UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

LAURIE SHINE :
:
V. : CIV. NO. 3:02CV1482 (JCH)
:
JO ANNE BARNHART, :
COMMISSIONER, SOCIAL SECURITY:
ADMINISTRATION :

CORRECTED RECOMMENDED RULING[1]

Plaintiff Laurie Shine seeks judicial review of a final decision by the Commissioner of Social Security denying her application for supplemental security income (SSI) pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§1381 et seq. Plaintiff argues that the evidence in the record demonstrates that defendant's decision to deny SSI disability benefits was not supported by substantial evidence. Plaintiff moves the Court for an order reversing the decision of the Commission and remanding for further proceedings pursuant to 42 U.S.C. §§405(g)m, 1383(c)(3).

For the reasons that follow, plaintiff's Motion for Order Reversing the Decision of the Commissioner and Order for Remand [**doc. #6**] is **GRANTED**. Defendant's Motion for Order Affirming the Decision

[1]The Court issues this ruling to correct a citation on page 45 of this ruling. The original recommended ruling improperly cited Social Security Ruling (SSR) 85-5; the correct citation is to SSR 85-15. This change was made at the request of plaintiff's counsel and with the consent of defendant's counsel. Spilka let. 3/18/04.

of the Commissioner [**Doc. #9**] is **DENIED**.

BACKGROUND

Laurie Shine was born on April 21, 1964 (See R. 45).[2] She finished high school and attended cosmetic school (R. 46, 182). Her past work experience includes employment as a building cleaner, veterinarian assistant, sewing machine operator, sales clerk, cashier, hostess and waitress (R. 66-67, 182). She has a history of bi-polar disorder; she also suffers from drug and alcohol dependence, but that is currently in remission.

Ms. Shine filed her first application for supplemental security income on November 13, 1996 (R. 120-123). That claim was denied on March 14, 1997 (R. 84-87), with plaintiff taking no further appeal.

On February 20, 1998, Ms. Shine reapplied for supplemental security income based on manic depression, anxiety, vision problems, and an eating disorder (R. 124-127, 180). She reported that she had been unable to hold a job since June 1, 1997. (R. 180). This application was denied, as was her subsequent request for reconsideration (R. 88-91, 94-97). Ms. Shine then requested a hearing before an Administrative Law Judge (ALJ) (R. 98). On April 26, 1999, Ms. Shine appeared with counsel before ALJ Ronald Thomas (R. 41). He heard testimony from Ms. Shine and Jeffrey R. Blank, a

[2]The administrative record filed by the Commissioner shall be referred to as "R.".

vocational expert. The ALJ issued an unfavorable decision on March 1, 2000 (R. 26-40). The Appeals Council denied Ms. Shine's request to review the hearing decision (R. 6-7). Ms. Shine then filed this action requesting judicial review.

Medical Records

Plaintiff claims a disability onset date of June 1, 1997. Accordingly, the Court reviews the medical evidence in the record from 1997.

Treatment for Alcohol and Drug Dependency

Shine sought treatment for alcohol and drug dependency at SCADD, Inc. (Southeastern Connecticut Alcohol and Drug Dependency) on January 22-23, 1997; March 9-10, 1997; May 30-June 2, 1997; and July 16-19, 1997. (R. 269-277). On January 22, 1997, plaintiff identified that she had a problem with alcohol and cocaine abuse. Against medical advice, she did not complete treatment. Plaintiff returned to SCADD on March 10, 1997. In addition to alcohol dependence, she presented problems with asthma and depression. She again left before completing treatment. (R. 270). Plaintiff made another attempt at detoxification with SCADD on May 30, 1997, and completed detox. Plaintiff refused a referral to the Community Health Center for treatment for depression. The discharge summary for admission to

SCADD in January, March and May/June states that Shine's prognosis is poor due to incomplete therapy and refusal of treatment recommendations. (R. 271). Ms. Shine returned to SCADD on July 16, 1997, and completed detox. (R. 272). The discharge summary states, "prognosis fair, the client could have benefitted from further [therapy]. No motivation to do so." (R. 272).

Plaintiff was admitted into a partial hospitalization program at Community Mental Health on June 2, 1998. (R. 319-327). She reported that she was "just off a 3 wk binge, 1 day's sobriety." (R. 322). Her intake mental status assessment states: "[a]lert-good eye contact-oriented to person, place time, anxious. Denies having any suicidal or homicidal ideation. She denies any hallucinations. She had a sad and anxious affect/depressed mood. Memory . . . judgment were all depressed." (R. 319). The diagnostic impression was alcohol withdrawal, bi-polar disorder, and alcohol dependence and abuse. (R. 325). The intake assessment stated that plaintiff's presenting symptoms included staying in bed all day in her room with the door closed, binge drinking for three weeks, not being able to fall asleep, no energy, decreased appetite, and suicidal ideation. (R. 322). She was treated in the partial hospitalization program for one month and was discharged on July 2, 1998. The discharge summary stated that, while plaintiff was compliant with her medications, plaintiff was non-compliant with her therapy program and had relapsed

into abusing alcohol while in the program. (R. 326-27).

On July 6, 1998, Ms. Shine sought treatment for lower cellulitis and diarrhea at Lawrence and Memorial Hospital. The discharge notes of July 11 indicate a diagnosis of cellulitis, alcohol detoxification, medication withdrawal, thrombocytopenia[3] and hypokalemia.[4] Her urine toxicology screen was positive for TCH, cocaine, and Benzodiazepines; it was noted, "there is a question also of withdrawal from alcohol." On the day of discharge her cellulitis and hypokalemia were resolved. (R. 409-423).

Shine returned to the emergency department at Lawrence and Memorial Hospital on July 26, 1998, complaining of a need to quit drinking. The treatment notes state:

> She states that she has been drinking too much and has been in detox in the past without much effect. She states she began drinking as soon as she left the hospital here on her last visit which was about three weeks ago. She states that she continued to drink at least ½ pint to a pint a day and has a history of DTs and seizures when she stops drinking. She also has a history of depression and had been on medication for that but stopped about six months ago. She states that she has a history

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[3]A condition in which there is an abnormally small number of platelets in the circulating blood. Stedman's Medical Dictionary 1808 (26th ed. 1995).

[4]The presence of an abnormally small concentration of potassium ions in the circulating blood; occurs in familial periodic paralysis and in potassium depletion due to excessive loss from the gastrointestinal tract or kidneys. Stedman's Medical Dictionary 836 (26th ed. 1995).

> of asthma and is supposed to use her inhalers which she has not been doing. She has continued to smoke and also has been using some drugs.

(R.410).

<u>Community Mental Health Services of Southeastern Connecticut</u>

Plaintiff's primary treating source for her mental health was Community Mental Health Services of Southeastern Connecticut (CMH).

