

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CEDAR RAPIDS DIVISION**

LENORA WEST,

Plaintiff,

vs.

**MICHAEL J. ASTRUE, Commissioner
of Social Security,**

Defendant.

No. C07-0003

**RULING ON REQUEST FOR
JUDICIAL REVIEW**

TABLE OF CONTENTS

I.	<i>INTRODUCTION</i>	2
II.	<i>PRIOR PROCEEDINGS</i>	2
III.	<i>PRINCIPLES OF REVIEW</i>	3
IV.	<i>FACTS</i>	4
	A. <i>Administrative Hearing Testimony</i>	4
	1. <i>West’s Testimony</i>	4
	2. <i>Testimony of West’s Witnesses</i>	6
	a. <i>Zerbel’s Testimony</i>	6
	b. <i>Jacobs’ Testimony</i>	7
	3. <i>Vocational Expert’s Testimony</i>	8
	B. <i>West’s Medical History</i>	10
	1. <i>West’s Physical Health</i>	10
	2. <i>West’s Mental Health</i>	12
V.	<i>CONCLUSIONS OF LAW</i>	18
	A. <i>ALJ’s Disability Determination</i>	18
	B. <i>West’s Residual Functional Capacity</i>	20
	1. <i>Aunan’s Opinions</i>	20
	2. <i>Credibility of the Testimony of West’s Two Witnesses.</i>	25
	3. <i>Credibility of West’s Testimony</i>	25
VI.	<i>CONCLUSION</i>	28
VII.	<i>ORDER</i>	28

I. INTRODUCTION

This matter comes before the Court on the Complaint (docket number 3) filed by Plaintiff Lenora West on February 16, 2007, requesting judicial review of the Social Security Commissioner's decision to deny her application for Title II disability insurance benefits and Title XVI supplemental security income ("SSI") benefits. West asks the Court to reverse the decision of the Social Security Commissioner ("Commissioner") and order the Commissioner to provide her disability insurance benefits and SSI benefits. In the alternative, West requests the Court to remand this matter for further proceedings.

II. PRIOR PROCEEDINGS

West applied for disability insurance benefits and SSI benefits on March 30, 2004. In her application, West alleged an inability to work since January 1, 2002 due to asthma, arthritis, and mental health issues. West's applications were denied on August 17, 2004. On October 28, 2004, her application for SSI benefits was denied on reconsideration. On October 29, 2004, her application for disability insurance benefits was denied on reconsideration. On December 14, 2004, West requested an administrative hearing before an Administrative Law Judge ("ALJ"). On November 15, 2005, West appeared with counsel before ALJ John P. Johnson for an evidentiary hearing. West, witnesses Sarah Zerbel and Marion Jacobs, and vocational expert Carma A. Mitchell testified at the hearing. In a decision dated May 26, 2006, the ALJ denied West's claim. The ALJ determined that West was not disabled and was not entitled to disability insurance benefits or SSI benefits because she was functionally capable of performing her past relevant work. West appealed the ALJ's decision. On November 14, 2006, the Appeals Council denied West's request for review. Consequently, the ALJ's May 26, 2006 decision was adopted as the Commissioner's final decision.

On February 16, 2007, West filed this action for judicial review. The Commissioner filed an answer on April 30, 2007. On July 17, 2007, West filed a brief arguing there is not substantial evidence in the record to support the ALJ's finding that she is not disabled and that she able to perform her past relevant work. On September 17,

2007, the Commissioner filed a responsive brief arguing the ALJ's decision was correct and asking the Court to affirm the ALJ's decision. West filed a reply brief on September 27, 2007. On April 20, 2007, both parties consented to proceed before the undersigned in this matter pursuant to the provisions set forth in 28 U.S.C. § 636(c).

III. PRINCIPLES OF REVIEW

Title 42, United States Code, Section 405(g) provides that the Commissioner's final determination following an administrative hearing not to award disability insurance benefits is subject to judicial review. 42 U.S.C. § 405(g). Pursuant to 42 U.S.C. § 1383(c)(3), the Commissioner's final determination after an administrative hearing not to award SSI benefits is subject to judicial review to the same extent as provided in 42 U.S.C. § 405(g). 42 U.S.C. § 1383(c)(3). 42 U.S.C. § 405(g) provides the Court with the power to: "[E]nter . . . a judgment affirming, modifying, or reversing the decision of the Commissioner . . . with or without remanding the cause for a rehearing." 42 U.S.C. § 405(g). "The findings of the Commissioner . . . as to any fact, if supported by substantial evidence, shall be conclusive . . ." *Id.*

The Court must consider "whether the ALJ's decision is supported by substantial evidence on the record as a whole." *Vester v. Barnhart*, 416 F.3d 886, 889 (8th Cir. 2005) (citing *Harris v. Barnhart*, 356 F.3d 926, 928 (8th Cir. 2004)). Evidence is "substantial evidence" if a reasonable person would find it adequate to support the ALJ's determination. *Id.* (citing *Sultan v. Barnhart*, 368 F.3d 857, 862 (8th Cir. 2004)). Furthermore, "[s]ubstantial evidence is 'something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions does not prevent an administrative agency's findings from being supported by substantial evidence.'" *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (quoting *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989), in turn quoting *Consolo v. Fed. Mar. Comm'n*, 282 U.S. 607, 620 (1966)).

In determining whether the ALJ's decision meets this standard, the Court considers "all of the evidence that was before the ALJ, but it [does] not re-weigh the evidence."

Vester, 416 F.3d at 889 (citing *Guilliams v. Barnhart*, 393 F.3d 798, 801 (8th Cir. 2005)). The Court not only considers the evidence which supports the ALJ’s decision, but also the evidence that detracts from his or her decision. *Guilliams*, 393 F.3d at 801. “[E]ven if inconsistent conclusions may be drawn from the evidence, the agency’s decision will be upheld if it is supported by substantial evidence on the record as a whole.” *Id.* (citing *Chamberlain v. Shalala*, 47 F.3d 1489, 1493 (8th Cir. 1995)).

