

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
NORTHERN DIVISION

DOUGLAS SPURGEON,)
)
 Plaintiff,)
)
 v.) No. 2:02 CV 29 DDN
)
 JO ANNE B. BARNHART,)
 Commissioner of)
 Social Security,)
)
 Defendant.)

MEMORANDUM

This action is before the court for judicial review of the final decision of the defendant Commissioner of Social Security denying the application of plaintiff Douglas Spurgeon for disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401 et seq. (Title II or the Act). The parties consented to the exercise of plenary authority by the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(c). Oral argument was heard on August 19, 2003.

On April 15, 1998, plaintiff, who was born on December 30, 1959, filed his application for disability insurance benefits under Title II. (Tr. 79-81.) Plaintiff alleged he became disabled on July 1, 1995, at age 35, because of a combination of emotional and physical impairments, including back pain and an immune system disorder. Plaintiff's application was denied initially and after reconsideration.

On October 1, 1999, after a hearing, an Administrative Law Judge (ALJ) found and concluded that plaintiff was not disabled and was not entitled to disability insurance benefits. The ALJ made the following enumerated findings and conclusions:

1. The claimant met the disability insured status requirements of the Social Security Act on July 1, 1995.

2. The claimant has not engaged in substantial gainful activity since at least July 1995.
3. The medical evidence establishes that the claimant has a history of a single episode of major depression. The claimant does not have a medically determinable severe physical impairment. The claimant does not have, and has not had, a severe mental impairment imposing significant limitations of function for a period of twelve continuous months in duration.
4. The claimant has not been under a disability as defined in the Social Security Act, at any time through the date of this decision. (20 CFR 404.1505(a) and 404.1520(c)).

(Tr. 21.) The Appeals Council denied plaintiff's request for review of the ALJ's decision. Thus, the ALJ's decision became the final decision of the Commissioner.

General rules of decision

Under the Act, plaintiff must prove that he is unable to perform any substantial gainful activity due to any medically determinable physical or mental impairment which would either result in death or which has lasted or could be expected to last for a continuous period of at least twelve months. See 42 U.S.C. § 423(a). In the five-step analysis used for determining disability, see 20 C.F.R. § 404.1520(a)-(f); Bowen v. Yuckert, 482 U.S. 137, 140-42 (1987), "the claimant bears the initial burden to show that he is unable to perform his past relevant work," Frankl v. Shalala, 47 F.3d 935, 937 (8th Cir. 1995). If a claimant successfully meets this burden, the burden shifts to the Commissioner to demonstrate that he retains the physical residual functional capacity to perform a job that exists in significant numbers in the national economy. Id.; see Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000).

When judicially reviewing the Commissioner's final decision, the court must determine whether the Commissioner's findings are supported by substantial evidence in the record as a whole. See 42 U.S.C. § 405(g); Krogmeier v. Barnhart, 294 F.3d 1019, 1022 (8th Cir. 2002). "Substantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." Krogmeier, 299 F.3d at 1022. In determining whether the evidence is substantial, the court must consider evidence that detracts from, as well as supports, the Commissioner's decision. Id. So long as substantial evidence supports that decision, the court may not reverse it because substantial evidence exists in the record that would have supported a contrary outcome or because the court would have decided the case differently. Id.

Administrative record

Plaintiff alleged he became disabled in July 1995 due to back pain, depression, immune dysfunction, flu-like symptoms, diarrhea, headaches, nausea, confusion, memory and concentration difficulties, sweaty palms, fever, swollen glands in his underarms which cut off the flow of blood to his hands, chronic fatigue syndrome, colds, and allergies. (Tr. 114, 147-48, 156.) His past work included factory worker and laborer. (Tr. 141-42, 158.)