Plaintiff first sought treatment at Community Mental Health on June 11, 1997, presenting problems of anxiety, poor sleep, and impaired concentration "since stopping drinking ten days ago." (R. 276). A history of substance abuse was noted starting at age 14; Shine also stated that she had experimented with other substances, but alcohol was "by far her substance of choice." (R. 278). Her appearance was appropriate and neat, but she was restless. (R. 279). Plaintiff displayed an anxious and depressed mood. She was oriented to person, place and time. (R. 279). There were no noted problems with thought process or perception. (R. 279). However, plaintiff described "several past incidents of visual and auditory hallucinations which she reports did not occur in context of heavy drinking or detox." (R. 279). "Says she has for many years slept with a hair drier in her bed to block out noise and also to drown out 'what sounds like a football stadium' that she 'hears' while trying to fall asleep. She describes this as a possible hallucination." (R. 279). Her immediate memory was not impaired, but plaintiff

displayed deficits with recent and remote recall. (R. 280). Her insight and judgment were found to be good by impression with social judgment intact. (R. 280). Plaintiff was diagnosed with dysthmic disorder, generalized anxiety disorder, and alcohol dependence. (Tr. 281).[5]

The record contains a "Service Plan Review" from CMH, dated September 11, 1997. (R. 287). Her current level of stress was moderate to severe. (R. 287). Under "progress toward goals defined on Service Plan," the review stated:

> 1. Ct. not seen since 8/7/97. At that time had relapsed on 7/17 [with alcohol] spent two days [in] detox in SCADD. Ct's involvement in AA/NA sporadic at best. Live in [boyfriend] active alcoholic which jeopardizes Ct's sobriety.
> 2. Ct. has recently started [part time] job at vet. clinic which has [increased] stress. She lacks confidence in herself and her ability to succeed. Mood can often be labile depending on what is going on in her life.
>
> Add new problem #3. Interpersonal Relationship Disturbance. Ct. is severe co-dependent who tends to hook up with very abusive men who take care of her financially.

(R. 287). Other concerns noted: "could be some organic impairment from years of heavy drinking." (R. 287).

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[5]As noted above, plaintiff suffered an alcohol relapse on July 16, 1997. (Tr. 272). She completed treatment with improvement. SCADD recommended that Ms. Shine seek further inpatient treatment. She declined, adding that she preferred to continue treatment at CMH. Plaintiff was discharged from SCADD on July 19, 1997, with a fair prognosis. (R. 272).

At her next Service Plan Review at CMH, on January 22, 1998, plaintiff was described as having severe levels of stress. (R. 290). "Laurie has reported maintained sobriety but is very aware of trigger which - put her sobriety into jeopardy. Mood continues to present depressed and neurovegetative signs of depression are present." (R. 290). Current problems identified as: 1. Her relationship with her mother and her "need to separate herself and become more independent and less dependent;" and "physical implications need to be addressed." (R. 290).

On February 18, 1999, plaintiff was reevaluated for readmission into Community Mental Health treatment program. (R. 445). Her presenting complaint was increased stress since her arrest six months earlier. (R. 445). She stated that she was an accomplice and was drinking at the time. (R. 446). She stated she was having problems sleeping because she was hearing music and conversations as well as having visual hallucinations. (R. 445). Her concentration was impaired (couldn't do serial sevens), she couldn't read and retain anything, sometimes she couldn't stop talking, sometimes she was hypersexual but, other times when depressed, she didn't want to be touched. Her judgment was poor and her speech was pressured. (R. 445-46). Plaintiff reported being sober for six months. (R. 445). Diagnostic impression: major depression/recurrent/severe with psychotic features, rule out bipolar disorder, rule out bulimia, and

alcohol dependence/early full remission, cocaine dependence/early full remission. (R. 446).

Treatment notes of March 2, 1999, stated that, since February 24, plaintiff had slept two days in a row, but then did not sleep the following two nights. (R. 441). "She remains forgetful-couldn't remember name of her baby that died at birth which upset her greatly. There could be organic damage from ETOH, as she has been severe alcoholic since age 10. Still irritable, but auditory hallucinations have [decreased] somewhat." (R. 441).

Treatment notes of March 16, 1999, stated that plaintiff had been sleeping through the night for the past 5-6 nights and auditory hallucinations had stopped. Plaintiff continued to complain of "mood swings that are appearing to be more and more like Bipolar II." (R. 440). Plaintiff stated,

> 'I feel I can do anything, am on top of the world,' was easily agitated and irritated, had racing thoughts, had [increased] sex drive, etc. She will then proceed to become very depressed and 'all my elaborate plans to accomplish this or that go down the drain.' She reports that she is more depressed . . . then hypomanic. When depressed she has no energy, doesn't want to be bothered or touched, has not motivation to do anything."

(R. 440).

Treatment notes of March 25, 1999 state that plaintiff has gone into a depression four days before and had not heard voices since last seen. (R. 439).

Treatment notes of April 1, 1999, stated that plaintiff's mood was more stable and she was in good spirits. (R. 438). "Energy is up and she does not appear to be hypomanic. Still sober." (R. 438).

On April 15, 1999, plaintiff stated she was very depressed over a thirty pound weight gain since beginning Depakote. "Moods have been stable but she will ask Dr. next week about switching to another med." (R. 438).

Medical Care

Plaintiff's primary care physician was Dr. Rocco Russo from Community Health Center. His treatment notes from October 1994 to April 1999 are part of the administrative record (Tr. 237-46, 291, 349-52, 424-31). Dr. Russo noted plaintiff experienced symptoms in her hands which included numbness, weakness, and blanching. (R. 291, 350-52, 426-27, 429). Plaintiff was treated for asthma and bronchitis and diagnosed with hepatitis C (R. 349, 426, 430, 431). In April 1999, a physical capacities evaluation form was completed by Dr. Russo in which he indicated that plaintiff had a physical functional capacity to perform work within the sedentary to light exertional range. (R. 425).

Neurological Complaints and Testing

In January 1998, Dr. Russo of the Community Health Center

referred plaintiff for an MRI of her brain. (R. 292). The examination revealed a small foci of abnormal signal present bilaterally, predominantly in the frontal lobe. (R. 292). The appearance of the lesions was non-specific. "However given the patient's relatively young age, and the clinical symptoms, one may consider the diagnosis of demyelinating process such as multiple sclerosis. . . . There are no other abnormalities noted." (R. 292). "The findings are non-specific, however, it could represent MS." (R. 293).

Plaintiff was referred to neurologist Dr. David Thomson for further evaluation. (R. 302). Thompson's treatment notes, dated January 30, 1998, stated that Shine "over the past several months . . . has noted almost daily episodes of colored visual scotoma[6] in the temporal visual fields lasting minutes at a time without associated symptoms." (R. 302). Plaintiff noted episodic pallor of her fingertips, unrelated to temperature changes, and a six week history of intermittent left leg weakness manifested as the leg 'giving out' when standing or after sitting or arising from bed." (R. 302). Dr. Thompson noted, "[m]otor examination shows full strength in all muscle groups with normal tone." (R. 303). Her cerebellar examination, gait and station were normal. The doctor found all other

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[6]An isolated area of varying size and shape, within the visual field, in which vision is absent or depressed. Stedman's Medical Dictionary 1583 (26th ed. 1995).

neurological exam points normal, negative, unremarkable and/or regular. In closing, Dr. Thompson stated,

> I plan on reviewing the patient's MRI scan. I have ordered visual evoked responses to further evaluate the visual pathway and patient's symptoms. I have also ordered connective tissue screen including ANA, rheumatoid factor, as well as, hypercoagulation profile. I will contact the patient with the results of her lab studies and after I have reviewed her MRI scan. A decision will be made at that time as to the need for any further investigations including the possibility of lumbar puncture.

(R. 303).

The record contains a handwritten note from Dr. Russo, dated March 4, 1998, which states that Shine is unable to work due to "intermittent neurological deficits causing weakness, numbness, dysestias." The note further states that plaintiff is being evaluated by neurologist Dr. Thompson. (R. 291).

On April 30, 1998, Shine returned to Dr. Thompson for a follow-up visit, having been seen for a lumbar puncture on March 17. (R. 308-09).

