capacity to make an adjustment to work that exists in significant levels in the national
23 economy. With the assistance of the VE, the ALJ found plaintiff capable of performing other jobs,

1 such as work as a laboratory helper, hand packer, auto detailer, recycler/reclaimer, and price
2 marker.

3 This Court's review of the ALJ's decision is limited to whether the decision is in
4 accordance with the law and the findings supported by substantial evidence in the record as a
5 whole. *See Penny v. Sullivan*, 2 F.3d 953, 956 (9th Cir. 1993). *Accord Marsh v. Colvin*, 792 F.3d
6 1170, 1172 (9th Cir. 2015) ("We will set aside a denial of benefits only if the denial is unsupported
7 by substantial evidence in the administrative record or is based on legal error.") Substantial
8 evidence means more than a scintilla, but less than a preponderance; it means such relevant
9 evidence as a reasonable mind might accept as adequate to support a conclusion. *Magallanes v.*
10 *Bowen*, 881 F.2d 747, 750 (9th Cir. 1989). If there is more than one rational interpretation, one of
11 which supports the ALJ's decision, the Court must uphold that decision. *Thomas v. Barnhart*, 278
12 F.3d 947, 954 (9th Cir. 2002).

13 Plaintiff argues the ALJ erred in relying on evidence not in the record, in evaluating
14 medical opinions and his testimony, in assessing the RFC, and at step five. He requests remand
15 for further administrative proceedings. The Commissioner argues the ALJ's decision has the
16 support of substantial evidence and should be affirmed.

17 Medical Opinions

18 Plaintiff challenges the ALJ's assessment of numerous medical opinions. Social Security
19 regulations distinguish between the different types of sources offering medical opinions.
20 "Acceptable medical sources" include, for example, licensed physicians and psychologists, while
21 other non-specified medical providers, such as nurse practitioners or therapists, are considered
22 "other sources." 20 C.F.R. §§ 416.902, 416.913, and Social Security Ruling (SSR) 06-03p
23

1 (rescinded effective March 27, 2017).³

2 In general, more weight should be given to the opinion of a treating physician than to a
3 non-treating physician, and more weight to the opinion of an examining physician than to a non-
4 examining physician. *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1996). The record in this case
5 contained contradictory physician opinions. The ALJ could reject the contradicted opinion of a
6 treating or examining physician only with “specific and legitimate reasons’ supported by
7 substantial evidence in the record for so doing.” *Id.* at 830-31 (quoting *Murray v. Heckler*, 722
8 F.2d 499, 502 (9th Cir. 1983)). The record also contained opinion evidence from other sources.
9 The ALJ could assign less weight to the opinions of other sources, *Gomez v. Chater*, 74 F.3d 967,
10 970 (9th Cir. 1996), and discount the evidence by providing reasons germane to each source,
11 *Molina v. Astrue*, 674 F.3d 1104, 1111 (9th Cir. 2012) (cited sources omitted).

12 A. Dr. Donna Johns

13 Dr. Donna Johns conducted a psychological examination in June 2009. Dr. Johns assessed
14 a Global Assessment of Functioning (GAF) score of 35,⁴ marked impairment in social functions,
15 and moderate impairment in day-to-day activities/concentration, persistence, and pace. (AR 268.)

16 The ALJ gave little weight to this opinion. She stated Dr. Johns “explicitly based” the
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18 ³ New regulations, effective for claims filed after March 27, 2017, include advanced practice
19 registered nurses, audiologists, and physician assistants as “acceptable medical sources,” other licensed
20 health care workers as “medical sources,” and other sources of evidence as “nonmedical sources.” 20 C.F.R.
21 § 416.902(a), (d), (e).

22 ⁴ A GAF score between: 21 and 30 describes behavior “considerably influenced by delusions and
23 hallucinations,” “serious impairment in communication or judgment,” or “inability to function in almost all
24 areas”; 31 and 40 describes “[s]ome impairment in reality testing or communication” or “major impairment
25 in several areas, such as work or school, family relations, judgment, thinking, or mood”; 41 and 50 describes
26 “serious symptoms” or “any serious impairment in social, occupational, or school functioning”; 51 and 60
27 describes “moderate symptoms” or “moderate difficulty in social, occupational, or school functioning”; and
28 61 and 70 describes “[s]ome mild symptoms” or “some difficulty in social, occupational, or school
29 functioning . . . , but generally functioning pretty well, has some meaningful interpersonal relationships.”
30 Diagnostic and Statistical Manual of Mental Disorders at 34 (4th ed. 2000) (DSM-IV-TR). This explanation
31 should be referred to whenever GAF scores are referenced in this Order.

1 GAF on a factor – plaintiff’s “economic situation” – having no bearing on the disability analysis.
2 (AR 516.) Overall, the opinion appeared to be based on plaintiff’s self-reports and presentation,
3 and plaintiff was not a credible historian. Notably, when examined by Dr. Donald Ramsthal that
4 same month, plaintiff presented with no memory, tracking, or understanding deficits.

5 Plaintiff notes Dr. Johns identified “economic problems” under “Axis IV”, not the GAF
6 score at “Axis V.” (AR 269.) The Commissioner observes that GAF scores nonetheless include
7 consideration of factors not relevant to the disability analysis, such as the death of a family member
8 or inadequate finances.⁵

9 “Axis IV [of the Multiaxial Assessment system] is for reporting psychosocial and
10 environmental problems that may affect diagnosis, treatment, and prognosis of mental disorders
11 (Axes I and II).” Diagnostic and Statistical Manual of Mental Disorders 31 (4th ed. 2000) (DSM-
12 IV-TR). “A psychosocial or environmental problem may be a negative life event, an
13 environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of
14 support or personal resources, or other problems relating to the context in which a person’s
15 difficulties have developed.” *Id.* Axis V, the GAF scale, “is for reporting the clinician’s judgment
16 of the individual’s overall level of functioning.” *Id.* at 32. “A GAF score is a rough estimate of
17 an individual’s psychological, social, and occupational functioning used to reflect the individual’s
18 need for treatment.” *Vargas v. Lambert*, 159 F.3d 1161, 1164 n.2 (9th Cir. 1998). It is based on
19 either an individual’s symptoms or his functional impairments, whichever is lower. DSM-IV-TR
20 at 32-33. Axis V calls for a rating “with respect to only psychological, social, and occupational

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22 ⁵ The Commissioner also points to a decision of this Court as holding a GAF score contains “no
23 specific functional limitations,” such that an ALJ commits no error by failing to mention the score at all.”
(Dkt. 27 at 4 (citing *Guzman v. Colvin*, No. C16-5349-BAT (Dkt. 20 at 8 (finding no error in failure to
mention GAF scores where ALJ discussed the assessing physician’s observations and claimant’s reporting
to physician, and claimant identified no specific functional limitations omitted)).) In this case, the ALJ did
address the GAF scores in the record.