On May 12, 1998, plaintiff was examined by Lawrence Lampton, M.D., at the request of the state Disability Determinations agency. Plaintiff had complaints of back pain, immune system disorder, abdominal pain, and numb spots on his body. Plaintiff had not seen a physician so there were no medical records for Dr. Lampton to review. Plaintiff had quit work in 1995 or 1996 due to his back pain. Dr. Lampton observed that, other than having some muscle atrophy from disuse and some stiffness in his back, very little could be found wrong with the plaintiff physically. Dr. Lampton's

impression was that plaintiff was considerably depressed with significant somatization but presented with no psychological problems. Dr. Lampton recommended that plaintiff have a psychological evaluation and treatment before he could undertake significant gainful employment. (Tr. 166-68.)

Also on May 12, 1998, plaintiff saw licensed psychologist Ruthie Moccia for a consultative mental examination. Plaintiff indicated that he had tried a number of drugs in the past and that his last drug use was "a few years ago." His remote memory and recent memory seemed intact. Plaintiff responded in an inappropriate manner to a question of social judgment. Ms. Moccia found that plaintiff had an agitated mood and poor self-care; had a history of alcohol and drug abuse; was oriented to the date but had difficulty with the day of the week, most likely due to inactivity; was alert for mental status tasks; grasped and followed directions well; was able to persist with a difficult mental task when required; did well with abstract numerical and verbal tasks of reasoning; had poor social judgment; and appeared able to manage his own funds. Ms. Moccia diagnosed dysthymic disorder; alcohol, cannabis, cocaine, amphetamine, and hallucinogen abuse; and conduct disorder. All of these diagnoses other than dysthymic disorder were noted in plaintiff's history. Plaintiff was also diagnosed with an anti-social personality disorder and given a Global Assessment of Functioning (GAF) score of 60, which indicated moderate symptoms. (Tr. 173-74.)

On June 11, 1998, plaintiff had a normal lumbar spine X-ray. (Tr. 175.)

During the rest of 1998 plaintiff was seen at the University of Missouri Hospital and Clinics. On August 17, 1998, he was given an initial psychiatric evaluation. He was noted to have been unemployed for the previous three years, assertedly due to back pain. Plaintiff complained of feeling depressed for the last two

years. He reported only four hours of sleep per night with "initial and middle" insomnia, and decreased appetite and decreased concentration for the last two years. He had feelings of hopelessness and worthlessness and had no energy for the same period of time. He expressed some guilty feeling as he lost the custody of his children because he could not take care of them. Plaintiff had suicidal thoughts in April 1998. He reported he stopped drinking alcohol three years earlier. He denied use of any illegal drugs. (Tr. 176.) Plaintiff expressed some paranoia by stating that "people were after him." His mood was depressed and his affect was flat. (Tr. 177.) Dr. Ahmad also found that plaintiff was alert, oriented, and cooperative, and his memory was intact. (Tr. 179.)

Plaintiff was diagnosed by Dr. Saleh Ahmad and Dr. Nemesio Gutierrez thus:

Axis I 1. Major depression, single. 2. Alcohol dependence in full remission. 3. Rule out malingering. Patient suggested that he is trying to be on disability.

Axis II Rule out dependent personality disorder.

Axis III History of chronic back pain.

Axis IV Severe, social, financial, occupational, physical and relationship problems.

Axis V GAF 45.

(Tr. 177.) Dr. Gutierrez found: "Don't see him as being clinically depressed; also states antidepressants don't help--after 2 wks." (Tr. 180.)

On August 31, Dr. Ahmad noted that plaintiff was suffering from major depression. Plaintiff's Paxil dosage was increased. (Tr. 182-83.) On September 14, Dr. Ahmad diagnosed recurrent major depression. Plaintiff's sleep, appetite, and concentration were

noted to be poor. He felt tired. Plaintiff was prescribed Trazodone. (Tr. 185-86.)

On September 28, Dr. Ahmad again diagnosed major depression, recurrent. He denied alcohol abuse or any other substance abuse. Plaintiff had vague suicidal thoughts with no plan. (Tr. 188.) Plaintiff was continued on Paxil and Trazodone, and started on Wellbutrin. (Tr. 189.) On October 12, Dr. Ahmad again diagnosed major depression. Plaintiff's mood was unchanged, his sleep was poor; he had poor concentration and energy level; he felt hopeless at times; and he complained of chronic back pain. (Tr. 191.)