> IMPRESSION: Abnormal MRI scan and visual evoked responses of unclear etiology. It is difficult to explain the patient's current symptoms on the basis of a demyelinating disorder given their abrupt onset, as well as, the nature of the symptoms. Her neurological examination today is unremarkable with the exception of pain and giving weakness of left hip flexion. I have ordered a repeat MRI scan with gadolinium to compare to her study of last January. If in fact the patient has new lesions or enhancing lesions on the current MRI

> scan, particularly in the right hemisphere I would be inclined to treat her with a short course of steroids. If, however, the repeat MRI shows no change and no evidence of an acute process I plan on speaking to Dr. Russo to see if any other medical studies are planned. I failed to mention above the patient has had blood work which I ordered following her last visit which included a normal hypercoagulation profile and protein electrophoresis, as well as, a negative ANA, a rheumatoid factor of 1-140.

(R. 308-09).

On December 1, 1998, plaintiff returned to Dr. Thompson for a follow-up visit, having last been seen April 30. (R. 390). Dr. Thompson noted that Shine's follow up MRI scan of the brain on May 8 showed change compared to her January 7 MRI. (R. 390). The report states in relevant part,

> The patient contacted our office shortly after the MRI to report that she had been experiencing weight loss, hair loss, fatigue and myalgias. It was recommended that the patient have a medical follow up with Dr. Russo. <u>The patient states that those symptoms seemed to have resolved spontaneously. The patient states that she has discontinued drinking.</u>

(R. 390, emphasis added). The neurological examination showed "full strength in all muscle groups with normal tone." All other examination notations were "normal" or "negative." (R. 390).

> IMPRESSION: Occipital headaches most likely muscular in origin. The patient has been placed on a trial of Amitriptyline 25 mg. nightly. The patient's distal extremity symptoms sound most consistent with Raynaud's

> phenomenon.[7] I have scheduled the patient for non-[in]vasive vascular studies to exclude a more serious circulatory disturbance. We will contact the patient with the results.

(R. 390). The record contains no neurological diagnosis and there are no records of neurological treatment after December 1998.

<u>Residual Functional Capacity, Mental Residual Function Capacity and Psychiatric Review Technique Assessments</u>

<u>1997</u>

A Psychiatric Review Technique (PRT) Form dated January 13, 1997, completed by Lindsey Harvey, Ph.D, indicated that Shine suffered from depression, alcohol abuse, anxiety, asthma, sleep disorder. (R. 256). The reviewer's notes stated that Shine had difficulty completing housework, and was anxious in public, that she cooks, cleans, shops, provides independent personal care, drives, "depressed-new meds helpful (Paxil)." (R. 257). The reviewer noted that Shine abuses alcohol and refuses to go to rehab. (R. 257). The reviewer found no evidence of organic mental disorders, schizophrenic, paranoid and other disorders, mental retardation, anxiety related disorders, somatoform disorders, personality disorders. (R. 258, 260). Under affective disorders, the reviewer

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[7] Spasm of the digital arteries, with blanching and numbness or pain of the fingers, often precipitated by cold. Stedman's Medical Dictionary 1346 (26th ed. 1995).

checked off "disturbance of mood, accompanied by a full or partial manic or depressive syndrome," as evidenced by depression (R. 259), and also noted substance addiction of alcohol abuse. (R. 262). In rating Shine's impairment severity for depression and alcohol abuse, Dr. Harvey found slight restriction of activities of daily living, and moderate difficulties in maintaining social functioning. She found that Shine often experienced deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner and never experienced episodes of deterioration or compensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms. (R. 263).

In reviewing Shine's Residual Functional Capacity (RFC), also on January 13, 1997, Dr. Harvey was asked to "record summary conclusions derived from the evidence in the file . . . evaluated in the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis." (R. 265). Plaintiff was found to be "not significantly limited" in her ability to remember locations and work-like procedures; understanding and remembering very short and simple instructions; carrying out very short and simple instructions; understanding and remembering and carrying out detailed instructions; performing activities within a schedule, maintaining regular attendance, and punctuality within

customary tolerances; sustaining an ordinary routine without special supervision; working in coordination with or proximity to others without being distracted by them; making simple work-related decisions; asking simple questions or requesting assistance; asking simple questions or requesting assistance; accepting instructions and responding appropriately to criticism from supervisors; maintaining socially appropriate behavior and adhering to basic standards of neatness and cleanliness; responding appropriately to changes in the work setting; awareness of normal hazards and taking appropriate precautions; and traveling to unfamiliar places or using public transportation. (R. 255-56). Plaintiff was assessed as "moderately limited" in maintaining attention and concentration for extended periods; completing a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; interacting appropriately with the general public; getting along with coworkers or peers without distracting them or exhibiting behavioral extremes; and setting realistic goals or making plans independently of others. (R. 255-56).

Dr. Harvey noted that:

> A. Claimant's understanding and memory are not significantly limited.
>
> B. Claimant's depression and substance abuse occasionally limit her ability to attend and concentrate and work at a consistent pace.

> C. Claimant's ability to interact with the general public is limited on occasion by her depression and labile affect, which can also be distracting to coworkers on occasion.
>
> D. Claimant has difficulty making independent plans on occasion.

(R. 267).

<u>1998</u>

Dr. Richard Robin of Community Mental Health completed a Medical Report for plaintiff dated April 15, 1998. (R. 460-467). Dr. Robin's diagnoses included major depression recurrent, borderline personality disorder, alcohol dependence and cocaine abuse in sustained full remission. (R. 461). Her current symptoms of depression included no appetite, over sleeping, no concentration, no sex drive, no motivation or pleasure. (R. 461). "All neurovegetative signs of depression still apparent." (R. 461). Her symptoms of personality disorder included a history of unstable/intense interpersonal relationships, frantic efforts to avoid abandonment, unstable self-image, impulsivity, substance abuse, and affection instability. (R. 461). Dr. Robin noted that plaintiff continued to drink alcohol sporadically, with no cocaine use reported. (R. 461). Dr. Robin did not identify any physical restrictions. (R. 463-64).

Dr. Robin also prepared a Mental Residual Functional Capacity Assessment. (R. 465-67). He found plaintiff to be moderately limited in all categories of functioning (understanding and memory,

sustained concentration and persistence, social interaction and adaptation).[8] (R. 466). He noted that Shine was being treated by a neurologist but diagnosis was not yet known. (R. 466).

A Residual Functional Capacity assessment was completed on June 2, 1998 by a non-treating, non-examining physician. (R. 328-35). The assessment stated that plaintiff could occasionally lift 20 pounds, frequently lift 10 pounds, stand and/or walk about 6 hours in an 8 hour workday, sit about 6 hours in an 8 hour workday, with no restriction on pushing and/or pulling. (R. 329). The reviewer based his conclusions on the following facts: "34 [year old] woman [with]

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[8]"Moderately Limited" is defined as "when the evidence supports the conclusion that the individual's capacity to perform the activity is diminished." (R. 465). Plaintiff's "moderate limitations" identified included: remembering locations and work-like procedures; understanding and remembering very short and simple instructions; understanding and remembering detailed instructions; carrying out very short and simple instructions; carrying out detailed instructions; maintaining attention and concentration for extended periods; performing activities within a schedule, maintaining regular attendance, and being punctual within customary tolerances; sustaining an ordinary routine without special supervision; working in coordination with or proximity to others without being distracted by them; making simple work-related decisions; completing a normal work-day and workweek without interruptions from psychologically based symptoms and to perform a consistent pace without an unreasonable number and length of rest periods; interacting appropriately with the general public; asking simple questions or requesting assistance; accepting instructions and responding appropriately to criticism from supervisors; getting along with coworkers or peers without distracting them or exhibiting behavioral extremes; responding appropriately to changes in the work setting; awareness of normal and taking appropriate precautions; traveling in unfamiliar places or using public transportation; setting realistic goals or making plans independently of others. (R. 465-66).

recent onset of neurologic symptoms. [Results] so far have been [negative] . . . except for abnormal MRI which is non-specific. Possibility of early [multiple sclerosis]." (R. 329). He noted that at the last exam was entirely normal and that the "restrictive RFC was given for likelihood of M.S." (R. 330). No postural, manipulative, visual, communicative, or environmental limitations were noted. (R.330-34).