1 functioning”, and evaluators are not to include “impairment in functioning due to physical (or
2 environmental) limitations.” *Id.* at 32.

3 Dr. Johns could have considered plaintiff’s economic or other problems at Axis V.
4 However, because she provided no explanation for the GAF score (*see* AR 269 (“Axis V:
5 GAF=35”)), she did not “explicitly” base it on a factor having no bearing on the disability analysis.
6 In any event, and as discussed below, the ALJ elsewhere in the decision provided specific and
7 legitimate reasons for declining to assign value to any GAF scores in the record.

8 The most recent version of the DSM does not include a GAF rating for the assessment of
9 mental disorders. DSM-V at 16-17 (5th ed. 2013). While the Social Security Administration
10 (SSA) continues to receive and consider GAF scores from “acceptable medical sources” as opinion
11 evidence, a GAF score cannot alone be used to “raise” or “lower” someone’s level of function,
12 and provides “only a snapshot opinion.” Administrative Message 13066 (“AM-13066”). Unless
13 the reasons behind the rating and the applicable time period are clearly explained, a GAF score
14 does not provide a reliable longitudinal picture of the claimant’s mental functioning for a disability
15 analysis. *Id.*

16 Here, consistent with AM-13066, the ALJ described the GAF scores in the record as highly
17 subjective ratings, varying from one practitioner to another, providing a snapshot on the day of the
18 assessment, unable to alone predict whether a claimant has the ability to sustain employment, and
19 of limited utility in the disability assessment. (AR 521.) The ALJ noted many of the scores ranged
20 between 51 and 60, reflecting only moderate symptoms or difficulties, and that, in 2015,
21 consultative psychological examiner Dr. Todd Bowerly assessed a GAF of 65,⁶ reflecting only
22 mild symptoms or difficulty. The ALJ reasonably found the variations in GAF scores over time
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⁶ The ALJ misidentified this score as 68. (*See* AR 521, 845.)

1 “appears to be related to the presentation of the claimant at any given assessment and is highly
2 dependent on the claimant’s self-reports of functioning.” (*Id.*)

3 The ALJ also properly considered inconsistency in plaintiff’s presentation to Drs. Johns
4 and Ramsthel. *See Morgan v. Commissioner of the SSA*, 169 F.3d 595, 603 (9th Cir. 1999) (ALJ
5 appropriately considers inconsistencies between physicians’ reports). Plaintiff rejects this
6 reasoning given that Dr. Ramsthel assessed his physical impairments and is not a psychiatrist.
7 However, whatever his area of expertise, it remains that Dr. Ramsthel observed normal behavior,
8 memory, tracking, and conversational understanding only a week after plaintiff presented as
9 impaired in these same areas in a psychological evaluation. (AR 267-68, 282.)

10 The remaining question is whether the ALJ reasonably concluded Dr. Johns based her
11 opinion on plaintiff’s self-reports and presentation. An ALJ may reject a physician’s opinion if
12 based “‘to a large extent’ on a claimant’s self-reports that have been properly discounted as
13 incredible.” *Tommasetti v. Astrue*, 533 F.3d 1035, 1041 (9th Cir. 2008) (quoting *Morgan*, 169 F.3d
14 at 602). “However, when an opinion is not more heavily based on a patient’s self-reports than on
15 clinical observations, there is no evidentiary basis for rejecting the opinion.” *Ghanim v. Colvin*,
16 763 F.3d 1154, 1162-63 (9th Cir. 2014) (ALJ “offered no basis” for conclusion medical opinions
17 were based more heavily on self-reports where letter and evaluation discussed treating providers’
18 “observations, diagnoses, and prescriptions, in addition to . . . self-reports.”)

19 Dr. Johns’ report provides some support for the ALJ’s conclusion. She assessed marked
20 impairment in social functioning “as evidenced by isolative behaviors that exclude family
21 members and only has one friend which is his girlfriend with whom he lives.” (AR 268.) She
22 pointed to reported constant auditory hallucinations as the primary cause of plaintiff’s inability to
23 engage in sustained work-related activities.

1 Dr. Johns' report also reflects consideration of her own findings. She found moderate
2 impairment in day-to-day activities indicated by plaintiff's inability to engage in any sustained
3 activities or use any persistent concentration. (*Id.*) The mental status examination (MSE)
4 conducted reflects a number of pertinent observations and findings, including mild psychomotor
5 agitation; behavioral distraction with frequent inability to respond to questions regarding personal
6 information and infrequent, hesitant eye contact; flat affect; confused content of thought with
7 evidence of moderate levels of hallucinations; tangential speech, slow-paced, with noticeable
8 latency; moderate impairment of immediate memory, evidenced by inability to complete three-
9 numeral digits span; moderate impairment in concentration, evidenced by unsuccessful serial
10 threes, inability to spell "world" backwards, and difficulty staying focused on conversation;
11 moderate impairment in abstract thinking, evidenced by inability to interpret glass houses proverb;
12 and impaired judgment and insight as a result of distractibility. (AR 267-68.)

13 The Court, on balance, finds the ALJ's assessment of Dr. Johns' opinion to lack the support
14 of substantial evidence. On remand, the ALJ should clarify any basis for rejecting the GAF score
15 and reassess the opinions as to functional limitations.

16 B. Dr. Jamie Carter

17 Dr. Jamie Carter conducted a psychological evaluation of plaintiff in October 2009. Dr.
18 Carter described plaintiff's reporting, including hearing voices, observed his attempt to open the
19 door while another client was being seen despite a "do not disturb" sign and written instructions
20 to remain in the waiting area, and described his presentation as mildly anxious, with restricted
21 affect, poor eye contact, and stammering at times. (AR 285-86.) Plaintiff was unable to recall of
22 one of three objects after a delay, perform two calculations, or spell "world" backwards, gave
23 concrete interpretations of proverbs, and incorrectly responded to a social reasoning question. (AR

1 286.) Prior psychological evaluations included diagnoses of malingering and schizoaffective
2 disorder, and the current evaluation included the report of auditory hallucinations and symptoms
3 of anxiety and possible post-traumatic stress disorder (PTSD), but not a consistently depressed
4 mood. (AR 286-87.) Plaintiff had deficits on the MSE “but a previous evaluation did raise
5 questions regarding motivational level and possible malingering on those types of tasks.” (AR
6 287.) “He does appear to have longstanding cognitive deficits and reported a childhood head
7 injury and a history of special education.” (*Id.*)

8 Plaintiff initially asserted the ALJ failed to discuss this evidence. However, the ALJ
9 described Dr. Carter’s evaluation. (AR 511-12.) The ALJ also noted inconsistency between
10 plaintiff’s report to Dr. Carter his mental health symptoms began in his early thirties and his report
11 to Dr. Johns his hallucinations began in his twenties. (AR 512; *see also* AR 267, 286.)