IV. FACTS

A. Administrative Hearing Testimony

1. West’s Testimony.

West was born in 1947. She testified that she has a high school education and is a certified nurse’s assistant (“CNA”). West testified that she worked as a CNA for three years. Most recently she worked as a hand packager for Oral-B in Iowa City, Iowa, packaging toothbrushes and toothpaste. West testified that she has not worked since her alleged disability onset date of January 1, 2002.

West testified that she stopped working due to depression. She acknowledged that she dealt with depression her entire life. She testified, however, that in 2002 “a nerve popped in her head” and she became over stressed and “couldn’t go on any longer.”¹ West testified that she did not seek mental health care, however, until 2004. She testified that from 2002 to 2004 she “just stayed in [her] room. Stayed in bed all day.”² In 2004, West began treatment at the Abbe Center for Community Mental Health (“Abbe Center”) in Cedar Rapids, Iowa. West testified that at the Abbe Center, she attends the “intense psychiatric recovery” program one day per week. In addition, she testified that at the suggestion of the Abbe Center, she also takes “readiness” classes at Kirkwood Community College five days per week for three hours each day. The Abbe Center also provides two

¹ See Administrative Record at 304.

² See Administrative Record at 305.

support workers, Sarah Zerbel and Marion Jones, to meet with West several times per month to check on her and make sure she is taking care of her basic needs.

At the hearing, West was also questioned regarding her physical health. She testified that she suffers from asthma. West testified that her asthma affects her ability to walk distances longer than a couple of blocks. She also testified that the medicine in her inhalers tires her out. West further testified that she suffers from arthritis in her knees and hands. She testified that because of her arthritis, she has difficulty standing for long periods of time and holding onto items such as a plate of food or glass of water.

At the hearing, the ALJ and West also had the following colloquy:

Q: Let's talk about how you spend your day. What time do you get up in the morning?

A: I get u[p] at 7:00 and I take my shower and brush my teeth and I get ready to catch the bus at ten minutes to 8:00 to go downtown to catch another bus to go to Kirkwood. That's five days a week.

Q: And you say that your classes are three hours long there?

A: Yes.

Q: To when, around noon?

A: Yes.

...

Q: What classes are you taking?

A: I'm taking reading and computer, computer skills and math, [and] basic math.

Q: Do you have, do you have lunch at Kirkwood?

A: No.

Q: Do you have that at home?

A: Yes.

Q: After lunch how do you spend the afternoon?

A: I spend the afternoon sometimes, sometimes I go out and window shop and most of the time I'm just in my apartment and I don't come back out until the next morning.

Q: If you stay in your apartment what do you do?

A: I sleep. I sleep a lot.

Q: Do you have any activities or hobbies that you engage in?

A: No.

Q: Are there things you used to do for enjoyment that you're no longer able to do?

A: Yes.

Q: And what would those be?

A: Going to the gym. I used to go to the gym with a friend but now I have no desire to do that anymore and I don't have too many friends anymore either. . . .

Q: Are you a member of any organizations you attend regularly?

A: No.

. . .

Q: And do you take care of all the chores around your apartment yourself?

A: Yes.

Q: What time do you normally go to bed?

A: I go to bed about 10:00, 10:30.

(Administrative Record at 327-29)

2. Testimony of West's Witnesses.

a. Zerbel's Testimony.

Sarah Zerbel testified that she serves as West's community support worker through the Abbe Center. She testified that she checks on West several times per month to make sure that West is taking her medicine, going to her groups at the Abbe Center, and attending her classes at Kirkwood. Zerbel also helps West problem solve when she has symptoms of depression and anxiety. West's attorney asked Zerbel whether she had seen improvement with West since Zerbel began working with her.³ Zerbel replied that "there has been some improvement. [West] seemed to do better in the summer months. [West]

³ The record indicates that Zerbel had been working with West for about one year at the time of the hearing.

seemed to feel better. Here in the past month, month and a half, she has started to decline again with having trouble making herself go to school and keep her appointments.”⁴

b. Jacobs’ Testimony.

Marion Jacobs testified that she is also employed by the Abbe Center and serves as West’s targeted case manager. She testified that a targeted case manager coordinates all of the services for individuals with chronic mental illness who cannot coordinate such services on their own. Jacobs testified that she sees West three to five times per month. Jacobs testified that she sees West more often than other patients because West has “more difficulty through the month coordinating things. She forgets what she’s supposed to do or who she’s supposed to see.”⁵ West’s attorney asked Jacobs whether she has seen improvement in West over the past year and six months since she has been working with her. Jacobs testified:

There is some improvement in the summer months. When she was attending Kirkwood this summer she did, she did really well attending classes everyday. However, things started getting too stressful for her. She was unable to attend her groups at the mental health center. She was also unable to meet with her community support person because there was way too many other things for her to do between school and homework and those other activities that I had to become involved again to assist her in training to problem solve so she can do all of those things and get all of her needs met.

(Administrative Record at 336) West’s attorney also asked Jacobs whether she has ever observed any physical problems with West. Jacobs testified that she had observed West’s difficulty with asthma when she helped West move into her current apartment. Specifically, Jacobs testified that West “was unable to lift any of the things that she needed

⁴ See Administrative Record at 333.

⁵ See Administrative Record at 336.

like the dresser or the bed. She was only able to carry the small things and had to take numerous breaks throughout the day.”⁶

3. Vocational Expert’s Testimony.

The ALJ provided vocational expert Carma A. Mitchell with a hypothetical for an individual with the following limitations:

[The individual] cannot lift more than 20 pounds, routinely lift ten pounds, but no standing or walking of more than six hours out of an eight-hour day, no sitting of more than six hours out of an eight-hour day. . . . [The individual] can only occasionally bend, stoop, squat, kneel, crawl, or climb. [The individual] should not be exposed to excessive heat, humidity, or cold, or excessive dust or fumes. [The individual] is not able to do very complex or technical work but is able to do more than simple, routine, repetitive work. [The individual] does require occasional supervision and . . . should not work at more than a moderate level of stress.

(Administrative Record at 342) Applying this hypothetical to West, the ALJ asked the vocational expert whether West could perform any of her previous jobs, including case aide, nurse aide, and hand packager. The vocational expert testified that West could perform her previous job as a case aide, but could not perform the jobs of nurse aide or hand packager.⁷ The ALJ provided the vocational expert with a second hypothetical which described an individual with the following limitations:

[The individual] cannot lift more than ten pounds. No standing of more than 20 to 30 minutes at a time, sitting of 30 minutes at a time, walking of less than a block with only occasional bending, stooping, squatting, kneeling, crawling, or climbing. [The individual] can only occasionally grip or perform gross or fine manipulation. [The individual] can only occasionally work with her arms overhead. [The individual] is not able to

⁶ See Administrative Record at 338.