A Psychiatric Review Technique was completed on June 12, 1998 by a non-treating, non-examining physician. (R. 336-44). The reviewer noted a diagnosis of bipolar disorder and anxiety, a history of polysubstance abuse with depression/anxiety. Her "treating physician reports anxiety is no longer part of her presentation. At last report, she was noted to be sober, but depressed. Plaintiff showed no evidence of organic mental disorders, schizophrenic, paranoid and other psychotic disorders, mental retardation and autism, anxiety related disorders, somatoform disorders, personality disorders. (R. 338-42). Evidence of affective disorders: disturbance of mood, dysthymic[9], with alcohol and cocaine abuse. (R. 339, 342). Plaintiff is moderately limited in activities of daily living and in

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[9]A chronic mood disorder manifested as depression for most of the day, more days than not, accompanied by some of the following symptoms; poor appetite or over eating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. Stedman's Medical Dictionary 536 (26th ed. 1995).

maintaining social functioning." (R. 343). The reviewer noted deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner "often" (R. 343), and episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms "[o]nce or twice." (R. 343).

A Mental Residual Function Capacity Assessment was completed on June 12, 1998 by a non-treating, non-examining physician. (R. 345-48). Plaintiff was found to be "not significantly limited" in her ability to remember locations and work-like procedures; understanding and remembering very short and simple instructions; carrying out very short and simple instructions; performing activities within a schedule, maintaining regular attendance, and punctuality within customary tolerances; sustaining an ordinary routine without special supervision; working in coordination with or proximity to others without being distracted by them; making simple work-related decisions asking simple questions or requesting assistance; asking simple questions or requesting assistance; accepting instructions and responding appropriately to criticism from supervisors; maintaining socially appropriate behavior and adhering to basic standards of neatness and cleanliness; responding appropriately to changes in the work setting; awareness of normal hazards and taking appropriate

precautions; and traveling to unfamiliar places or using public transportation. (R. 345-46). Plaintiff was assessed to be "moderately limited" in understanding and remembering and carrying out detailed instructions; maintaining attention and concentration for extended periods; completing a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; interacting appropriately with the general public; getting along with coworkers or peers without distracting them or exhibiting behavioral extremes; and setting realistic goals or making plans independently of others. (R. 345-46).

The reviewer noted: "(a) preoccupation limits recall for detailed information; (b) low mood and preoccupations sometimes compromises attention/concentration. Low mood and low frustration tolerance sometimes restrict persistence . . . consequently limit execution of detailed operations; (c) liability sometimes distracts co-workers and may impair relations with the public; (d) [illegible] . . . are sometimes compromised by negative mood." (R. 347).

A Residual Functional Capacity assessment was completed on September 18, 1998 by a non-treating, non-examining physician. (R. 369-76). The assessment stated that plaintiff could occasionally lift 20 pounds, frequently lift 10 pounds, stand and/or walk about 6 hours in an 8 hour workday, sit about 6 hours in an 8 hour workday,

with no restriction on pushing and/or pulling. (R. 370). The reviewer based his conclusions on the following facts: "34 year old woman with recent onset of neurologic symptoms. 1/98 MRI of head revealed 'several bilateral foci of abnormal white matter suggestive of M.S. ' 5/98 MRI revealed no [significant] change. Neuro exam reveals full motion strength . . . ." (R. 370). No postural, manipulative, visual, communicative, or environmental limitations were noted. (R.371-74). "Intermittent numbness, weakness [with] pain in lower extremities is credible given her potential for M.S."[10] (R. 374).

A Psychiatric Review Technique was completed on October 22, 1998, by a non-treating, non-examining physician. (R. 377-85). The reviewer noted plaintiff's long history with alcoholism and depression with various diagnoses of major depression, and bipolar disorder, ruling out M.S. (R. 378). Plaintiff reported being in detox four times but records revealed that she relapsed and dropped out of therapy in July. (R. 378). Plaintiff presented as alert, with good eye contact, oriented, anxious, denying suicidal ideation, and auditory hallucinations. Her affect was sad and anxious, her mood depressed. Diagnosis: bipolar disorder and alcoholism, withdrawal phase. It was noted that on July 2, 1998, plaintiff withdrew her consent for therapy. She was noncompliant, she was not

[10]The remaining symptoms listed were illegible.

taking her medications and she was drinking. (R. 378).

Plaintiff showed no evidence of organic mental disorders, schizophrenic, paranoid and other psychotic disorders, mental retardation and autism, anxiety related disorders, somatoform disorders, or personality disorders. (R. 379-83). Evidence of affective disorders: sleep disturbance, psychomotor agitation or retardation, decreased energy, difficulty concentrating or thinking with substance addition disorders present. (R. 380, 383). Plaintiff was "slightly limited" in activities of daily living and "moderately limited" in maintaining social functioning. (R. 384). The reviewer noted deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner "often" (R. 384), and episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms "[o]nce or twice." (R. 384).

A Mental Residual Function Capacity Assessment was completed on October 22, 1998 by a non-treating, non-examining physician. (R. 386-89). Plaintiff was found to be "not significantly limited" in her ability to remember locations and work-like procedures; understanding and remembering very short and simple instructions; carrying out very short and simple instructions; performing activities within a schedule, maintaining regular attendance, and punctuality within

customary tolerances; sustaining an ordinary routine without special supervision; working in coordination with or proximity to others without being distracted by them; making simple work-related decisions asking simple questions or requesting assistance; asking simple questions or requesting assistance; accepting instructions and responding appropriately to criticism from supervisors; maintaining socially appropriate behavior and adhering to basic standards of neatness and cleanliness; responding appropriately to changes in the work setting; awareness of normal hazards and taking appropriate precautions; and traveling to unfamiliar places or using public transportation. (R. 386-87). Plaintiff was assessed as "moderately limited" in understanding and remembering and carrying out detailed instructions; maintaining attention and concentration for extended periods; completing a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; interacting appropriately with the general public; getting along with coworkers or peers without distracting them or exhibiting behavioral extremes; and setting realistic goals or making plans independently of others. (R. 386-87).

The reviewer noted: "(a) intellectual ability probably WNL [within normal limits]. Has some problems with memory. Is being evaluated for a neurological condition of M.S.; (b) claimant has

variable degree of depressive symptoms. Alcoholism appear to be greater impediment to completion of a normal workweek; (c) she reports increased isolation, history of occasional behavioral extremes; (d) admitted to PHP last summer but relapsed and was not compliant with therapy. If allowed, DAA would be material (return to me for preparation of RFC exclusive of DAA if applicable)." (R. 388).