12 In reply, plaintiff noted the ALJ’s failure to discuss his inability to perform serial sevens
13 or threes on examination, or his report of a childhood head injury and history of special education.
14 Plaintiff does not, however, explain how such omissions demonstrate reversible error. *See Turner*
15 *v. Comm’r of Social Sec. Admin.*, 613 F.3d 1217, 1223 (9th Cir. 2010) (where physician’s report
16 did not assign any specific limitations or opinions in relation to an ability to work, ALJ need not
17 provide reasons for rejecting the report because the ALJ did not reject any of the report’s
18 conclusions); *Morgan*, 169 F.3d at 601 (physician’s reports did not show how a claimant’s
19 “symptoms translate into specific functional deficits which preclude work activity.”); *Vincent v.*
20 *Heckler*, 739 F.2d 1393, 1394-95 (9th Cir. 1984) (ALJ need not discuss each piece of evidence in
21 the record; ALJ “must explain why ‘significant probative evidence has been rejected.’”) (quoted
22 source omitted). The ALJ adequately summarized Dr. Carter’s evaluation and considered
23 evidence in the record relating to plaintiff’s head injuries and history of special education. (*See*

1 AR 511, 515-16, 520, 523.) The ALJ also included RFC limitations pertinent to the findings and
2 observations of Dr. Carter, including an ability to remember simple, but not detailed instructions
3 and complete simple, routine tasks in two-hour increments, and the initial need for additional
4 supervision and encouragement. (AR 509.) The court finds no error.

5 C. Dr. David Morgan

6 Psychologist Dr. David Morgan evaluated plaintiff in October 2010. He assessed a GAF
7 of 45, marked limitations in relating to co-workers and supervisors, tolerating pressures and
8 expectations of a work setting, and maintaining appropriate behavior at work, and a severe
9 limitation in public contacts. (AR 363-64.) Plaintiff reported medication made his symptoms “not
10 so severe,” but did not eliminate them entirely; he did not have psychotic experiences while on
11 medication, but his anxiety symptoms remained. (AR 364.) Dr. Morgan stated: “Client seems to
12 be able to manage his own life in the context of his own home, but other than that, he seems fairly
13 limited. Client would not necessarily be able to effectively have multiple responsibilities for other
14 individuals at this time.” (*Id.*) Plaintiff “was somewhat of a poor historian,” “appears to depend
15 much on the help of others, and does not seem to have many independent skills that would
16 [unintelligible] to regular employment.” (AR 366.)

17 The ALJ gave Dr. Morgan’s opinion little weight “because it appears to be exclusively
18 based on the claimant’s self-reports, and [the] examination notes show the claimant was not
19 forthright with Dr. Morgan.” (AR 518.) “For example, the claimant reported he did not leave the
20 house except for necessities, such as appointments.” (*Id.*) The ALJ did not find plaintiff credible,
21 and found Dr. Morgan’s opinion “in large parts speculative and couched in equivocal terms.” (*Id.*)

22 Plaintiff argues that, because Dr. Morgan checked boxes indicating he observed symptoms
23 of anxiety and depression (*see* AR 362), the ALJ erred in finding “exclusive” reliance on self-

1 reports. However, the remainder of the evaluation (*see* AR 364, 366) supports the ALJ's
2 interpretation. *See Tommasetti*, 533 F.3d at 1041 (physician's records largely reflected claimant's
3 reports of pain "with little independent analysis or diagnosis."). The use of the term "exclusively"
4 is appropriately deemed harmless. *See Molina*, 674 F.3d at 1115 (error harmless where it is
5 "inconsequential to the ultimate nondisability determination."); the court looks to "the record as
6 a whole to determine whether the error alters the outcome of the case.")

7 Plaintiff denies he incorrectly reported he does not go out into the community much due to
8 his anxiety. However, the ALJ reasonably contrasted this report with other reporting plaintiff went
9 grocery shopping, clothes shopping, and to the gym and food bank (AR 513, 521 (citing AR 344).)
10 *See Tommasetti*, 533 F.3d at 1041 (ALJ may consider inconsistency with the record); *Rollins v.*
11 *Massanari*, 261 F.3d 853, 856 (9th Cir. 2001) (ALJ may consider inconsistency with level of
12 activity). Earlier, the ALJ had identified inconsistency between plaintiff's October 2010 report to
13 Dr. Morgan he had been "clean and sober for over five years" (AR 363), and his May 2009 report
14 to Dr. Lawrence Moore he last used amphetamines "about two years ago." (AR 513, 363, 352.)
15 The inconsistencies identified by the ALJ were particularly relevant given the apparent reliance
16 on plaintiff's reporting.

17 Finally, the ALJ construed Dr. Morgan's opinion as speculative and couched in equivocal
18 terms. This interpretation was reasonable (*see, e.g.*, AR 364, 366 ("seems to be able", "seems
19 fairly limited", "appears to depend", and "does not seem"; plaintiff had only recently been
20 diagnosed and treated, and his medications were being "changed and monitored" to find the correct
21 combination)), and serves as an additional specific and legitimate reason for assigning little weight
22 to the opinion of Dr. Morgan. *See Rounds v. Comm'r of Social Sec. Admin.*, 807 F.3d 996, 1006
23 (9th Cir. 2015) (ALJ may "rationally rely on specific imperatives regarding a claimant's

1 limitations, rather than recommendations.”). *Cf.* 20 C.F.R. § 416.945(a) (RFC “is the most you
2 can still do despite your limitations.”)

3 D. Sue Gebhardt, MA, MHP

4 Mental health practitioner Sue Gebhardt assessed a GAF of 45 in January 2010. (AR 334-
5 36.) The ALJ noted Gebhardt’s observation of several Axis IV factors, including financial and
6 dental needs, and gave little weight to the GAF score “because it is explicitly based on factors
7 having no bearing on the disability analysis. (AR 517.)