⁷ Specifically, the vocational expert testified that West could not perform the job of hand packager according to the standards of the Dictionary of Occupational Therapy or the national economy, but it was feasible that she could perform the job as she had done it in the past. See Administrative Record at 342.

do very complex or technical work but is able to do more than simple, routine, repetitive work that does not require constant close attention to detail. . . . [The individual] does require close supervision, and by close supervision . . . requires a supervisor on site but not necessarily looking over her [or his] shoulder, and . . . should not work at more than a regular pace or more than a moderate level of stress.

(Administrative Record at 343) Applying this hypothetical to West, the ALJ again asked the vocational expert whether West could perform any of her previous jobs. The vocational expert testified that West could not perform any of her previous jobs. The ALJ further questioned the vocational expert regarding this hypothetical:

Q: And what limitations in this hypothetical would preclude performance of past work?

A: Okay, it would mainly be the lifting limitations, the standing and walking limitations, the limitations around like only occasional gripping, gross or fine manipulation. Those would be the main limitations that would preclude past work.

Q: Does [West] have any skills acquired from her past work which she should be able to transfer to other work within the limitations of the hypothetical?

A: No, she does not.

Q: And what limitations in the hypothetical would preclude transference of acquired skills?

A: Okay, again it would be those same limitations; the lifting, standing, walking, only occasional gripping, gross or fine manipulation.

Q: Within the parameters of this hypothetical would [West] be able to perform the full and/or wide range of light work activity?

A: No.

Q: Would there remain unskilled light work jobs that could be performed within the limitations of this hypothetical?

A: No, there would not.

(Administrative Record at 343-44) The ALJ also asked the vocational expert whether there were any other factors not discussed in the hypotheticals which would hinder West's opportunity for employment. The vocational expert identified testimony from the witnesses at the hearing regarding West isolating herself at times, including not answering

her door or phone and not leaving her apartment. The vocational expert testified that such behavior would make full-time competitive employment difficult if West regularly missed more than two days of work per month.

B. West's Medical History

1. West's Physical Health.

On June 9, 2004, West was examined by Dr. Robert J. Schultes, M.D., a consultative doctor for Disability Determination Services ("DDS"). West told Dr. Schultes that she suffered from arthritis in her right knee and ankle which makes it hard for her to walk and stand. West also told Dr. Schultes that she has decreased strength in her right hand which causes her to drop things. Lastly, West informed Dr. Schultes that she cannot drive a car.

Dr. Schultes also reviewed the medication West takes on a regular basis. Dr. Schultes noted that West takes Serevent twice per day, Azmacort as needed, and Proventil prn for asthma, Premarin and Cenestin every other day for estrogen, ibuprofen up to four times per day for arthritis, Rhinocort for sinus problems, aspirin for headaches, and Trazodone at bedtime for depression. Dr. Schultes also noted that West has a history of asthma, high blood pressure, high cholesterol, and depression.

Dr. Schultes also noted that West informed him that she could do the following: (1) lift 20 pounds for four hours per day, (2) carry 20 pounds for four hours per day, (3) stand for four hours per day, (4) move about four hours per day, (5) walk two hours per day, (6) sit three hours per day, (7) stoop ten minutes per day, (8) handle objects, see, hear, and speak eight hours per day, and (9) travel three hours per day. West also told Dr. Schultes that she could not (1) climb due to dizziness, (2) kneel or crawl due to right knee pain, (3) work around dust, fumes, or temperatures above 80 degrees because such environmental conditions cause her shortness of breath, and (4) work around hazards due to unsteadiness.

On examination, Dr. Schultes found the following:

[T]he head is normocephalic. Normal TM's and external
canals. . . . Normal extraocular motion without

nystagmus. . . . Heart normal sinus rhythm without murmur. Lungs clear to auscultation and percussion. Abdomen soft, nontender, no masses felt, no hernia, no hepatosplenomegaly. Normal bowel sounds. [West] has tenderness over the lumbar spine. DTR's are 2/2. Normal sensation to touch and pain throughout. No ankle edema. . . . Oxygen saturation 99% on room air. Peak expiratory flow rate 250 liters per minute, predicated 386 liters per minute. . . . Tenderness over the right temple. [West] is able to squat and walk on her tip toes. She is unable to walk on her heels.

(Administrative Record at 188) Strength testing showed that West had normal grip strength, upper extremity muscle strength, and lower extremity muscle strength. Dr. Schultes also noted that West had normal station and gait. Dr. Schultes diagnosed with a history of severe depression with auditory hallucinations, tenderness of the right temple, asthma, chronic low back pain, and history of chronic pain of the right knee and ankle.

On August 17, 2004, a doctor⁸ provided a Residual Functional Capacity ("RFC") assessment for West at the request of the Social Security Administration. The doctor concluded that West could (1) occasionally lift 20 pounds, (2) frequently lift 10 pounds, (3) stand and/or walk with normal breaks for about six hours in an eight-hour workday, (4) sit with normal breaks for about six hours in an eight-hour workday, (5) push and/or pull without limitation, and (5) occasionally climb, balance, stoop, kneel, crouch, and crawl. The doctor found no manipulative, visual, or communicative limitations. The doctor determined that West should avoid concentrated exposure to fumes, odors, dusts, gases and poor ventilation due to her asthma. The doctor concluded that West's allegations of limitations based on asthma and arthritis were not "totally supported by the medical evidence in [the] file. [West's] credibility is eroded as she had not sought medical attention ongoing for her physical condition. . . . [West] indicates that she is able to stand

⁸ The signature of the doctor who reviewed West's medical records and provided the Social Security Administration with a Residual Functional Capacity assessment for her is illegible. *See* Administrative Record at 219.

up to 4 hours and walk up to 2. [West] states she walks to the store to buy groceries and carries them home. [West] is able to do household chores. [West] would be deemed capable of the RFC as outlined.”⁹ On October 27, 2004, after review of all of the evidence in the file, Dr. J.D. Wilson, M.D., affirmed the doctor’s assessment as written.