1999

On April 15, 1999, plaintiff's therapist Carole Renza, LPC of Community Mental Health completed a Supplemental Questionnaire as to Residual Functional Capacity. (R. 11-12, 434-35). Ms. Renza rated plaintiff's impairments as "moderately severe"[11] in relating to people; responding to co-workers; and performing simple and repetitive tasks. (R. 434-44). Ms. Renza found plaintiff was "severely"[12] restricted in her daily activities; the degree of deterioration in her personal habits; degree of constriction of interests; and in her ability to understand, carry out and remember instructions; respond appropriately to supervision, customary work

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[11]"Moderately Severe" is defined as "an impairment which seriously affects ability to function." (R. 435).

[12]"Severe" is defined as an "extreme impairment of ability to function." (R. 435).

pressures; perform complex and varied tasks. (R. 434-44). The examiner noted that the impairment had lasted over twelve months with an earliest onset of 1997. (R. 444). The current diagnosis was bipolar disorder (primary). (R. 444).

2000

The following reports were submitted to the Appeals Counsel and were not considered by the ALJ.

Ronald Serolia, MD of Community Mental Health prepared a medical statement and medical report for plaintiff dated February 14, 2000. (R. 15-22). Dr. Serolia's diagnoses included Bipolar I disorder, alcohol dependence in remission and cocaine dependence in remission. (R. 16). He found that her symptoms of bipolar disorder were marked by "severe mood swings that can cycle very rapidly. When depressed she isolates and cannot function. When in manic state she is unable to sleep, easily irritated, and very scattered, forgetful, hyperactive." (R. 16). Her prognosis was guarded. (R. 17). Dr. Serolia did not identify any physical restrictions. (Tr. 18-19).

Dr. Serolia also prepared a Mental Residual Function Capacity Assessment. He found plaintiff to be "markedly limited"[13] in remembering locations and work-like procedures; maintaining attention and concentration for extended periods; performing activities within

[13]"Markedly Limited" is defined as "when the evidence supports the conclusion that the individual cannot usefully perform or sustain the activity." (R. 20).

a schedule, maintaining regular attendance, and being punctual within customary tolerances; sustaining an ordinary routine without special supervision; completing a normal work-day and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; getting along with coworkers or peer without distracting them or exhibiting behavioral extremes; and to travel in unfamiliar places or use public transportation." (R. 20-21). Dr. Serolia found "moderate limitations"[14] in Shine's capacity to understand, remember and carry out detailed instructions; to make simple work-related decisions; to respond appropriately to changes in the work setting; and to set realistic goals or make plans independently of others. (R. 20-21). The doctor did not find any significant limitations[15] on plaintiff's ability to carry out simple instructions; interact appropriately with the general public; ask simple questions or request assistance; accept instructions or criticism from supervisors; to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness; and to be aware of normal hazards and take appropriate precautions. (R. 20-21).

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[14]"Moderately Limited" is defined as "when the evidence supports the conclusion that the individual's capacity to perform the activity is diminished." (R. 20).

[15]"Not Significantly Limited" is defined as "when the effects of the mental disorder do not prevent the individual from consistently and usefully performing the activity." (R. 20).

Dr. Serolia noted that bipolar disorder is a lifelong illness. "In the past [plaintiff] has . . . been [diagnosed with] deterioration of nerve endings in the brain, severe asthma & respiratory problems and liver dysfunction." (R. 21). Plaintiff's other restrictions and limitations include, "is extremely forgetful [with] much memory impairment. She often cannot remember what she did yesterday, and 'gets lost' on her way to places she has been to numerous times previously." (R. 21).

Disability Questionnaires

On April 28, 1998, plaintiff was evaluated by Disability Determination Services of Connecticut, completing a Psychiatric Questionnaire. (R. 294). Plaintiff presented a casual appearance. She admitted to daily alcohol use, 6-8 beers per day, with intermittent use of ETOH and codeine. (R. 294). The examining physician noted that plaintiff was oriented to person, place and time, but also demonstrated impaired memory and concentration and poor judgment. (R. 294). Her mood was depressive and anxious, affect was labile, with no evidence of psychotic behavior.

The last mental status exam was conducted on November 27, 1996. (R. 295). Under the headings daily activities, social interactions, task performance and stress reaction, the review states "unknown." (R. 295). The reviewer described Ms. Shine's illness as "depressed,

irritable, mood swings, sleep disturbances, appetite disturbance, anxiety attacks, nightmares. Do not know her current symptoms." No workshop evaluations were conducted. The reviewer noted that plaintiff's ability to handle benefits was questionable. The reviewer commented that plaintiff was "compliant for the short time she received treatment here. Inconsistent." (R. 296). "Diagnosis: major depression, episodic ETOH abuse, history of Hepatitis (ETOH, C)." (R. 296).

On April 29, 1998, plaintiff completed a Daily Activities Questionnaire for the State of Connecticut Bureau of Rehabilitation Services. (R. 297-296). She stated that on an average day she usually slept or watched television. She stated that she sometimes slept for 17-20 hours at a time. "I have such a hard time communicating with others outside my home." (R. 297). "It's been going on for 20 years and its been untreated, but through therapy and medication I've been able to function better." (R. 297). Plaintiff stated that she sometimes prepared meals and cooked for others but "when I'm in the mood." She stated that she sometimes grocery shopped, "but I always have someone with me." (R. 297). Shine described her difficulties with preparing meals as a "lack of motivation and concentration." (R. 297). Household chores are completed by either plaintiff and her mother or plaintiff and her boyfriend. Plaintiff stated she cared for her personal needs and

grooming. She stated she didn't think she did anything for fun, because everything was an effort. (R. 298). She stated that she played cards and watched t.v. or listened to the radio and sometimes went bowling. (R. 298). Plaintiff stated that she handled her own money, but "I don't do it well because I have a hard [time] remembering what I spent it on. So I'm always making notes to remind myself." (R. 299). She droves occasionally or got rides from her boyfriend. Plaintiff reported no involvement in organizations or volunteer work. (R. 299). She visited friends occasionally, "maybe once every 3-4 weeks." (Tr. 299). She indicated she had difficulty getting along with other people as she felt out of place, "I get paranoid that people don't like me - therefore I keep my distance." (R. 300).

Also on April 29, 1998, plaintiff completed a Substance Abuse Questionnaire for the State of Connecticut Bureau of Rehabilitation Services. (R. 301). She stated she did not drink alcohol, but that she used to drink beer. She listed attendance at SCADD and Stonington Institute treatment programs for drinking. (R. 301). Plaintiff stated she does not and has not used other substances that would prevent her from working. (R. 301).

Hearing Testimony

Plaintiff appeared with counsel at a hearing before ALJ Ronald

Thomas on April 26, 1999. Also present was vocational expert Dr. Jeffrey Blank. (R. 41-78).

At the time of the hearing, plaintiff was 35 years old. (R. 45). Her employment history included: three weeks with Service Master, two months as a veterinary assistant, five months at Jayfro as a sewing machine operator, two weeks in retail at The Limited, two weeks at Stengall in an unspecified position, six months as a cashier at The National Tea Company, and a couple of months as a cashier at Oges. She worked at Liffins and Olympic Sporting Goods for a few months in unspecified positions, and as a cocktail waitress at the Days Inn for a month. (R. 46-50).

Plaintiff testified that she was unable to work because of lack of concentration, impaired memory, alcoholism, and bipolar disorder. (R. 50). "I've had problems, but never did anything about it due to alcohol. I would drink." (R. 50). Shine testified that she had been sober since September 1998, but did not attend Alcohol Anonymous meetings. (R. 51). She was living with a boyfriend who does not drink. (R. 52). She testified that she doesn't associate with people, doesn't have any friends, doesn't like to go out, "I don't do anything." (R. 52). She stated she would go out to dinner and out on her boyfriend's boat on occasion, but not with other people. (R. 52, 58).