On October 19, Dr. Ahmad saw plaintiff as still depressed. (Tr. 194.) When plaintiff was seen on October 26, 1998, Dr. Ahmad started him on psychotherapy. (Tr. 198.)

On November 2 and 9, 1998, Linda Hodges saw plaintiff for psychotherapy by Linda Hodges. He related that he "hangs around the house" and watches religious shows on television that contribute to his gloominess and negative outlook. She saw him again on November 9, 1998. (Tr. 199-02.)

On November 16, 1998, plaintiff was seen by Dr. Ahmad who noted that plaintiff's symptoms had improved and that he was doing relatively well and feeling better. His mood was good; his energy and concentration had improved. Plaintiff denied further suicidal thoughts. (Tr. 203.)

Plaintiff also saw Linda Hodges for psychotherapy on November 16, 1998. He told Ms. Hodges he was moving to his grandfather's farm to help care for his grandmother. He was concerned that his family "may expect more of him than he is capable of." All during the session, plaintiff held his neck and his hands and shifted his position frequently because of pain. Hodges diagnosed continued depression but noted that plaintiff was doing better. (Tr. 205.)

In April 1999, plaintiff began treatment with Dr. Ann Genovese, a psychiatrist. He had seen her before. He complained of fatigue, impaired concentration, and low self worth. he was living with his grandparents and running some errands for them. Dr. Genovese diagnosed plaintiff with severe recurrent major depression and dysthymia; alcohol abuse, in remission; rule out antisocial personality disorder; rule out chronic fatigue syndrome. (Tr. 208.)

Plaintiff saw Dr. Genovese on May 24, 1999, and continued to complain of insomnia and chronic suicidal ideation. His motivation for treatment seemed low. Dr. Genovese stated, "It is possible that he is feeling discouraged about the possibility of benefit at this time." (Tr. 209.)

On May 24, 1999, Dr. Genovese completed a Medical Assessment of Ability to do Work-Related Activities (Mental). Dr. Genovese assessed plaintiff's abilities to relate to co-workers, deal with the public, interact with supervisors, deal with work stresses, maintain attention and concentration, behave in an emotionally stable manner, relate predictably in social situations, and demonstrate reliability. These were all rated "Fair," which was defined as the "ability to function in this area is seriously limited, but not precluded." Rated "good" were plaintiff's abilities to follow work rules; use judgment; function independently; and understand, remember, and carry out simple job instructions. Dr. Genovese wrote, "I have had only 3 outpatient visits with this gentleman. It is difficult for me to judge his motivation for treatment at this time." (Tr. 206-07.)

On July 9, 1999, plaintiff saw Dr. Daryl Miller at the Quincy Medical Group in Quincy, Illinois. Plaintiff's chief complaints were fatigue, recurrent flu-like symptoms, and a problem with sweating. (Tr. 218.) Plaintiff complained that his problems had been going on for the past two to three years. Dr. Miller's

impressions were that plaintiff had a variant of chronic fatigue syndrome versus a fibromyalgia. (Tr. 219.) Plaintiff did not have 11 out of 18 tender points associated with fibromyalgia, but did have an altered sleep pattern in conjunction with his myalgias and arthralgias. This was an atypical presentation. (Tr. 220.)

On July 22, 1999, plaintiff saw Dr. Russel Newton, a psychologist, at the request of the state Disability Determinations agency. Dr. Newton wrote that plaintiff's psychomotor activity was mildly slowed and his affect was mildly restricted. Plaintiff complained that his moods were not good, his sleep and appetite were poor, his thoughts of suicide had lessened, and his future seemed grim. (Tr. 211.)

Plaintiff took a Minnesota Multiphasic Personality Inventory (MMPI) test which generated a profile that was grossly elevated and suspected to be a "fake bad" profile. Dr. Newton stated that persons with the scores that plaintiff had suggested plaintiff tried to present himself in the worst possible light. Plaintiff's test results indicated a person with severe depression. (Tr. 213.) He went on to state:

Persons with comparable elevations are basically dependent and ineffective. They have problems being assertive. They are irritable and resentful, fear loss of control, do not express themselves directly. They try to deny impulses.