2. West’s Mental Health.

On April 7, 2001, West visited Dr. Julie Filips, M.D., for depression. West indicated that she had been depressed for about two weeks. West indicated that she was suffering from the following symptoms: (1) no self-esteem, (2) fears of how she would survive, (3) lost appetite, (4) waking up frequently during the night, (5) self-doubt, (6) decreased energy, (7) decreased enjoyment in activities, (8) crying easily, and (9) decreased interest in enjoying the outdoors. Dr. Filips noted that her psychiatric history included being hospitalized for depression on two separate occasions in 1975 and 1976. West also informed Dr. Filips that she had not had any medication or consistent treatment for depression for over 25 years. Dr. Filips diagnosed West with major depressive disorder, recurrent and currently depressed. Dr. Filips treated West’s depression with Celexa.

On January 7, 2002, West saw Dr. William Stutts, D.O. regarding depression. Dr. Stutts noted that in May 2001, West switched from Celexa to Zoloft to treat her depression. West informed Dr. Stutts that the Zoloft did not help her depression and that she was currently depressed over her finances and being unemployed. West also told Dr. Stutts that she tended to sleep a lot to deal with her stress. Dr. Stutts diagnosed West with major depressive disorder, recurrent and currently depressed. Dr. Stutts treated West’s depression with Effexor XR.

On March 11, 2004, West met with Joan Thaler (“Thaler”), a licensed independent social worker employed by the Abbe Center, regarding stress and depression. Thaler noted that West had the following symptoms of depression and anxiety:

⁹ See Administrative Record at 218.

[West] has the following symptoms of depression: she's sad, discouraged, loss of appetite and sleep difficulty. She also has a loss of energy, agitation and loss of concentration. She feels hopeless, helpless, loss of motivation, thinking slowed, irritability, crying spells, difficulty coping.

[West] has the following symptoms of Anxiety: headaches, dyspnea, irritability, dizziness, tiredness, palpitations and feeling tense and nervous with poor sleep. She also has a few symptoms of Post-Traumatic Stress Disorder because she said she was severely physically abused so has flashbacks and is vigilant and strangers scare her.

In terms of Panic Disorder, [West] has palpitations, shortness of breath, dizziness and fear of dying. She said, "I can't get a grip on life." The only psychotic symptoms she talked about was hearing voices in the past.

(Administrative Record at 253) Thaler diagnosed West with major depressive disorder, recurrent, severe without psychosis. Thaler recommended that West meet with a doctor and a case manager from the Abbe Center. Thaler also noted that West might be candidate for weekly or bi-weekly therapy at the Abbe Center.

On March 11, 2004, West also met with Dr. Collyer Ekholm, M.D., a psychiatrist employed by the Abbe Center, regarding her depression. Dr. Ekholm noted that West complained of difficulty with pervasive low mood, apathy, anhedonia, initial/middle/terminal insomnia, daytime fatigue, decreased appetite with no weight loss, and trouble with finding motivation to do much in the way of personal grooming. Dr. Ekholm diagnosed West with depression, recurrent (severe). Dr. Ekholm prescribed Lexapro and Trazodone to treat West's depression.

On July 7, 2004, Dr. Dee Wright, Ph.D., completed a Psychiatric Review Technique Form for DDS. After reviewing West's medical records,¹⁰ Dr. Wright determined that West had a moderate degree of limitation in the restriction of activities of

¹⁰ Dr. Wright noted that the file she received on West did not contain any medical or mental health records from January 1, 2002 through February, 2004.

daily living and a moderate degree of limitation with difficulties in maintaining social functioning. Dr. Wright further found that West had a marked degree of limitation in difficulties in maintaining concentration, persistence, or pace. Dr. Wright also noted that West had one or two episodes of decompensation for an extended duration.

Dr. Wright also completed a psychological functional capacity assessment on July 7, 2004 for DDS based on a review of West's records. Dr. Wright found that West was not significantly limited in any area on the form, including understanding and memory, sustained concentration and persistence, social interaction, and adaptation. Dr. Wright concluded that:

[West's] previous history would indicate that when on prescribed medications her condition does improve significantly. This has been established by previous treatment notes reviewed in 2002. [West] has not been actively involved in treatment and only recently sought the same on [March 11, 2004]. If [West] remains treatment compliant, her condition will most probably continue to improve such that she could return to work activity by March 2005 which would be within twelve months of established onset date. [West's] limitations of functions at that time would not meet 12.04 listing severity.

(Administrative Record at 210)

On September 24, 2004, West met with Carol D. Aunan ("Aunan"), a family psychologist nurse practitioner employed by the Abbe Center. West's care was transferred to Aunan by Dr. Ekholm. West reported to Aunan that she was depressed at times, but her medications helped keep her together most of the time. Aunan diagnosed West with major depressive disorder, recurrent and moderate. Aunan suggested that West continue her prescriptions for Lexapro and Trazodone as treatment.

On November 3, 2004, West had a follow-up visit with Aunan. West indicated that her mood was not good. Aunan noted that West was more depressed than at her previous visit and had less energy. Aunan also noted that West was not sleeping well. Aunan once again diagnosed West with major depressive disorder, recurrent and moderate. Aunan

suggested that West take her medications at 9:00 p.m. and then go to bed at 10:00 p.m. to treat her sleeping problems. Aunan also prescribed Seroquel to help her sleep.

On December 8, 2004, West saw Aunan and reported that she had been depressed since her last visit. West also informed Aunan that the Trazodone helped her sleep, but caused her nightmares. She also told Aunan that the Seroquel provided more peaceful sleep, but caused her to be fatigued the next day. Aunan noted that West was in a depressed and anxious mood at their meeting. Aunan diagnosed West with major depressive disorder, recurrent and moderate to severe. Aunan discontinued West's prescriptions for Trazodone and Seroquel and started her on Wellbutrin to treat her sleeping problems.