Plaintiff testified that she was attending therapy once a week

to discuss her bipolar disorder. (R. 53). She stated she had not had any overnight hospital stays for depression. (R. 53-54). Plaintiff's average day depended on her depression. She testified that, "if I'm in a depressed state, I usually stay in bed all day and I keep the doors closed. I will not answer the phone. I won't answer the door. . . I keep it dark. I close the blinds." (R. 57). She might watch t.v. (R. 57). A depressive state can last up to two weeks. (R. 57). When she is manic she moves around the house, but does not do anything constructive. (R. 57). Plaintiff described her sleep habits in extremes. She can go up to four days without sleep followed by sleeping 6 to 20 hours. (R. 59). She stated that these sleeping habits have been present since she quit drinking nine months prior. (R. 59). While in a manic phase, she described talking a lot, doing strange things, impaired memory, inability to concentrate. (R. 60). Plaintiff stated her moods were more depressed then manic. (R. 60). She estimated that she is manic one to two times a month. (R. 60).

Plaintiff testified that her boyfriend grocery shops, cooks and cleans up most of the time but, depending on her mood she does some cooking. (R. 57). He also does the laundry; she accompanies him depending on the day if the laundry mat is not crowded. (R. 57). They seldom attend movies or go out to dinner. (R. 58). Plaintiff testified that she goes clothes shopping occasionally with her

boyfriend. (R. 58). Plaintiff is a member of no clubs or organizations. (R. 50).

Finally, plaintiff testified about treatment for asthma, gastro-esophagal reflux disease, hepatitis C and problems with her hands going numb and turning white. (Tr. 54-55, 61-62).

Vocational expert Dr. Jeffrey Blank testified that plaintiff's past work was unskilled employment.[16] (R. 66). Dr. Blank testified in response to the ALJ's hypothetical that plaintiff could perform her past work as a sewing machine operator.[17] (R. 68). Dr. Blank found

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[16]Dr. Blank testified that plaintiff's past work with Service Master as a building cleaner is in the light range of exertion, unskilled in nature; a veterinarian assistant answering phones and billing is sedentary and unskilled in nature; at Jayfro as a sewing machine operator is in the light range of exertion, unskilled in nature; at The Limited as a sales clerk, and all other sales clerk positions she held, is routinely in the light range of exertion and unskilled in nature; a cashier position is between sedentary and light range of exertion and unskilled in nature; and a waitress or cocktail waitress or hostess position is also in the light range of exertion, unskilled in nature. (R. 66-67).

[17]The ALJ asked,

> "Dr. Blank, take an individual of the Claimant's age, education, and past relevant work experience, with somebody performing light work as defined in the regulations, and has the further restrictions of the need for a job which is supervised, has a low-stress environment, which is defined as requiring few decisions. Secondly, it's only limited interaction with the public, co-workers, and supervisors. Thirdly, an environment free from poor ventilation, dust, fumes, gases, odors, humidity, wetness, and temperature extremes. Based on these limitations, could such a person

that "because of the limited amount of interaction with the public and with the co-workers, which would eliminate the waitressing, the hostessing, which [requires] frequent contact with the public." (R. 68). He concluded that cashiering required frequent contact with the public and a job as a building cleaner was ruled out due to contact with environmental pollutants. (R. 68). He ruled out a job as a veterinarian's assistant because of the decision making responsibilities and dealing with the public. (R. 68). He also stated that an individual with these limitations could perform production work such as machine packaging, marking machine operator, inspecting positions. (R. 69).[18]

In response to a hypothetical posed by plaintiff's counsel,[19] Dr. Blank testified, that "[w]ith respect to having a severe impairment in those functional areas, understanding, carrying out,

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> do their past relevant work, and if not, why not? And I would limit the past relevant work just to those jobs that were beyond the few weeks.

(R. 68).

[18]Dr. Blank stated that in Connecticut there are approximately 3,000 positions available for machine packaging, 1,000 positions available for marking and 1,500 positions available for inspecting. (R. 69).

[19]Plaintiff's counsel inquired, "She's not able to respond to customary work pressures because of the severe impairment. She's not able to respond appropriately to supervision. She's not able to understand, carry out and remember instructions. She's not able to perform complex tasks." (R. 73-74).

remembering instructions, responding to supervision, and responding to customary work pressures, I would [say] an individual not being able to perform competitive employment under those condition." (R. 74).

Disability and the Standard of Review

To be eligible for supplemental security income, Ms. Shine must establish that she suffered from a disability within the meaning of the Social Security Act. The Act defines "disability" as an inability to engage in substantial gainful activity by reason of a medically determinable impairment that can be expected to cause death or to last for twelve continuous months. 42 U.S.C. §1382c(a)(3)(A). Ms. Shine was disabled if her impairments were of such severity that she was unable to perform work that she had previously done, and if, based on her age, education, and work experience, she could not engage in any other kind of substantial gainful work existing in the national economy. 42 U.S.C. §1382c(a)(3)(B).[20]

This standard is a stringent one. The Act does not contemplate degrees of disability or allow for an award based on partial disability. Stephens v. Heckler, 766 F.2d 284, 285 (7th Cir. 1985). "Disability" is defined as an "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or expected to last for a continuous period of not less

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[20]As part of the Contract with America Advancement Act of 1996, Congress amended this definition to exclude disability for which alcoholism or drug addiction is a material contributing factor. See 42 U.S.C. §1381c(a)(3)(J).

than 12 months." 42 U.S.C. §423(d)(1).

In evaluating Ms. Shine's case, the ALJ followed the familiar five-step analysis, set forth in 20 C.F.R. §416.920, to determine whether she was disabled under the Social Security Act. The steps are as follows:

(1) Is the claimant engaging in substantial gainful activity? 20 C.F.R. §§416.910(b), 416.972(b). If so, he or she is not disabled. 20 C.F.R. §416.920(b).

(2) If not, does the claimant have an impairment or combination of impairments that are severe? If not, he or she is not disabled. 20 C.F.R. §416.920(c).

(3) If so, does the impairment(s) meet or equal a listed impairment (the "Listings"), in the appendix to the regulations? If so, the claimant is disabled. 20 C.F.R. §416.920(d); Bowen v. Yuckert, 482 U.S. 137, 141 (1987); Balsamo v. Chater, 142 F.3d at 79-80.

(4) If not, can the claimant do his or her past relevant work? If so, he or she is not disabled. 20 C.F.R. §416.920(e).

(5) If not, can the claimant perform other work given his or her residual functional capacity, age, education, and experience? If so, then he or she is not disabled. A claimant is entitled to receive disability benefits only if he cannot perform any alternate gainful

employment. See 20 C.F.R. §416.920(f).

When applying this test, the burden of proof is on the claimant for the first four steps and on the Commissioner for the fifth step, if the analysis proceeds that far. Balsamo v. Chater, 142 F.3d 75, 80 (2d Cir. 1998) (citing cases).

In applying the test to Ms. Shine's case, the ALJ found that the first two steps were satisfied. Ms. Shine "has not engaged in substantial gainful activity since June 1, 1997, because her work since that time has been of short duration and does not exhibit the ability to perform substantial gainful activity." (R. 36). The ALJ also found that the medical evidence established that Ms. Shine has bipolar disorder, asthma, and a history of substance abuse disorder, impairments which are severe." (R. 36).