(Tr. 213.) Psychologist Newton diagnosed "Malingering, Major Depressive Disorder, Single Episode (by history)." Dr. Newton failed to diagnose any personality disorder and assessed a GAF of 55. Dr. Newton wrote:

Douglas presents with a clear sensorium, intact attention and concentration. His ability to maintain himself, to drive here without accident, and other factors are inconsistent with the level of depression suggested by the MMPI clinical scales, and confirm the diagnosis of malingering.

(Tr. 214.) Dr. Newton rated plaintiff's abilities to relate to co-workers and deal with the public as seriously limited, but not precluded. His abilities to follow work rules, use judgment, interact with supervisors, deal with stresses, function independently, and maintain attention and concentration were rated "good." (Tr. 216.)

At the hearing before the ALJ, plaintiff testified he was living with his wife in a trailer beside his grandfather's house. Plaintiff graduated high school. (Tr. 31.) He had been in jail three times, twice for trespassing and once for carrying a concealed weapon. (Tr. 32.) Plaintiff last worked in 1995 as a factory worker. He quit his job because he thought he would be fired due to high absenteeism caused by back pain. (Tr. 34.) He drove approximately 60 or 70 miles to the hearing. (Tr. 35.)

Plaintiff also testified that his disabling problems were his pain in his back, neck, and shoulders, joint pain and stiffness, flue-like symptoms, weakened immune system, nausea, diarrhea, headaches, and fever, along with depression, confusion, short term memory loss, and difficulty concentrating. (Tr. 35.)

Plaintiff testified he was denied Medicaid, because he had owned property in Clarence, Missouri, which was worth approximately \$12,000. (Tr. 37.) He smokes half of a pack of cigarettes per day, had not consumed alcohol since 1998, and had not used any illegal drugs in the last five years. (Tr. 38.) His sleep was very poor at night. A typical day included getting up at 9:00 a.m. and going to his grandfather's house to help his grandparents by driving them to the doctor or to the store or watering their garden. (Tr. 38-39.) His grandfather planted the garden, which was about one-fourth of an acre. (Tr. 40.)

Plaintiff last saw Dr. Genovese at the end of May. He was seeing this doctor for depression. Plaintiff indicated that his depression caused him to feel like doing nothing. He would just

stay in his trailer. Sometimes he would go sit with his grandmother. Plaintiff also thought about suicide. Plaintiff sometimes slept during the day because he could not sleep at night. He would sleep up to three hours during the day. (Tr. 41-44.)

Administrative Law Judge opinion

The ALJ found that the plaintiff did not have either a medically determinable severe physical or mental impairment which imposed significant limitation of function for twelve continuous months. Therefore, the ALJ concluded that plaintiff was not disabled. (Tr. 21.)

The parties' arguments

Plaintiff argues that the ALJ erred by finding that the plaintiff's mental impairment was not severe. Defendant argues-- and the court agrees--that the ALJ's determination was supported by substantial evidence on the record as a whole.

Plaintiff has the burden of proving disability by establishing a physical or mental impairment which will last for at least 12 consecutive months and for 12 months prevents him from engaging in substantial gainful activity. See 42 U.S.C. § 423(d); Barnhart v. Walton, 122 S.Ct. 1265, 1268-70 (2002); Wiseman v. Sullivan, 905 F.2d 1153, 1155 (8th Cir. 1990).

At Step Two of the decisional sequence, the ALJ found that plaintiff had a single episode of major depressive disorder, but did not have any "severe" impairment. A severe impairment is an impairment or combination of impairments which significantly limits a claimant's physical or mental ability to perform basic work activities without regard to age, education, or work experience. See 20 C.F.R. §§ 404.1520(c), 404.1521(a). Basic work activities encompass the abilities and aptitudes necessary for most jobs. These include walking, standing, sitting, lifting, pushing,

pulling, reaching, carrying, or handling; capacities for seeing, hearing, and speaking; understanding, performing, and remembering simple instructions; using judgment; responding appropriately to supervision, co-workers, and usual work situations; and dealing with changes in a routine work situation. See 20 C.F.R. § 404.1521(b)(1)-(6).