On December 17, 2004, Aunan provided West's counsel with a mental impairment questionnaire regarding West's mental functional capacity. Aunan began treating West on September 24, 2004 and saw her once in November and once in December before rendering this opinion for West's counsel. Aunan diagnosed West with major depressive disorder, recurrent and moderate to severe. Aunan noted that West's depression was treated with medication and adult day treatment. Aunan stated that West's depression was minimally responsive to the treatment. Aunan further stated that West "is able to remain safe with significant external support."¹¹ Aunan also noted that West has difficulty processing new information and has difficulty accessing services to meet her basic needs.

In the questionnaire, Aunan listed the following signs and symptoms of West's depressive disorder: Decreased energy, thoughts of suicide, blunt, flat or inappropriate affect, feelings of guilt and worthlessness, poverty of content of speech, mood disturbance, difficulty thinking or concentrating (significant), recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress (nightmares), retardation, pathological dependence, passivity, or aggressivity, persistent disturbances of mood or affect, apprehensive expectation, perceptual or thinking disturbances ("nerve snapped in

¹¹ See Administrative Record at 222.

my head”), hallucinations or delusions (history), manic syndrome (history), memory impairment, sleep disturbance, emotional withdrawal or isolation, bipolar syndrome (history), and oddities of thought, perception, speech, or behavior¹².

Aunan also reported in the questionnaire that West was seriously limited but not precluded in working in coordination with or proximity to others without being unduly distracted and getting along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes. Aunan further found that West was unable to meet competitive standards for remembering work-like procedures, understanding and remembering very short and simple instructions, carrying out very short and simple instructions, maintaining regular attendance and being punctual within customary, usually strict tolerances, completing a normal workday and workweek without interruptions from psychologically based symptoms, asking simple questions or requesting assistance, and accepting instructions and responding appropriately to criticism from supervisors. Aunan also determined that West had no useful ability to function in maintaining attention for two hour segments, sustaining an ordinary routine without special supervision, making simple work related decisions, performing at a consistent pace without an unreasonable number and length of rest periods, responding appropriately to changes in a routine work setting, dealing with normal work stress, being aware of normal hazards, understanding and remembering detailed instructions, carrying out detailed instructions, setting realistic goals or making plans independently of others, and dealing with the stress of semiskilled and skilled work.¹³ In the “mental abilities and aptitude needed to do particular types of jobs” section of the questionnaire, Aunan found that West was seriously limited, but not precluded from adhering to basic standards of neatness and cleanliness and using public transportation. Aunan further found that West was unable to meet the competitive

¹² See Administrative Record at 223-24.

¹³ See Administrative Record at 225-26.

standards of interacting appropriately with the general public, maintaining socially appropriate behavior, and traveling in an unfamiliar place.

In the questionnaire, Aunan also commented that West had a “history of inability to care for herself without significant help from others.”¹⁴ Aunan also stated that West has either a low IQ or reduced intellectual functioning because she has “poverty of content of speech.”¹⁵ Aunan also found that West had marked functional limitations in the restriction of activities of daily living and maintaining social functioning. Aunan further found that West had an extreme functional limitation in concentration, persistence, and pace. Aunan also stated that West had three episodes of decompensation within the past twelve months, each of which lasted at least two weeks. Lastly, Aunan anticipated that West’s impairments or treatment would cause her to be absent for more than four days from work each month.

In a progress note dated December 28, 2004, Aunan provided the following “Interval History and Record of Session:”

[West] stated that the “medications are working.” Mood is pretty good, but depression is the “same.” She has increased energy. She is supposed to start IPR. She’s not ready to start school and did no[t] show [for] her appointment with the counselor who was suppose[d] to help her with school. She said that she feels like her “mind is not ready to obtain that information.” She’s not as motivated as she would like to be. She is up during the day. She feels like she is disappointing others. Sleep is restful. She’s not sleeping all day.

(Administrative Record at 233) Aunan diagnosed West with major depressive disorder, recurrent and moderate. Aunan continued to treat West’s depression with medication.

On January 25, 2005, West met with Aunan and reported that after Christmas, she decompensated and felt house-bound. West also told Aunan that she felt like she was in a “room with no walls and no floor” and in a small box. Aunan diagnosed West with

¹⁴ See Administrative Record at 226.

¹⁵ *Id.*

major depressive disorder, recurrent and moderate to severe with possible psychosis. Aunan continued to treat West with medication. West followed up with Aunan on February 23, 2005. In Aunan's progress notes for the follow-up visit, Aunan noted that West's mood had improved and she no longer felt like she was in a small box. Aunan diagnosed West with major depressive disorder, recurrent and moderate. Aunan continued treating West with medication. In a progress note from April 12, 2005, Aunan noted that West's mood had further improved and was good. Aunan's diagnosis continued to be major depressive disorder, recurrent and moderate. Aunan continued to treat West with medication. On August 31, 2005, in a progress note, Aunan noted that West's "[m]ood is improved, although she still suffers periodically from significant depression."¹⁶ On October 25, 2005, in a progress note, Aunan noted that "[m]ood-wise, [West] is doing well. She is stable."¹⁷ Aunan continued her diagnosis of major depressive disorder, recurrent and moderate. Aunan continued to treat West with medication.

V. CONCLUSIONS OF LAW

A. ALJ's Disability Determination

The ALJ determined that West is not disabled. In making this determination, the ALJ was required to complete the five-step sequential test provided in the social security regulations. *See* 20 C.F.R. § 404.1520(a)-(f); *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987); *Page v. Astrue*, 484 F.3d 1040, 1042 (8th Cir. 2007); *Anderson v. Barnhart*, 344 F.3d 809, 812 (8th Cir. 2003). The five steps an ALJ must consider are:

- (1) whether the claimant is gainfully employed, (2) whether the claimant has a severe impairment, (3) whether the impairment meets the criteria of any Social Security Income listings, (4) whether the impairment prevents the claimant from performing past relevant work, and (5) whether the impairment necessarily prevents the claimant from doing any other work.

¹⁶ *See* Administrative Record at 286.

¹⁷ *See* Administrative Record at 283.

Goff v. Barnhart, 421 F.3d 785, 790 (8th Cir. 2005) (citing *Eichelberger v. Barnhart*, 390 F.3d 584, 590 (8th Cir. 2004)); *see also* 20 C.F.R. § 404.1520(a)-(f). “If a claimant fails to meet the criteria at any step in the evaluation of disability, the process ends and the claimant is determined to be not disabled.” *Eichelberger*, 390 F.3d at 590-91 (citing *Ramirez v. Barnhart*, 292 F.3d 576, 580 (8th Cir. 2002)).