8 As with Dr. Johns, Gebhardt did not “explicitly” base the GAF rating on factors irrelevant
9 to the disability analysis. (AR 334 (“Axis IV: This consumer has mental health, financial,
10 employment, occupational, medical and dental needs. Axis V: GAF 45 (current)”)). The GAF
11 score could have been based on clinical observations or findings on examination. For example,
12 on MSE, plaintiff had difficulty sitting still in his chair, looked down throughout much of the
13 assessment, presented with depressed mood and flat affect, had impaired impulse control,
14 cognition, and memory recall, and was impaired in intelligence and concrete in abstract abilities.
15 (*Id.*) Therefore, while the ALJ’s reason for declining to assign value to all of the GAF scores is
16 supported by substantial evidence, clarification is warranted in relation to Gebhardt.

17 E. Dr. Daniel Beavers

18 Dr. Daniel Beavers began treating plaintiff in June 2010 and, at that time, assessed a GAF
19 of 60. (AR 470-71.) In May 2011, Dr. Beavers assessed a GAF of 50 and described plaintiff’s
20 response to treatment as limited and the prognosis as fair. (AR 472.) Plaintiff had some
21 restrictions of activities of daily living, with inability to maintain personal grooming or hygiene at
22 times, and difficulty planning activities and initiating and participating in events independent of
23 supervision. Plaintiff did not pay the bills or usually shop, but occasionally participated in cooking

1 and used public transportation with assistance. He had difficulties in social functioning, such as
2 responding to authority, avoiding altercations, getting along with others, communicating clearly
3 and effectively, and establishing interpersonal relationships. (AR 473.) His pace was usually
4 slowed, he had difficulty persisting in tasks to completion or in a timely manner, and difficulty
5 concentrating on a repetitive basis. He could deteriorate or decompensate in a work-like setting,
6 with, for example, likely attendance problems, possible threats of violence or inability to cope with
7 a schedule, and difficulty with changes, performance demands, and supervision. He could have
8 difficulty in other areas, such as remembering procedures, responding to supervisors and getting
9 along with co-workers, with simple instructions, maintaining attention for more than two hours at
10 a time, or responding to normal hazards. Dr. Beavers believed plaintiff had a serious mental
11 disorder, occasionally threatens violence, had a limited capacity to modulate his behavior, did best
12 in a calm and predictable environment, and anything disrupting that environment could be
13 destructive and greatly exacerbate symptoms.

14 The ALJ gave little weight to Dr. Beaver's opinion. She found it speculative, couched
15 largely in equivocal terms, and inconsistent with treatment notes showing generally unremarkable
16 MSEs and no angry or aggressive behavior towards Dr. Beaver or his staff. (AR 518 (citing AR
17 452-71).) Notably, the treatment records did not show any significant difficulty with
18 communication or significant cognitive deficits. The ALJ construed the opinion as based largely
19 on plaintiff's discredited self-reports. She stated GAF scores represent a snapshot and not a
20 longitudinal history of functioning over time. She gave more weight to Dr. Beaver's treatment
21 notes, which showed general stability on medications, euthymic mood, and only occasional
22 hallucinations.

23 Plaintiff avers error in the failure to accord proper deference to Dr. Beaver's treating role.

1 He asserts consistency with the treatment notes and differentiates how he appeared during
2 treatment with how he would behave in a more stressful situation. Plaintiff denies any evidence
3 Dr. Beaver based the opinion on self-reporting, observing the “primary function of medical records
4 is to promote communication and recordkeeping . . . not to provide evidence for disability
5 determinations.” *Orn v. Astrue*, 495 F.3d 625, 634 (9th Cir. 2007).

6 Plaintiff also maintains the ALJ improperly relied on evidence outside the record. The
7 following exchange occurred at hearing:

8 ALJ: Okay, so recently I’ve had experience with Dr. Beavers, so
9 I’m not real excited about Dr. Beavers today. So you probably don’t
10 want to tell me about how wonderful he is.

11 ATTY: Now we’re getting a little extrajudicial, though. I mean, if
12 you have something –

13 ALJ: No I wasn’t –

14 ATTY: – extrajudicial that’s –

15 ALJ: I’m simply saying, you know, I have to use everything that
16 I’ve got to try and make a decision here, and I do. If I’m raising
17 something extrajudicial, believe me, I will talk about it in my
18 decision.

19 ATTY: Uh-huh.

20 ALJ: I haven’t made a final decision in this case. All I’m currently
21 telling you is currently Dr. Beavers is not on my hit parade of
22 doctors that – you know, if Dr. Beavers says it’s this way, then, you
23 know, I trust the man. I don’t totally distrust him, but I’m looking
at his assessments with a very careful eye, let us say, today.

ATTY: . . . I mean, if – like you said, if you’ve learned something
about Dr. Beavers, I’d like to be able to rebut it, if I can. If I would
– I knew what it was, or --

ALJ: Well, I haven’t – you know, I haven’t learned anything more
about Dr. Beavers, other than he hasn’t become one of the doctors
that I can look at and say I 100% trust him to give me an objective
opinion.

1 ATTY: Does he have – I mean, did he get in trouble? Does he
2 have—I mean, he’s – it –

3 ALJ: I’m not going to say anything more. I’m not – I don’t want to
4 go – . . . down the rabbit hole here, because I haven’t made a decision
5 in this case.

6 ATTY: Okay.

7 ALJ: Okay? I was just saying if you’re – if you are resting the
8 majority of your case on Dr. Beavers, that might not – that might be
9 a mistake.

10 (AR 905-07.)

11 It could be said the ALJ reasonably interpreted Dr. Beaver’s opinion as speculative and
12 couched largely in equivocal terms, inconsistent with the treatment notes, and relying in large part
13 on plaintiff’s self-reports. The ALJ also accurately described GAF scores as not properly
14 understood to represent a longitudinal picture of functioning over time. *See* AM-13066. However,
15 at hearing, the ALJ made clear she did not fully trust Dr. Beavers to provide an objective opinion
16 due to one or more unrelated matters. The Commissioner contends none of the ALJ’s reasons for
17 rejecting Dr. Beaver’s opinion relate to the hearing discussion of any extra-record evidence. Given
18 that the ALJ did not state as such in the decision, or even mention the lengthy discussion regarding
19 Dr. Beavers, the basis for the Commissioner’s contention is not clear. The Court finds the ALJ’s
20 consideration of Dr. Beaver’s opinion called into question by the comments made at hearing. The
21 ALJ should reassess Dr. Beaver’s opinion on remand and, in so doing, provide clarification as to
22 any and all factors considered in the assessment.