The ALJ's evaluation may be terminated at Step Two only when an impairment or combination of impairments would have no more than a minimal effect on the claimant's ability to work. Nguyen v. Chater, 75 F.3d 429, 431 (8th Cir. 1996).

The ALJ determined that plaintiff's testimony was not credible. (Tr. 18.) In doing so, the ALJ was consistent with the standard set forth in Polaski v. Heckler, 751 F.2d 943 (8th Cir. 1984), and the regulations at 20 C.F.R. § 404.1529. The ALJ considered the entire record of evidence and discussed the objective and opinion medical evidence, plaintiff's testimony, treatment measures, plaintiff's activities, and plaintiff's work history in finding his allegations of significantly limiting impairments not fully credible. (Tr. 11-21.)

Dr. Lampton saw plaintiff on May 12, 1998, and indicated that plaintiff was considerably depressed, but presented no psychological problems. (Tr. 12, 168.) On that same date, Dr. Moccia saw plaintiff for a consultative psychological evaluation and found that he had a dysthymic disorder and an anti-social personality, but was able to perform serial sevens and simple math calculations. (Tr. 12, 174.) Furthermore, plaintiff's GAF value at that time was 60, which indicated, at most, moderate symptoms. (Tr. 12, 174.) Plaintiff finally sought treatment for mental health problems on August 17, 1998, from Dr. Saleh Ahmad. (Tr. 12, 176.) Although Dr. Ahmad diagnosed a single episode of major depression, he noted that plaintiff was not clinically depressed. (Tr. 12-13, 179-80.) Dr. Ahmad further found that plaintiff was

alert, oriented, and cooperative, and that his memory was intact. (Tr. 13, 179.)

Even assuming plaintiff had a "severe" mental impairment, there is no indication that his depressive symptoms lasted 12 months. By November 1998, his symptoms had improved and he was doing relatively well. (Tr. 13, 199, 203, 205.) His mood was noted to be good, his affect was bright, his speech was normal, and his concentration, energy, and sleep were improving. (Tr. 13, 203.)

A claimant's subjective complaints cannot be disregarded only because they are not fully supported by objective medical evidence, they may be discredited by inconsistencies in the record. Johnson v. Chater, 108 F.3d 942, 947 (8th Cir. 1997).

Plaintiff began treatment with Dr. Genovese in April 1999. (Tr. 13, 208.) On April 2, 1999, and on May 24, 1999, she diagnosed severe recurrent major depression and dysthymia. (Tr. 14, 208-09.) In a medical assessment of plaintiff's ability to perform work-related activities dated May 24, 1999, she indicated that plaintiff had serious limitations in several areas of work-related activities and personal-social adjustments. (Tr. 14, 206-07.) In evaluating the severity of plaintiff's alleged mental problems, the ALJ considered and properly found Dr. Genovese's assessment entitled to little weight. (Tr. 14.) Dr. Genovese only saw plaintiff on three occasions and noted that it was difficult to judge his motivation for treatment. (Tr. 14, 207.) Unlike Dr. Ahmad's treatment notes, Dr. Genovese's do not contain many personal observations but reflect plaintiff's complaints. (Tr. 14, 208-09.) Plaintiff's reported symptoms to Dr. Genovese are inconsistent with the findings and observations of Dr. Ahmad as well as plaintiff's statements to Dr. Ahmad regarding the improvement of his symptoms. (Tr. 14, 176-205.)

Also, Dr. Genovese's assessment of serious symptoms is not consistent with the findings of Drs. Ahmad and Moccia, or Dr. Newton. (Tr. 12-16, 173-75, 176-205, 211-13.) "Although a treating physician's opinion is generally entitled to substantial weight, such opinion does not automatically control, since the record must be evaluated as a whole." Wilson v. Apfel, 172 F.3d 539, 542 (8th Cir. 1999) (internal quotation omitted). The ALJ properly discredited the treating physician's opinions which are inconsistent with, and contradicted by, other evidence in the record. Weber v. Apfel, 164 F.3d 431, 432 (8th Cir. 1999).