“To establish a disability claim, the claimant bears the initial burden of proof to show that he [or she] is unable to perform his [or her] past relevant work.” *Frankl v. Shalala*, 47 F.3d 935, 937 (8th Cir. 1995) (citing *Reed v. Sullivan*, 988 F.2d 812, 815 (8th Cir. 1993)). If the claimant meets this burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the residual functional capacity to perform a significant number of other jobs in the national economy that are consistent with claimant’s impairments and vocational factors such as age, education, and work experience. *Id.* The RFC is the most an individual can do despite the combined effect of all of his or her credible limitations. 20 C.F.R. § 416.945. “‘It is the ALJ’s responsibility to determine a claimant’s RFC based on all relevant evidence, including medical records, observations of treating physicians and others, and claimant’s own descriptions of his [or her] limitations.’” *Tellez v. Barnhart*, 403 F.3d 953, 957 (8th Cir. 2005) (quoting *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001)).

The ALJ applied the first step of the analysis and determined that West had not engaged in substantial gainful activity since her alleged onset date, January 1, 2002. At the second step, the ALJ concluded, from the medical evidence, that West had the following impairments “asthma, mild degenerative joint disease in her bilateral knees, chronic low back pain, and recurrent depression.” At the third step, the ALJ found that West did not have “an impairment or combination of impairments which specifically meets or equals the criteria of any impairment listed in [20 C.F.R. § 404.] Appendix 1, Subpart P, Regulations No. 4 (the Listing of Impairments).” At the fourth step, the ALJ determined West’s RFC as follows:

[West can] lift and carry up to 20 pounds occasionally and ten pounds frequently. She can sit, stand, or walk for a total of

about six hours in an eight-hour day with normal breaks. She can occasionally bend, stoop, squat, kneel, crawl, or climb. She cannot tolerate excessive heat or cold. She cannot tolerate more than a moderate amount of cold. She cannot perform very complex-technical work, but is capable of performing more than simple, routine, repetitive work. She requires occasional supervision. She cannot tolerate more than a mild amount of work-related stress.

Using this RFC, the ALJ determined that West “was capable of performing her past relevant work as a case aide as that work is normally performed in the national economy and as she actually performed it. In addition . . . the claimant was capable of performing her past relevant work as a hand packager as she actually performed it.” Therefore, the ALJ concluded that since West was capable of performing her past relevant work, she was “not disabled.”

B. West’s Residual Functional Capacity

West contends that the ALJ erred in three respects. First, West argues that the ALJ failed to give proper weight to the opinions of Aunan or give good reasons for discounting her opinions. Next, West argues that the ALJ failed to properly consider the testimony of West’s two witnesses from the administrative hearing. Lastly, West argues that the ALJ failed to properly evaluate her subjective allegations of functional limitations and total disability. West requests that the Court reverse the Commissioner’s decision and remand it with directions to award benefits. Alternatively, West requests this matter be remanded for further proceedings. The Commissioner argues that there is substantial evidence in the record as a whole which supports the ALJ’s decision; and therefore, the decision should be affirmed.

1. Aunan’s Opinions.

West argues that the ALJ erred in giving no weight to Aunan’s opinions regarding the mental portion of West’s RFC. The ALJ provided the following reasons for giving Aunan’s opinions no weight:

First, at the time she rendered her opinion, [Aunan] had only seen [West] three times. Her subsequent treatment records

indicate that [West's] condition improved substantially in 2005. Second, [Aunan] stated in her opinion that [West] was experiencing a number of significant psychotic symptoms. However, her treatment records do not confirm this. Third, [Aunan] is not a psychiatrist. When Dr. Ekholm was treating [West], he noted that her symptoms had significantly improved. There is nothing in the treatment records to indicate that [West's] psychiatric condition declined significantly after she started seeing [Aunan]. Fourth, [Aunan's] opinion is inconsistent with the fact that [West] was able to begin attending Kirkwood Community College in early 2005. She also was able to complete the partial hospitalization program and start the IPR program. Finally, [Aunan] recommended that [West] have a representative payee if benefits were awarded to her. However, on October 13, 2004, [Aunan], Dr. Ekholm, and Susan M. Blome, B.S.N., R.N.C., stated that [West] was capable of managing benefits on her own behalf.

(Administrative Record at 20)

West offers several arguments to support her contention that the ALJ's reasons for giving no weight to Aunan's opinions were improper. First, West argues that even though Aunan had only seen her three times before rendering an opinion regarding her mental RFC, the ALJ ignored the fact that Aunan was a part of her "treatment team" at the Abbe Center. West directs the Court to *Shontos v. Barnhart*, 328 F.3d 418 (8th Cir. 2003) to support her conclusion that "[w]hile the ALJ is technically correct in that [Aunan] had seen [West] only three times, his implication that she had limited information about [West] is wrong."¹⁸ West points out that other medical professionals at the Abbe Center saw her in 2004. Specifically, Dr. Ekholm saw her three times, Carol DePaepe ("DePaepe"), a registered nurse, saw her once, Thaler saw her twice, and from September, 2004 through November, 2004, West was a participant in the Adult Day Treatment program. West asserts that all of these individuals and all of her records from the Abbe Center were at Aunan's disposal when she offered her opinion regarding West's her mental RFC.

¹⁸ See West's Brief at 11.

The Court finds West's first argument unpersuasive. First, there is nothing in the record which suggests that the medical professionals at the Abbe Center worked as a team when treating West. Second, there is also nothing in the record which suggests Aunan reviewed the various findings of Dr. Ekholm, DePaepe, or Thaler when she rendered her opinion regarding West's mental RFC. Lastly, *Shontos* is distinguishable from the present case. In *Shontos*, the Eighth Circuit Court of Appeals found that there was substantial evidence that the three medical professionals in that case treated the claimant as a team. *Shontos*, 328 F.3d at 426. Furthermore, in *Shontos*, one of the medical professionals saw the claimant 49 times in a fifteen month period. *Id.* In this case, there is no evidence in the record that the medical professionals from the Abbe Center treated West using a team approach. Moreover, Aunan combined with the other medical professionals saw West a total of nine times compared to one medical professional seeing the claimant 49 times in *Shontos*.