23 F. Jessica Spencer, Avery Kennedy, and Michelle Scott

 Plaintiff saw several providers at Lifeline Connections. In September 2013, Jessica
 Spencer, MA, CDP, conducted an MSE and assessed a GAF of 50. (AR 800-03.) On a number

1 of occasions between September 2013 and November 2014, Avery Kennedy, ARNP, conducted
2 MSEs and assessed GAF scores of 40 or 45. (AR 804-19.) In September 2014, Michelle Scott,
3 LMHC, conducted an MSE and assessed a GAF of 50. (AR 796-99.)

4 Plaintiff contends the ALJ erred in failing to discuss the significant clinical findings of
5 these providers and by improperly rejecting their GAF scores based on a misunderstanding of Axis
6 IV. The Commissioner maintains the ALJ provided a reasonable analysis of the GAF scores, as
7 well as the treatment provided by Kennedy. (*See* AR 514-15, 519, 521.)

8 The ALJ gave little weight to the Lifeline Connection GAF scores “because the providers
9 offered no explanation regarding what factors (Axis IV) were considered[.]” (AR 519.) The ALJ
10 also provided the above-described specific and legitimate reasons for declining to assign value to
11 the GAF scores of record. (AR 521.) Whether or not the ALJ appropriately referred to Axis IV,
12 she provided a germane reason for rejecting the Lifeline Connection GAF scores, both as a general
13 matter and based on the failure of these particular sources to provide an explanation for the scores
14 assessed. *See* AM-13066.

15 G. Dr. Todd Bowerly

16 Consultative examiner Dr. Bowerly first assessed plaintiff in November 2006. Plaintiff
17 reported a traumatic brain injury (TBI) sustained at age eight and addiction to methamphetamine
18 for the preceding five years, with last use in February 2006. (AR 479.) Dr. Bowerly diagnosed
19 cognitive disorder, not otherwise specific (NOS), psychotic disorder, NOS, and amphetamine
20 dependence, early full remission (per self-report), and assessed a GAF of 50. (AR 483.) Testing
21 revealed impaired general memory, working memory, processing speed, and attention/
22 concentration. (AR 483.) The cognitive impairment was most likely related to the TBI, with
23 possible influence of chronic back pain and substance use. (AR 483-84.) Plaintiff endorsed

1 situational depression, but not symptoms suggesting an acute mood disorder. (AR 484.) He
2 endorsed hearing voices for the past three or four years, with no diagnosis or treatment. He did
3 not begin hearing voices until after he started using methamphetamine, but continued to hear them
4 once or twice a week in eight or nine months of abstinence. Dr. Bowerly recommended a
5 comprehensive neuropsychological evaluation, further psychological evaluation based on
6 “unreliable self-report,” and deferred diagnosis of antisocial personality-based difficulties given
7 the possible contribution of cognitive impairment and psychosis on legal, substance, anger, and
8 behavior problems. (*Id.*) He found plaintiff unable to manage finances secondary to cognitive
9 impairment, with adequate persistence and social interaction skills, and limited understanding,
10 reasoning, attention/concentration, memory, and adaptation abilities secondary to multiple factors,
11 including past TBI, substance abuse, and chronic pain. (AR 484-85.)

12 In an April 2015 examination, Dr. Bowerly noted plaintiff was a poor historian, offered
13 vague information, presented as simple and concrete, with a flat, restricted affect, but no indication
14 of an acute mood disorder, had generally clear and linear thinking, no observable hallucinations or
15 delusions, and poor performance on all tests of cognitive functioning. (AR 843-44.) The testing
16 results revealed invalid scores underestimating actual functioning “secondary to poor effort, some
17 likely feigned behavior on very easy tasks, and stuporous behavior towards the end of the exam.”
18 (AR 846.) Plaintiff provided inconsistent details about his personal information compared to the
19 2006 evaluation and withheld truthful information about his history of using substances,
20 specifically methamphetamine. Dr. Bowerly assessed a GAF of 65, did not offer a medical source
21 statement given the lack of reliable information, and opined malingering should be ruled out. (AR
22 845-46.)

23 The ALJ gave little weight to the 2006 opinion because it predated the relevant time period

1 by several years and the record suggested plaintiff may have been using methamphetamine at that
2 time. (AR 519.) In describing the 2015 opinion, the ALJ noted Dr. Bowerly's reference to Dr.
3 Moore's "alleged assessment of malingering" in 2005, and stated she disregarded that reference
4 because the record did not contain any 2005 examination or opinion from Dr. Moore. (AR 515 at
5 n.2.)⁷ She gave little weight to the GAF score assessed in 2015 "because it was based on factors
6 having no bearing on the disability analysis, including homelessness and financial concerns." (AR
7 521.)

8 Plaintiff contends Dr. Bowerly's opinion is tainted by his review of Dr. Moore's May 2009
9 evaluation, which referenced the 2005 evaluation in which Dr. Moore allegedly diagnosed
10 malingering. He avers error in the ALJ's reliance on an opinion based, in part, on evidence that is
11 not a part of the record, and that the ALJ's "disregarding" of the reference does not change the fact
12 Dr. Bowerly improperly relied on missing evidence.

13 The Court finds no error. In remanding the matter to an ALJ, the Appeals Council pointed
14 to a citation to Dr. Moore's 2005 evaluation, completed in connection with a prior disability claim,
15 dated outside the period at issue in this case ("from October 5, 2009 forward"), and not contained
16 in the record. (AR 643-44.) Consistent with the stipulated remand, the Appeals Council directed
17

18 ⁷ The record does contain a May 2009 evaluation from Dr. Moore. (AR 351-57.) The ALJ stated
19 that, in accordance with the remand order, she disregarded all portions of Dr. Moore's 2009 evaluation
20 based on the alleged 2005 evaluation. (AR 510 at n.1.) In 2009, Dr. Moore did not offer a formal MSE
21 score in light of plaintiff's questionable effort, particularly on questions of orientation, found all other tasks
22 performed well within normal limits, and no clear indication of cognitive deficits. (AR 357.) Plaintiff was
23 able to keep up with activities of daily living and offered no particular functional complaints. Dr. Moore
opined plaintiff appeared able to reason, understand, remember, concentrate, persist in activities, adapt to
new situations, and interact socially without significant difficulty. The ALJ gave great weight to Dr.
Moore's conclusion plaintiff did not put forth good effort on examination suggestive of malingering, but
little weight to the opinion plaintiff did not have significant difficulties. (AR 517.) Based on complaints of
irritability, fatigue, mood lability, and occasional hallucinations, the ALJ gave more weight to the opinions
of non-examining Stage agency consultants. Plaintiff does not challenge the ALJ's consideration of Dr.
Moore's 2009 opinion.