At step three, the ALJ found that Ms. Shine's impairments did not meet or equal the severity of any impairment listed in the appendix to the regulations leading to an automatic finding of disability without further analysis. (R. 36). He made specific findings regarding plaintiff's impairments pursuant to 20 C.F.R. §416.929, as follows. Under "nature, location, onset, duration, frequency, radiation and intensity of any pain," the ALJ noted plaintiff's complaints of poor concentration, feelings of isolation, poor motivation and difficulty being around people. (R. 32). Under "precipitating and aggravating factors," the ALJ noted Shine's

difficulties shopping and eating out. He noted her testimony describing her symptoms of depression, staying in bed all day, sleeping 16 to 18 hours a day, followed by manic behavior where she "talks a lot and does strange things," and experienced impaired memory. (R. 33). Under "type, dosage, effectiveness, and adverse side-effects of any pain medication," the ALJ noted that plaintiff has gained 30 pounds on her medication Depakote. (R. 33). Under "treatment, other than medication, for relief of pain," the ALJ noted that plaintiff testified that she receives counseling once a week for treatment of her bipolar disorder. (R. 33). Under "functional restrictions," the ALJ noted "Ms. Shine testified that [she] does not associate with people. She stays home, because she does not like to be around people. She testified that she feels too nervous to drive an automobile." (R. 33). Finally, under "claimant's daily activities," the ALJ noted plaintiff's testimony regarding living with her boyfriend, that she stays in bed all day, "although she does go to dinner with her friend and goes out [on] his boat twice per week. She also shops for clothes with her friends." (R. 33).

The ALJ then assessed Ms. Shine's residual functional capacity as required in step four. The ALJ found Ms. Shine to be capable of light work with the following limitations: "lift and carry no more than 20 pounds or more than ten pounds on a regular basis and or work in exposure to environmental irritants including poor ventilation,

dust, fumes, gases, odors, humidity, wetness, and temperature extremes. She is restricted to limited interaction with the public, co-workers, and supervisors and a supervised low stress environment which requires few decisions" (R. 36). Because her past relevant work as a sewing machine operator did not require these restrictions precluded by her residual functional capacity, the ALJ found that Ms. Shine was able to perform her past relevant work as a sewing machine operator (R. 36).

At step five, the ALJ concluded,

> The claimant's statements concerning her impairment and its impact on her ability to work are not entirely credible in light of the claimant's own description of her activities and life style, discrepancies between the claimant's assertions and information contained in the documentary reports, and the findings made on examination.

The ALJ further found,

> The claimant lacks the residual functional capacity to lift and carry more than 20 pounds or more than ten pounds on a regular basis and or work in exposure to environmental irritants . . . . She is restricted to limited interaction with the public, co-workers, and supervisors and a supervised, low stress environment which requires few decisions.

(R. 36). Based on the testimony of the vocation expert, the ALJ concluded that Shine's "past work as a sewing machine operator did not require these restrictions" and she is able to perform her past relevant work. Even if Ms. Shine could not return to her past

relevant work, the ALJ found that she was capable of making a successful adjustment to work which exists in significant numbers in the national economy. A finding of "not disabled" is therefore reached within the framework of the Medical-Vocational guidelines. (R. 35).

Based on these findings, the ALJ determined that Ms. Shine was not disabled within the meaning of the Social Security Act and therefore was not entitled to receive supplemental security income.

Standard of Review

The Social Security Act provides for judicial review of the Commissioner's denial of benefits. 42 U.S.C. §1383(c)(3).The scope of review of a social security disability determination involves two levels of inquiry. The court must first decide whether the Commissioner applied the correct legal principles in making the determination. Next, the court must decide whether the determination is supported by substantial evidence. See Balsamo v. Chater, 142 F.3d 75, 79 (2d Cir. 1998). Substantial evidence is evidence that a reasonable mind would accept as adequate to support a conclusion; it is more than a "mere scintilla." Richardson v. Perales, 402 U.S. 389, 401 (1971); Yancey v, Apfel, 145 F.3d 106, 110 (2d Cir. 1998). The substantial evidence rule also applies to inferences and conclusions that are drawn from findings of fact. See Gonzalez v. Apfel, 23 F. Supp. 2d 179, 189 (D. Conn. 1998); Rodriguez v.

Califano, 431 F. Supp. 421, 423 (S.D.N.Y. 1977). The court may not decide facts, reweigh evidence or substitute its judgment for that of the Commissioner. See Dotson v. Shalala, 1 F.3d 571, 577 (7th Cir. 1993). The court must scrutinize the entire record to determine the reasonableness of the ALJ's factual findings. Furthermore, "'[w]here there is a reasonable basis for doubt whether the ALJ applied correct legal principles, application of the substantial evidence standard to uphold a finding of no disability creates an unacceptable risk that a claimant will be deprived of the right to have her disability determination made according to correct legal principles.'" Schaal v. Apfel, 134 F.3d 496, 504 (2d Cir. 1998) (quoting Johnson v. Bowen, 817 F.2d 983, 986 (2d Cir. 1987)).

DISCUSSION

Ms. Shine does not contest the ALJ's findings with respect to her alleged physical limitations. She asserts that the ALJ erred in three principal ways relevant to her mental impairments. First, plaintiff contends that the Commissioner failed to properly evaluate the opinions of the plaintiff's treating sources within the parameters of the regulations and Social Security Ruling 96-2p. Second, she asserts the ALJ erred in evaluating her credibility. Last, plaintiff argues that the ALJ erred in finding that she had the Residual Functional Capacity to work in a low stress environment.

1. Opinions of Treating Mental Health Professionals

Plaintiff contends that the Commissioner failed to properly evaluate the opinions of the plaintiff's treating sources within the parameters of the regulations and Social Security Ruling 96-2p.

Plaintiff argues that the ALJ "failed to apply the relevant factors in determining how much weight to give to the opinion of the treating source," and failed to state why he rejected the opinions of the treating mental health sources. [Doc. #7 at 24-25].

Plaintiff cites the mental health treatment records from her CMH treaters, including a Supplemental Residual Functional Capacity form prepared her therapist Carol Senca, dated April 15, 1999 (R. 11-12), and mental functional capacity assessments prepared by Dr. Robin, dated April 15, 1998 (R. 465-66), and by Dr. Serolia, dated February 16, 2000. She argues that this evidence supports a finding that she could not perform substantial gainful activity on a "regular and continuing basis." See Social Security Ruling 96-8p.

The record contains three mental residual function capacity assessments by plaintiff's mental health treating professionals.[21]

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[21]Residual Functional Capacity (RFC) "is what an individual can still do despite his or her limitations." Social Security Ruling 96-8p. "Ordinarily, RFC is the individual's maximum remaining ability to do sustained work activities in an ordinary work setting on a regular and continuing basis, and the RFC assessment must include a discussion of the individual's abilities on that basis. A "regular and continuing basis" means 8 hours a day, for 5 days a week, or an equivalent work schedule. RFC does not represent the least an individual can do despite his or her limitations or restriction, but

In April 1998, plaintiff's CMH psychiatrist Dr. Robin diagnosed plaintiff with major depression recurrent, borderline personality disorder, with alcohol dependence, cocaine abuse sustained full remission. (R. 461). Dr. Robin described plaintiff's symptoms of depression as "no appetite, oversleeping, no sex drive, no motivation or pleasure, all neurovegetative signs of depression still apparent." (R. 461). He found present the following symptoms of borderline personality disorder: history of unstable/intense interpersonal relationship; frantic efforts to avoid abandonment; unstable self image; impulsivity-sex and substance abuse; and affective instability. (R. 461). Dr. Robin found plaintiff to be "moderately limited" in all areas on the Mental Residual Functional Capacity Assessment. (R. 465-66).