West further argues that if the ALJ believed that her condition had improved in 2005, then the ALJ should have re-contacted Aunan for updated information on her condition or ordered a consultative examination to support his belief that her condition had improved. "The Commissioner's regulations explain that contacting a treating physician is necessary only if the doctor's records are 'inadequate for us to determine whether the claimant is disabled' such as 'when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.'" *Goff*, 421 F.3d at 791 (quoting 20 C.F.R. §§ 404.1512(e), 416.912(e)). In this case, the ALJ did not find Aunan's records inadequate, unclear, or incomplete, nor did he find that Aunan used unacceptable clinical techniques. Instead, the ALJ discounted Aunan's opinions because he found them to be inconsistent with other substantial evidence. Under such circumstances, an ALJ may discount Aunan's opinion without seeking clarification. *See Goff*, 421 F.3d at 791. Accordingly, the Court finds this particular argument from West to be without merit.

Lastly, West argues that the inconsistencies in the record and Aunan's opinion regarding her mental RFC described by the ALJ in his decision are not supported by substantial evidence. As a nurse practitioner, Aunan's opinion is considered "other medical evidence." 20 C.F.R. §§ 404.1513(d)(1), 416.913(d)(1) (2007). "In determining what weight to give 'other medical evidence,' the ALJ has more discretion and is permitted to consider any inconsistencies found within the record." *Raney v. Barnhart*, 396 F.3d 1007, 1010 (8th Cir. 2005); 20 C.F.R. § 416.927(d)(4). The factors for considering opinion evidence from a source such as Aunan include: (1) How long the source has known and how frequently the source has seen the individual; (2) how consistent the opinion is with other evidence; (3) the degree to which the source presents relevant evidence to support an opinion; (4) how the source explains the opinion; (5) whether the source has a specialty or area of expertise related to the individual's impairment(s); and (6) any other factors that tend to support or refute the opinion. *Sloan v. Astrue*, 499 F.3d 883, 889 (8th Cir. 2007).

In her answers to the mental impairment questionnaire regarding West's mental functional capacity provided to her by West's attorney, Aunan opined that West was unable to meet competitive standards for remembering work like procedures, understanding and remembering very short and simple instructions, carrying out very short and simple instructions, maintaining regular attendance and being punctual within customary, usually strict tolerances, completing a normal workday and workweek without interruptions from psychologically based symptoms, asking simple questions or requesting assistance, and accepting instructions and responding appropriately to criticism from supervisors. Aunan also determined that West had no useful ability to function in maintaining attention for two hour segments, sustaining an ordinary routine without special supervision, making simple work related decisions, performing at a consistent pace without an unreasonable number and length of rest periods, responding appropriately to changes in a routine work setting, dealing with normal work stress, being aware of normal hazards, understanding and remembering detailed instructions, carrying out detailed instructions, setting realistic goals

or making plans independently of others, and dealing with the stress of semiskilled and skilled work. Furthermore, Aunan also stated that West has either a low IQ or reduced intellectual functioning because she has “poverty of content of speech.” Aunan also found that West had marked functional limitations in the restriction of activities of daily living and maintaining social functioning. Aunan further found that West had an extreme functional limitation in concentration, persistence, and pace.

The record demonstrates that prior to providing her opinion with regard to West’s mental RFC, Aunan met with West three times. The progress notes from those three meetings provide that Aunan and West mainly discussed West’s medications, how those medications helped West’s depression, and West’s sleeping problems. After the first two meetings, Aunan diagnosed West with major depressive disorder, recurrent and moderate both times. After the third meeting, Aunan diagnosed West with major depressive disorder, recurrent and moderate to severe. Eleven days after providing her opinion on West’s mental RFC, Aunan met with West and in her progress note stated West’s mood was good and the medications were working. In January 2005, Aunan met with West and noted that she decompensated after Christmas and felt house-bound; however, in subsequent meetings in February, April, and August, 2005, Aunan noted that West’s mood had improved since January and was good. In addition, in 2005, West began taking classes at Kirkwood Community College and continued to attend programs at the Abbe Center.

In comparing Aunan’s opinions regarding West’s mental RFC with her treatment notes and diagnoses and other evidence in the record, the Court finds that there is substantial evidence which supports the ALJ’s finding that West’s condition improved in 2005 and Aunan’s opinions were inconsistent with West’s treatment records and ability to attend classes at Kirkwood Community College and programs at the Abbe Center. The Court, having considered the entire record and the factors set forth in *Sloan*, finds that the ALJ’s determination that Aunan’s opinions are entitled to no weight is supported by substantial evidence. Even though inconsistent conclusions could be drawn on this issue,

the court upholds the conclusions of the ALJ because they are supported by substantial evidence on the record as a whole. *Guilliams*, 393 F.3d at 801.

2. Credibility of the Testimony of West's Two Witnesses.

West argues that the ALJ failed to explain his reasons for giving Zerbel and Jacobs' hearing testimony some weight, the meaning of "some weight," and how their testimony was applied to her mental RFC. Assessment of the credibility of witness testimony lies within the province of the ALJ. *Siemers v. Shalala*, 47 F.3d 299, 302 (8th Cir. 1995). Deference is given to an ALJ's witness credibility determination, if his or her determination is supported by good reasons and substantial evidence. *Vester*, 416 F.3d at 889 (citation omitted). In his decision, the ALJ thoroughly reviewed Zerbel and Jacobs' testimony from the hearing.¹⁹ The ALJ concluded that Zerbel and Jacobs' testimony was

entitled to some weight in determining the mental portion of [West's] residual functional capacity. Both indicated that [West] does not tolerate stress very well. In addition, both indicated that [West] has some limitations in her ability to maintain concentration, persistence, and pace.