1 that any evidence from a prior claim relied upon must be made a part of the record and proffered
2 to the claimant. (AR 645 and 632-33.) The ALJ complied with this directive by disregarding any
3 reference by Dr. Bowerly to evidence not contained in the record.

4 Plaintiff does not support the contention Dr. Bowerly based his opinion on missing
5 evidence, or that the ALJ was obligated to disregard this or any other opinion referencing Dr.
6 Moore's 2005 evaluation. Dr. Bowerly noted both the 2005 and 2009 evaluations of Dr. Moore
7 only in the initial portion of his 2015 evaluation, outlining plaintiff's complaints and the records
8 reviewed. (AR 841.) Dr. Bowerly rendered his opinion based on "currently authorized objective
9 testing", the examination, and as to "current or recent functioning." (AR 841-46.) His opinion
10 "rests on his own independent examination" and properly serves as substantial evidence supporting
11 the ALJ's conclusion. *Tonapetyan v. Halter*, 242 F.3d 1144, 1149 (9th Cir. 2001).

12 H. Dr. Landon Poppleton

13 Consultative examiner Dr. Landon Poppleton assessed plaintiff over the course of several
14 days in December 2014/January 2015. (AR 828-37.) Dr. Poppleton found plaintiff met the criteria
15 for alcohol use disorder and mild neurocognitive disorder due to TBI, noting global cognitive delay
16 and functioning in the first percentile relative to other adults his age. (AR 836.) Plaintiff also
17 presented consistent with major depressive disorder with psychotic features, with relevant
18 symptoms reported, psychomotor slowing and fatigue, difficulty managing his anger/often acting
19 out violently, and auditory and command hallucinations. Testing showed markedly impaired
20 memory, and monthly MSE scores showed fluctuating neurocognitive impairments, most likely
21 explained by distracting auditory hallucinations. Dr. Poppleton opined plaintiff could benefit from
22 continued treatment. (AR 836-37.) Also, responding to questions from counsel, Dr. Poppleton
23 opined plaintiff was disabled and that his other impairments would not likely improve to the point

1 of non-disability absent the use of substances. (AR 838-39.)

2 The ALJ gave little weight to the IQ scores and memory test results from Dr. Poppleton in
3 light of Dr. Bowerly’s 2015 examination findings. (AR 520.) She gave very little weight to the
4 opinion and examination findings overall, finding plaintiff’s reports to Dr. Poppleton very different
5 from his testimony at hearing and his reports to other providers. “For example, he reported to Dr.
6 Poppleton that he became lost taking local transit, however, at the hearing, he explained that he
7 was able to take public transportation without any trouble at all.” (*Id.*) Plaintiff also reported to
8 Dr. Poppleton his hallucinations began in adolescence, while elsewhere reporting they began in
9 his twenties, thirties, and in the context of past methamphetamine use.

10 Plaintiff asserts improper reliance on Dr. Bowerly’s allegedly tainted opinion. This
11 argument fails for the reasons stated above. Plaintiff states his report and testimony about riding
12 the bus are not “*very different[.]*” (Dkt. 26 at 11 (emphasis retained).) The ALJ reasonably found
13 inconsistency. (*Compare* AR 829 (“According to Jeffrey his case manager accompanies him when
14 she can but he sometimes has to ride [the bus] alone. He reported he is comfortable riding the bus
15 locally using major streets but otherwise cannot recall directions. He and Brenda admitted that he
16 sometimes gets lost even locally and will have to call her for assistance.”), *with* AR 937 (“Q[.] Do
17 you ever have problems taking the bus? A[.] No. Q[.] You always know exactly where you’re
18 going, you get there okay[.] A[.] Yeah.”)) Plaintiff also states he specifically reported to Dr.
19 Poppleton he had auditory hallucinations “for a while . . . about 15 years I think[.]” and, upon
20 further questioning, “recalled that the voices ‘were always there sometimes’ since he was a
21 teenager.” (AR 831.) The ALJ reasonably found inconsistency in plaintiff’s reporting to Dr.
22 Poppleton and to other sources throughout the record. (*See, e.g.*, AR 266 (mental health symptoms
23 began in early thirties), 286 (began hearing voices in his twenties), 479, 484 (2006 report of hearing

1 voices for past three or four years), 879, 882 (September 2015 report of hearing voices for past
2 fifteen years.) The ALJ, in sum, provided specific and legitimate reasons for discounting the
3 opinion of Dr. Poppleton.

4 I. Dr. Conrad Swartz and Lizz Schallert, MSW, CSWA

5 On September 23, 2015, mental health practitioner Lizz Schallert found plaintiff impaired
6 in multiple respects on MSE and assigned a GAF of 30. (AR 879-86.) On October 14, 2015,
7 examining psychiatrist Dr. Conrad Swartz found plaintiff had “extremely concrete mentation,
8 simple approach, not able to handle complexity, barely able to handle simple questions” and
9 impaired in several respects on MSE, and diagnosed PTSD and cognitive impairment/psychosis/
10 dysexecutive syndrome due to TBI, psychosis. (AR 870-77.) In a progress note from that same
11 month, Dr. Swartz addressed Dr. Bowerly’s 2015 examination and interpreted the observations of
12 drowsiness and somnolence to indicate plaintiff was obtunded during testing, and this “may have
13 been sedation by medication,” or “delirium associated with [TBI], e.g., nonconvulsive seizure
14 activity.” (AR 889.) He further stated: “The psychologist wrote a different interpretation
15 (feigning) that is more speculative than medication or delirium effects, and I do not endorse it.”
16 (AR 889-90.) In a October 23, 2015 letter, Schallert stated plaintiff “is a perfect candidate for
17 SSI”, “has no other option for income, and his disability impacts all levels of day to day
18 functioning.” (AR 891.) She described plaintiff’s symptoms as persistent and serious, his
19 experience of high levels of anxiety and “hearing voices for most of his adult life[.]” his inability
20 to concentrate on a single task, communicate and form sentences clearly, or remember very basic
21 information, and stated these “symptoms impair him from working.” (*Id.*) Schallert also stated
22 that, because of severe impairment of organizational skills, plaintiff relies heavily on his girlfriend
23 to meet his basic needs, “is appropriate for disability support, and I advocate for his receiving SSI.”

1 (*Id.*)

2 The ALJ gave little weight to Dr. Swartz's opinion of Dr. Bowerly's observations. It failed
3 to take into account other factors considered by Dr. Bowerly, such as inconsistent statements made
4 between Dr. Bowerly's 2006 and 2015 examinations, plaintiff's failure to report his history of
5 methamphetamine abuse at the 2015 examination, and his inconsistent performance on
6 examination, including erring on simple tasks, while accurately answering more difficult questions
7 testing the same skill. (AR 520.) The ALJ also found it notable no other source had assessed
8 plaintiff with delirium associated with a TBI.