Plaintiff's therapist, Carol Senca, found in a Supplemental Residual Functional Capacity dated April 1999, that plaintiff's current psychiatric impairment was "severe" in eight of the 12 categories she was asked to assess. (R. 11-12). She found plaintiff's impairment "moderately severe" in the other four categories. (R. 11-12).

In February 2000, a Mental Residual Function Capacity Assessment was completed by Dr. Serolia and submitted to the Appeals

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the most." Id.

Council. Dr. Serolia diagnosed plaintiff with Bipolar I, alcohol and cocaine dependence in remission. (R. 16). Plaintiff "has severe mood swings that can cycle rapidly. When depressed she isolates and cannot function. When in manic state she is unable to sleep, easily irritated, and very scattered, forgetful, hyperactive." (R. 16). Dr. Serolia assessed plaintiff as "markedly limited" in eight categories; "moderately limited" in six categories; and "not significantly limited" in six categories. (R. 20-21). The doctor observed that bipolar disorder is a "lifelong illness," adding that plaintiff is "extremely forgetful with much memory impairment. She often cannot remember what she did yesterday, and "gets lost" on her way to places she has been to numerous times previously." (R. 21). Although the ALJ never received Dr. Serolia's assessment, it was presented to the Appeal Council.

The Second Circuit has repeatedly stated that the opinion of the treating physician is given controlling weight if it is well supported by medical findings and not inconsistent with substantial evidence. See Rosa v. Callahan, 168 F.3d 72, 78-79 (2d Cir. 1999). In Schall v. Apfel, our Circuit Court explained

> "[i]f we find that a treating source's opinion on the issue(s) of the nature and severity of [the claimant's] impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the [claimant's] record, we will give it controlling weight. When we do not give

> the treating source's opinion controlling weight, we apply [various factors] in determining the weight to give the opinion. 20 C.F.R §§404.1527(d)(2), 416.927(d)(2).The various factors applied when the treating physician's opinion is not given controlling weight include: (i) the frequency of examination and the length, nature, and extent of the treatment relationship; (ii) the evidence in support of the opinion; (iii) the opinion's consistency with the record as a whole; (iv) whether the opinion is from a specialist; and (v) other relevant factors. citing 20 C.F.R. §§404.1527(d)(2), 416.927(d)(2). In addition, the 1991 Regulations provide that the Commissioner will always give good reasons in our notice of determination or decision for the weight we give [claimant's] treating source's opinion.

134 F. 3d 496, 503-04 (2d Cir. 1998).

Plaintiff argues that the ALJ failed to specifically address the evidence pertaining to chronic symptoms and functional capacity; he did not discuss the consistency of the symptoms; and he did not recognize that the opinions of the treating sources were opinions from "specialists" in the field of psychiatry. [Doc. #7 at 24]. She contends that the ALJ's failure to apply the factors required by the regulations in determining how much weight should be given to the treating source's opinion is significant as there are "no opinions from any other psychiatric examining sources stating that she was minimally impaired by her bipolar disorder." [Doc. #7 at 25].

The Court agrees that the ALJ failed to address these factors in his opinion. There is no evidence that the ALJ considered the

mental residual function capacity assessments by plaintiff's treating mental health professionals or, if he did, what weight if any he gave these opinions. The ALJ's decision does not assess the record before him from plaintiff's treating mental health professionals. There can be no question that the issue before the ALJ is whether plaintiff has the mental residual functional capacity to perform her past relevant work or any other work that exists in significant numbers in the national economy. The ALJ did not cite any contrary medical evidence from other mental health providers in his opinion.[22] As there is no explanation in the ALJ's opinion why these opinions were rejected in favor of his contrary finding, this Court remands the case to the Commissioner for further proceedings to allow the ALJ to consider the opinions of plaintiff's treating mental health professionals and properly apply the treating physician regulations.

2. Other Issues on Appeal

[22]The Court notes that the ALJ rejected her treating physician Dr. Russo's opinion regarding her ability to lift and carry more than five pounds occasionally based on the objective medical evidence. (R. 34). The ALJ found that plaintiff retained the "residual functional capacity to perform the exertional demands of light work, or work which requires maximum lifting of twenty pounds and frequent lifting of ten pounds; some light jobs are performed while standing, and those performed in the seated position often require the worker to operate hand or leg controls." This finding regarding plaintiff's physical residual functional capacity is not challenged here. Rather, plaintiff challenges the finding by the ALJ that she is not disabled based on her mental health.

On remand, the ALJ should consider the evidence regarding plaintiff's mental health and her ability to function in a competitive work environment on a "regular and continuing" basis, see SSR 96-8p, and related arguments.

The ALJ should also reconsider his finding that plaintiff could work in a "low stress environment" in light of plaintiff's arguments, social security ruling 85-15 (specifically addressing stress and mental illness), and supporting case law. See SSR 85-15 ("The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and unusual work situations and to deal with changes in a routine work setting."); Lancellotta v. Secretary of Health and Human Services 806 F.2d 284, 285 (1st Cir. 1986)("Without an evaluation of claimants vocational abilities in light of [her diagnosis of bipolar disorder], there is no basis for the ALJ's conclusion that [she] can perform low stress work."); Dowty v. Barnhart, No. 02-7103, 2003 WL 21509142, *2 (10th Cir. July 2, 2003) (finding that the ALJ properly gave an individualized assessment of claimant's ability to deal with stress, where ALJ specifically found that claimant could not perform work that required understanding, remembering, and carrying out detailed or complex instruction, that required more then superficial contact with the public, or that was

categorized as stressful."); Durrett v. Apfel, No. IP 99-904-C H/G, 2000 WL 680430, *7 (S.D. Ind. Mar. 27. 2000) ("Both Lancellotta and Social Security Rule 85-15 require the ALJ to consider the effect of stress on the individual claimant and not to make unsupported conclusions regarding a claimant's ability to cope with stress."); Felver v. Barnhart, 243 F. Supp. 2d 895, 907 (N.D. Ind. 2003)(finding that "the ALJ made no findings about how the plaintiff's stress affects his ability to understand, carry out and remember instruction, respond appropriately to supervision, and coworkers, and deal with customary work pressures. Thus, not having fully painted this vocational picture, the ALJ failed to elicit testimony from the VE directed to the plaintiff's particular stress-causing condition or conditions.").

CONCLUSION

For the reasons stated above, plaintiff's Motion for Order Reversing the Decision of the Commissioner and Order for Remand [**doc. #6**] is **GRANTED**. Defendant's Motion for Order Affirming the Decision of the Commissioner [**doc. #9**] is **DENIED**. The decision of the Commissioner is reversed and the case is remanded for further proceedings consistent with this decision.

Any objections to this recommended ruling must be filed with the Clerk of the Court within ten (10) days of the receipt of this

order. Failure to object within ten (10) days may preclude appellate review. See 28 U.S.C. § 636(b)(1); Rules 72, 6(a) and 6(e) of the Federal Rules of Civil Procedure; Rule 2 of the Local Rules for United States Magistrates; Small v. Secretary of H.H.S., 892 F.2d 15 (2d Cir. 1989)(per curiam); F.D.I.C. v. Hillcrest Assoc., 66 F.3d 566, 569 (2d Cir. 1995).

SO ORDERED at Bridgeport this 8th day of March 2004.

/s/
HOLLY B. FITZSIMMONS
UNITED STATES MAGISTRATE JUDGE