(Administrative Record at 21) In discussing West's mental impairments, the ALJ found that West had "mild restrictions in her activities of daily living, mild difficulties in maintaining social functioning, and moderate difficulties in maintaining concentration, persistence, or pace."²⁰ Additionally, in West's overall RFC, the ALJ provides that West has difficulty dealing with stress. After reviewing the record, the Court finds that the ALJ provided a thorough review of Zerbel and Jacobs' testimony, the ALJ explained the weight he gave their testimony, and he applied their testimony to his finding regarding West's mental RFC in a manner consistent with his explanation of their testimony. Accordingly, the Court will defer to the ALJ's credibility determination of Zerbel and Jacobs' testimony. *Vester*, 416 F.3d at 889.

3. Credibility of West's Testimony.

¹⁹ See Administrative Record at 20-21.

²⁰ See Administrative Record at 21.

West argues that the ALJ failed to properly evaluate her subjective allegations of functional limitations and total disability because he did not identify inconsistencies in the record as a whole. West further argues that the record as a whole does not contain inconsistent evidence with regard to subjective allegations of functional limitations and total disability. Specifically, West states “[g]iven the weight of the evidence in the record as a whole, the ALJ’s credibility analysis should be reversed and this matter should be remanded for a proper credibility assessment.”²¹

When evaluating the credibility of a claimant’s subjective complaints, the ALJ may not disregard them “solely because the objective medical evidence does not fully support them.” *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984). However, the absence of objective medical evidence to support a claimant’s subjective complaints is a relevant factor for an ALJ to consider. *Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citation omitted). “The [ALJ] must give full consideration to all the evidence presented relating to subjective complaints, including the claimant’s prior work record, and observations by third parties and treating and examining physicians relating to such matters as: (1) the claimant’s daily activities; (2) the duration, frequency, and intensity of the pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness and side effects of medication; [and] (5) functional restrictions.” *Polaski*, 739 F.2d at 1322. However, the ALJ is not required to “explicitly discuss each *Polaski* factor.” *Wagner v. Astrue*, 499 F.3d 842, 851 (8th Cir. 2007) (quoting *Goff*, 421 F.3d at 791). Subjective complaints may be discounted if inconsistencies exist in the evidence as a whole. *Pelkey v. Barnhart*, 433 F.3d 575, 578 (8th Cir. 2006) (citing *Polaski*, 739 F.2d at 1322). However, the ALJ must give reasons for discrediting the claimant. *Id.* (citing *Strongson v. Barnhart*, 361 F.3d 1066, 1072 (8th Cir. 2004)). Where an ALJ seriously considers, but for good reason explicitly discredits a claimant’s subjective complaints, the Court will not disturb the ALJ’s credibility determination. *Johnson v. Apfel*, 240 F.3d 1145, 1148 (8th Cir. 2001) (citing

²¹ See West’s Brief at 21.

Pena v. Chater, 76 F.3d 906, 908 (8th Cir. 1996)); *see also* *Guilliams*, 393 F.3d at 801 (explaining that deference to an ALJ's credibility determination is warranted if the determination is supported by good reasons and substantial evidence). "The credibility of a claimant's subjective testimony is primarily for the ALJ to decide, not the courts." *Wagner*, 499 F.3d at 851 (quotation *Pearsall*, 274 F.3d at 1218).

In determining that West's subjective allegations of functional limitations and total disability were not credible, the ALJ found:

[West's] allegation of total disability is not credible. First, [West's] allegation is not supported by the objective medical evidence. [West] has asthma and needs to use an inhaler periodically. However, she has never been hospitalized for an asthma exacerbation or required emergency room treatment. . . . [West] has low back and right knee pain. When she was examined by Dr. Schultes, she had some limitations in the range of motion of her lumbar spine, bilateral knees, and bilateral ankles. However, she had normal strength in her upper and lower extremities, normal grip strength, and normal neurological findings. . . . [West] has a history of recurrent depression. She was treated for depression at the Center in 2001, but stopped going for treatment after a few months. She then sought treatment at the Abbe Center in March 2004. Once she started undergoing treatment at the Abbe Center, her symptoms improved. She completed the partial hospitalization program in 2005, and then started attending classes at Kirkwood Community College. Second, [West] reported that she has experienced recurrent major depression for a number of years. However, she was able to perform substantial gainful activity in the past. Third, [West] testified that she has a learning disability. However, she graduated from high school and also became a certified nurse's assistant. She has maintained a "B" or "C" average while taking classes at Kirkwood Community College. . . . Finally, [West's] activities of daily living are inconsistent with her allegation. She cooks her own meals, shops, takes care of her own personal hygiene tasks, performs household chores, and attends community college classes on a daily basis." She has an unrestricted driver's license. She uses public transportation to get to school.

(Administrative Record at 24) Having reviewed the record, the Court finds that the ALJ seriously considered West's subjective allegations of functional limitations and total disability, applied the *Polaski* factors, and discredited her allegations for good reasons. *See Pelkey*, 433 F.3d at 578 (good reasons must be given for discrediting a complainant); *see also Tellez*, 403 F.3d at 957 (deference to and ALJ's findings regarding the credibility of a claimant is supported by an ALJ's finding that a claimant's activities of daily living are inconsistent with his or her allegations of total disability). Therefore, the court will not disturb the ALJ's credibility determination. *Johnson*, 240 F.3d at 1147. After considering the weight of the evidence and balancing the factors supporting the ALJ's credibility determination against the factors in support of West's claim, the court finds that the ALJ's determination that West's allegations of functional limitations and total disability were not credible is supported by substantial evidence.

VI. CONCLUSION

The court finds that the ALJ considered all of the relevant evidence in this case, including the medical records of West's treating, examining, and evaluating sources, the testimony of West's witnesses, and West's own description of her conditions. *See Tellez*, 403 F.3d at 957. The ALJ's determination of West's RFC was influenced by his finding that West was not fully credible and Aunan's opinions regarding West's mental RFC was entitled to no weight. Furthermore, the ALJ properly weighed the credibility of West's witnesses. Therefore the Court determines that the ALJ's decision is supported by substantial evidence and shall be affirmed.

VII. ORDER

For the foregoing reasons, it is hereby **ORDERED**:

1. The final decision of the Commissioner of Social Security is **AFFIRMED**;
2. Plaintiff's Complaint (docket number 3) is **DISMISSED** with prejudice; and
3. The Clerk of Court is directed to enter judgment accordingly.

DATED this 10th day of December, 2007.

JON STUART SCOLES
United States Magistrate Judge
NORTHERN DISTRICT OF IOWA