9 In challenging the ALJ's analysis, plaintiff reiterates the contention that Dr. Bowerly's
10 examination was tainted. This argument fails for the reasons stated above.

11 Nor did the ALJ otherwise err in considering the evidence from Dr. Swartz. "The ALJ is
12 responsible for resolving conflicts in the medical record." *Carmickle v. Comm'r of SSA*, 533 F.3d
13 1155, 1164 (9th Cir. 2008). When evidence reasonably supports either confirming or reversing
14 the ALJ's decision, the court may not substitute its judgment for that of the ALJ. *Tackett v. Apfel*,
15 180 F.3d 1094, 1098 (9th Cir. 1999). "Where the evidence is susceptible to more than one rational
16 interpretation, it is the ALJ's conclusion that must be upheld." *Morgan*, 169 F.3d at 599. The
17 ALJ here appropriately relied on contrary evidence from Dr. Bowerly and Dr. Swartz's failure to
18 consider all of the factors considered by Dr. Bowerly, as well as the absence of any other
19 assessment of delirium. *Id.* at 603 (ALJ may consider inconsistencies within and between
20 physicians' reports); *Tommasetti*, 533 F.3d at 1041 (ALJ may consider inconsistency with the
21 record); 20 C.F.R. § 416.927(c)(4) ("Generally, the more consistent a medical opinion is with the
22 record as a whole, the more weight [the ALJ] will give to that medical opinion.").

23 The ALJ assigned little weight to Schallert's GAF score and letter. The score appeared to

1 be based primarily or exclusively on plaintiff's report "he had hallucinations 'all the time,'" and
2 they "told him to 'hurt people.'" (AR 520.) This was "wildly different" from every other
3 description in the record, which generally showed hallucinations as only occasional, deprecating,
4 and negative. (*Id.*) The ALJ also found the opinions in the letter to show exclusive reliance on
5 plaintiff's self-reports, noting no indication Schallert reviewed the treatment record or consultative
6 evaluations, or performed any testing. The ALJ found inconsistency with the treatment record,
7 including Dr. Beaver's treatment notes and Dr. Ramsthal's examination findings, which did not
8 show any difficulty with communication, and further found inconsistency with plaintiff's ability
9 to testify clearly at both remand hearings.

10 Plaintiff counters that Schallert was able to rely on both her own findings and the findings
11 of Dr. Swartz. However, the ALJ rationally interpreted the evidence to show the reliance on
12 plaintiff's self-reports and inconsistency with the record, and bolstered her conclusions with
13 specific examples. The ALJ also reasonably considered the absence of evidence Schallert was
14 familiar with the remainder of the record. *See* 20 C.F.R. § 416.927(c)(6) (ALJ may consider
15 extent to which a source is familiar with other information in the record). The ALJ, as such,
16 properly considered the opinion evidence from both Schallert and Dr. Swartz.

17 J. Dr. Xiaotian Yan

18 Plaintiff describes treatment records from primary care provider Dr. Xiaotian Yan and
19 argues the ALJ erred by failing to acknowledge this evidence is consistent with the opinions of his
20 other treatment providers and examiners. The ALJ considered the evidence from Dr. Yan (AR
21 512-14), and the record did not contain a medical opinion from Dr. Yan requiring assessment.
22 *Turner*, 613 F.3d at 1223 (ALJ need not provide reasons to reject physician's statement when
23 statement did not assess any limitations). While plaintiff takes a different view of Dr. Yan's

1 treatment records and the impact on the ALJ's analysis, he fails to demonstrate the ALJ's
2 interpretation was not rational.

3 K. Dr. Donald Ramsthal:

4 Dr. Ramsthal examined plaintiff in June 2009 and rendered opinions on physical
5 functioning consistent with the RFC. (AR 284.) The ALJ gave the opinion great weight, finding
6 consistency with Dr. Ramsthal's examination findings and the record as a whole, including
7 minimal findings on MRI and intact strength on examination. (AR 516.)

8 Plaintiff avers more recent records show his physical impairments became more severe
9 over time. However, the records cited by plaintiff do not undermine either the ALJ's consideration
10 of Dr. Ramsthal's report or the physical limitations in the RFC. (See AR 390-91, 394-95, 434-36,
11 446 (finding tenderness on back in January 2010, April 2010, and January 2011); AR 407-08
12 (finger pain in September 2010, following injury to finger three days prior (see AR 416)); AR 427-
13 28 (tenderness below right knee cap in June 2010); and AR 429-30 (June 2010 physical therapy
14 evaluation finding, *inter alia*, no neurological deficits, normal joint mobility, lumbar
15 pain/tenderness, unable to perform double leg squat, and able to walk on heels and toe walk).) The
16 ALJ's rational interpretation of the evidence will not be disturbed.

17 L. Non-examining Physicians

18 In January 2010, non-examining Stage agency psychiatric consultant Dr. Richard Winslow
19 rendered opinions consistent with the RFC. (AR 314.) In March 2010, psychological consultant
20 Dr. Carla van Dam agreed with Dr. Winslow. (AR 347.) The ALJ gave great weight to these
21 opinions, finding consistency with the record as a whole, including plaintiff's testimony, Dr.
22 Beaver's treatment notes showing plaintiff's mood as generally euthymic and his hallucinations
23 described as occasional, and evidence showing plaintiff is able to follow television programs and

1 engages in yard work/landscaping in exchange for rent. (AR 517.) The ALJ gave little weight to
2 the opinion plaintiff might have difficulty with public transportation in light of his testimony to
3 the contrary.

4 Plaintiff argues the opinions of Drs. Winslow and van Dam are entitled to little weight
5 because they did not review any evidence beyond March 2010. The ALJ was tasked with
6 considering plaintiff's claim of disability as of October 5, 2009 and properly considered and
7 reasonably weighed these relevant medical opinions. Plaintiff does not establish error in the ALJ's
8 consideration of the opinions of Drs. Winslow and van Dam.