Also, plaintiff's treatment was minimal and sporadic. (Tr. 16-17.) Although plaintiff alleged disability since July 1995, he did not seek treatment for depression until August 1998. (Tr. 16, 176.) There is no evidence of treatment sought on more than three occasions from November 1998 through June 1999, and there is no evidence of mental health treatment after June 1999. (Tr. 16, 199-210.) Furthermore, the evidence shows only sporadic use of medication. (Tr. 16.) On August 17, 1998, plaintiff had been using Paxil for two weeks. (Tr. 16, 176, 180.) Prior to that he used only over-the-counter herbal supplements. (Tr. 16, 180.) Allegations of disabling pain may lawfully be discounted due to minimal or conservative treatment. Barrett v. Shalala, 38 F.3d 1019, 1023 (8th Cir. 1994).

The record indicates that plaintiff exaggerated his symptoms. (Tr. 15.) On July 22, 1999, Dr. Newton administered the MMPI to plaintiff. (Tr. 15, 213.) Testing revealed a "grossly elevated," "suspicious," and "fake bad profile." (Tr. 15, 213-14.) His scores reflected a "focused and purposeful effort to present himself in the worst possible light," and "could not conceivably be produced without such an effort." (Tr. 15, 214.) Furthermore, Dr. Newton's evaluation revealed only mildly slowed psychomotor activity, mildly restricted affect, clear sensorium, intact

attention and concentration, the ability to maintain himself, and the ability to drive himself to the examination. (Tr. 15, 211-14.) The doctor also found that plaintiff was capable of making nearly all adjustments to work-related activities in a satisfactory manner. (Tr. 15, 216-17.) Dr. Newton diagnosed malingering and a single episode of major depressive disorder by history. (Tr. 15, 214.) An ALJ may properly consider a claimant's exaggeration of his symptoms in evaluating his subjective complaints. Jones v. Callahan, 122 F.3d 1148, 1152 (8th Cir. 1997).

The ALJ also lawfully considered that plaintiff's daily activities were inconsistent with the presence of severe mental or physical limitations. (Tr. 18-19.) Plaintiff testified that he helped care for his grandparents, took his grandfather on errands, went fishing, and helped his grandfather with his quarter-acre garden. (Tr. 18-19, 38-40, 42, 149-50, 208.) "Allegations of pain may be discredited by evidence of daily activities inconsistent with such allegations." Davis v. Apfel, 239 F.3d 962, 967 (8th Cir. 2001).

The record indicates that plaintiff did not stop working due to medical impairments, but after his company made a statement about abuse of medical leave. (Tr. 20, 34, 146.) Plaintiff testified that he felt this statement was directed at him. (Tr. 20, 34.) The ALJ may consider the claimant's leaving work for reasons other than a medical condition. Barrett, 38 F.3d at 1023. No physician recommended that he stop working or stated that he was disabled despite his absenteeism from work. (Tr. 20.) Brown v. Chater, 87 F.3d 963, 965 (8th Cir. 1996) (lack of significant restrictions imposed by treating physicians indicated no disability).

Plaintiff's extensive criminal history also weighs against his overall credibility. (Tr. 19.) Plaintiff reported on May 12, 1998, that he had been arrested "fifteen or twenty" times for

charges of concealed weapon, assault, trespassing, driving without a license, and driving while intoxicated. (Tr. 19, 173.) He also reported in May 1998 that he sells "illegal stuff." (Tr. 20, 173.) Although these facts do not disprove alleged disabling symptoms, they are properly considered in evaluating his overall credibility. (Tr. 19-20.)

For these reasons, substantial evidence supports the ALJ's decision denying benefits. The decision of the Commissioner is affirmed. An appropriate order is issued herewith.

DAVID D. NOCE
UNITED STATES MAGISTRATE JUDGE

Signed this _____ day of September, 2003.