9 Plaintiff's Symptom Testimony

10 Absent evidence of malingering, an ALJ must provide specific, clear, and convincing
11 reasons to reject a claimant's testimony.⁸ *Burrell v. Colvin*, 775 F.3d 1133, 1136-37 (9th Cir.
12 2014) (citing *Molina*, 674 F.3d at 1112). *See also Lingenfelter v. Astrue*, 504 F.3d 1028, 1036 (9th
13 Cir. 2007). "General findings are insufficient; rather, the ALJ must identify what testimony is not
14 credible and what evidence undermines the claimant's complaints." *Lester*, 81 F.3d at 834. The
15 ALJ may consider a claimant's "reputation for truthfulness, inconsistencies either in his testimony
16 or between his testimony and his conduct, his daily activities, his work record, and testimony from
17 physicians and third parties concerning the nature, severity, and effect of the symptoms of which
18 he complains." *Light v. Social Sec. Admin.*, 119 F.3d 789, 792 (9th Cir. 1997).

19 The ALJ here found plaintiff's statements concerning the intensity, persistence, and
20 limiting effects of his symptoms not entirely credible. The ALJ found plaintiff's symptoms

21 ⁸ In SSR 16-3p, the SSA rescinded SSR 96-7p, eliminated the term "credibility" from its sub-
22 regulatory policy, clarified that "subjective symptom evaluation is not an examination of an individual's
23 character[.]" and indicated it would more "more closely follow [its] regulatory language regarding symptom
evaluation." SSR 16-3p. However, this change is effective March 28, 2016 and not applicable to the
December 10, 2015 ALJ decision in this case. The Court, moreover, continues to cite to relevant case law
utilizing the term credibility.

1 disproportionate to the objective and clinical findings. (AR 510-16.) She found the record to
2 suggest plaintiff's unemployment was due to the inability to find a baking job and lack of
3 motivation to search for a job. (AR 521.) The ALJ identified inconsistencies in plaintiff's
4 reporting regarding his use of illicit substances, between his symptoms and activities of daily
5 living, in his different accounts as to when he began to experience hallucinations, and in his
6 presentation to providers depending on whether the examination regarded his physical or mental
7 complaints. (AR 521-22.) The ALJ noted plaintiff's failure to consistently complain about
8 hallucinations, and discussed evidence from examiners of poor effort or feigned poor performance,
9 and vagueness in presenting history, including legal and substance use history. (AR 522.) She
10 described plaintiff's treatment as exceedingly conservative in nature, with his symptoms managed
11 with medication. She also noted plaintiff did not seek or receive mental health treatment for large
12 parts of the relevant time period, despite access to medical care, including the absence of any
13 mental health treatment between September 2011 and September 2013. Finally, the ALJ pointed
14 to plaintiff's "generally unpersuasive appearance and demeanor" during his testimony at hearing,
15 stating he displayed no evidence of pain or discomfort and no apparent difficulty understanding or
16 responding to questions. (*Id.*) The ALJ emphasized that this observation was only one of many
17 factors relied upon, but was entitled to some weight.

18 The need for further consideration of medical evidence may implicate the assessment of
19 symptom testimony. The ALJ should reconsider plaintiff's testimony as warranted on remand.
20 However, the Court otherwise finds specific, clear, and convincing reasons provided in support of
21 the ALJ's assessment of plaintiff's symptom testimony. *See Rollins*, 261 F.3d at 857 (subjective
22 testimony cannot be rejected *solely* on the ground it is not fully corroborated by objective medical
23 evidence, but "medical evidence is still a relevant factor in determining the severity of the

1 claimant’s pain and its disabling effects.”), and *Carmickle*, 533 F.3d at 1161 (ALJ may reject
2 claimant’s subjective testimony based on contradiction with the medical record); *Bruton v.*
3 *Massanari*, 268 F.3d 824, 828 (9th Cir. 2001) (ALJ may consider reason why a claimant stopped
4 working), and *Osenbrock v. Apfel*, 240 F.3d 1157, 1165-67 (9th Cir. 2001) (ALJ may consider
5 evidence of self-limitation and lack of motivation); *Bray v. Comm’r of SSA*, 554 F.3d 1219 (9th
6 Cir. 2009) (“ . . . ALJ may weigh inconsistencies between the claimant’s testimony and his or her
7 conduct, daily activities, and work record, among other factors.”); *see also Tommasetti*, 533 F.3d
8 at 1039 (inconsistent statements), *Verduzco v. Apfel*, 188 F.3d 1087, 1090 (9th Cir. 1999)
9 (inconsistent statements regarding alcohol use), *Orn*, 495 F.3d at 639 (inconsistency with
10 activities), and *Greger v. Barnhart*, 464 F.3d 968, 972 (9th Cir. 2006) (inconsistent or non-existent
11 reporting of symptoms); *Thomas*, 278 F.3d at 959 (self-limiting behavior, failure to give maximum
12 or consistent effort, or efforts to impede accurate testing provide compelling evidence detracting
13 from subjective symptom testimony); *Tommasetti*, 533 F.3d at 1039-40 (ALJ may also consider
14 evidence a claimant was vague in providing information or explanations, favorable response to
15 conservative treatment, and unexplained or inadequately explained failure to seek treatment or to
16 follow a prescribed course of treatment); and *Orn*, 495 F.3d at 639-40 (ALJ’s personal
17 observations may be used as a part of the overall evaluation of a claimant’s symptom testimony).⁹

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20 ⁹ An ALJ may not employ a “sit and squirm” test and reject a claimant’s symptom testimony
21 based solely on the failure to exhibit alleged symptoms at hearing. *Perminter v. Heckler*, 765 F.2d 870,
22 872 (9th Cir. 1985). However, the inclusion of an ALJ’s observations does not render the decision
23 improper. *See Verduzco*, 188 F.3d at 1090. Personal observations may be included as part of the overall
evaluation, *Orn*, 495 F.3d at 639-40, but should not be “used as a substitute for medical diagnosis.” *Marcia*
v. Sullivan, 900 F.2d 172, 177, n.6 (9th Cir. 1990) (cited sources omitted). *See, e.g., Verduzco*, 188 F.3d at
1090 (claimant exhibited symptoms inconsistent with both the medical evidence and other behavior at
hearing); *Quang Van Han v. Bowen*, 882 F.2d 1453, 1458 & n.8 (9th Cir. 1989) (claimant was
“overdramatizing” alleged pain by “dishonestly attempting to display too much pain.”). In this case, the
ALJ appeared to properly consider her personal observations as only one of many different factors.

1 RFC and Step Five

2 The ALJ's RFC assessment and step five conclusion may be implicated by further
3 consideration of medical evidence. The ALJ should, as warranted on remand, reconsider
4 plaintiff's claim at step four and step five.

5 CONCLUSION

6 For the reasons set forth above, this matter is REMANDED for further administrative
7 proceedings.

8 DATED this 22nd day of November, 2017.

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11 _____
12 Mary Alice Theiler
13 United States Magistrate Judge
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