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September 30, 2008

DECISION AND ORDER
OFFICE OF HEARINGS AND APPEALS

Hearing Officer Decision

Name of Case: Personnel Security Hearing

Date of Filing: March 27, 2008

Case Number: TSO-0618

This Decision concerns the eligibility of XXXXXXXXXX (the individual) to hold an access authorization under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria and Procedures for Determining Eligibility for Access to Classified Matter or Special Nuclear Material." In this Decision, I will consider whether, on the basis of the testimony and other evidence in the record of this proceeding, the individual's access authorization should be restored. As discussed below, after carefully considering the record before me in light of the relevant regulations, I have determined that the individual's access authorization should be restored.

I. Background

The individual is an employee of a contractor at a DOE facility. On October 1, 2007, the individual reported to the local DOE security office (LSO) that she was under the care of a counselor and a psychiatrist for the treatment of bipolar disorder. *See* Exhibit 4. Due to the security concern raised by this condition, the LSO conducted a Personnel Security Interview (PSI) with the individual on October 16, 2007. *See* Exhibit 3. Because the security concern remained unresolved after the PSI, the LSO requested that the individual be interviewed by a DOE consultant psychiatrist. The psychiatrist interviewed the individual on December 5, 2007. *See* Exhibit 2. The LSO ultimately determined that the derogatory information concerning the individual created a substantial doubt about her eligibility for an access authorization, and that the doubt could not be resolved in a manner favorable to her. Accordingly, the LSO proceeded to obtain authority to initiate an administrative review proceeding.

The administrative review proceeding began with the issuance of a Notification Letter to the individual. *See* 10 C.F.R. § 710.21. That letter informed the individual that information in the possession of the DOE created a substantial doubt concerning her eligibility for access authorization. The Notification Letter included a statement of that derogatory information and informed the individual that she was entitled to a hearing before a Hearing Officer in order to resolve the substantial doubt regarding her eligibility for access authorization. The individual requested a hearing, and the LSO forwarded the individual's request to the Office of Hearings and Appeals (OHA). The Director of OHA appointed me as the Hearing Officer in this matter.

At the hearing convened pursuant to 10 C.F.R. § 710.25(e) and (g), I took testimony from the individual, her husband, a neighbor, a long-time friend, her supervisor, two co-workers, the site physician, her treating psychiatrist, one of her treating counselors, and the DOE consultant psychiatrist. The DOE Counsel and the individual submitted exhibits prior to and at the hearing.

II. The Notification Letter and the Security Concern at Issue

In the Notification Letter, the DOE characterized the derogatory information in its possession as indicating that the individual has an illness or mental condition of a nature which, in the opinion of a psychiatrist, causes, or may cause, a significant defect in her judgment or reliability. Exhibit 1 (citing 10 C.F.R. § 710.8(h) (Criterion H)). These statements were based on a December 5, 2007, report by the DOE consultant psychiatrist concluding that the individual suffered from "Bipolar Disorder Type I." *Id.* The DOE psychiatrist further stated that bipolar disorder is an illness or mental condition that causes, or may cause, a significant defect in the individual's judgment or reliability. *Id.*

The Notification Letter also alleged the following: (1) in November 2006, the individual had a mood disturbance that interfered with her occupational functioning in that she missed work for a number of days; (2) in July 2007, she had severe anxiety, obsessive worrying, racing thoughts, and paranoid thinking; (3) in August 2007, she experienced a manic episode that led her to be hospitalized for 11 days, at which time she was diagnosed with bipolar disorder; and (4) the DOE consultant psychiatrist concluded that Bipolar Disorder Type I is not a curable condition, although it is manageable with proper care, which includes medication management and psychotherapy to manage stress, and may recur despite proper treatment. *Id.*

I find that the information set forth above constitutes derogatory information that raises questions under Criterion H. The security concern associated with Criterion H is that certain mental conditions "can impair judgment, reliability or trustworthiness." Guideline I of the *Revised Adjudicative Guidelines for Determining Eligibility for Access to Classified Information* issued on December 29, 2005, by the Assistant to the President for National Security Affairs, The White House. For her part, the individual does not dispute any of the facts set forth in the Notification Letter, nor the security concern raised by those facts.

III. Analysis

I have reviewed and carefully considered the evidence in the record. I have considered the evidence that raises a concern about the individual's eligibility to hold a DOE access authorization, as well as the evidence that mitigates that concern. I conclude, based on the evidence before me and for the reasons explained below, that the security concern in this case has been resolved.

A. Regulatory Standard

A hearing under Part 710 is held "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization," i.e., "to have the substantial doubt regarding eligibility for access authorization resolved." 10 C.F.R. § 710.21(b)(3), (6). Under the Part 710 regulations, the Hearing Officer is directed to make a predictive assessment as to whether granting or restoring access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.7(a).

It is my role as the Hearing Officer to issue a Decision that reflects my comprehensive, common-sense judgment, made after consideration of all the relevant evidence, favorable and unfavorable, as to whether the granting or continuation of a person's access authorization will not endanger the common defense and security and is clearly consistent with the national interest. 10 C.F.R. § 710.7(a). I am instructed by the regulations to resolve any doubt as to a person's access authorization eligibility in favor of the national security. *Id.*

"In resolving a question concerning an individual's eligibility for access authorization," I must consider

> the nature, extent, and seriousness of the conduct; the circumstances surrounding the conduct, to include knowledgeable participation; the frequency and recency of the conduct; the age and maturity of the individual at the time of the conduct; the voluntariness of participation; the absence or presence of rehabilitation or reformation and other pertinent behavioral changes; the motivation for the conduct; the potential for pressure, coercion, exploitation, or duress; the likelihood of continuation or recurrence; and other relevant and material factors.

10 C.F.R. § 710.7(c). Considering all of the above factors, I find that the nature, extent, and seriousness of the conduct, the frequency and recency of the conduct, and the likelihood of recurrence are the most relevant factors in this case, with the last being the critical issue in this case.

B. The Diagnosis of Bipolar Disorder

It is undisputed that the individual suffers from bipolar disorder under the criteria set forth in the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition (DSM-IV). Both the DOE psychiatrist and the individual's treating psychiatrist, both of whose hearing testimony is discussed in more detail below, are in accord on this matter. Tr. at 112, 265. The remainder of the decision, therefore, will focus primarily on whether her condition is under control to such a degree that I may conclude that the risk of recurrence of symptoms is low enough to resolve the DOE's concerns under Criterion H.

C. Whether the Security Concern Raised by the Diagnosis of Bipolar Disorder Has Been Resolved

1. Testimony Regarding the Onset, Treatment and Management of the Individual's Bipolar Disorder

a. The Individual

The individual testified that in November 2006, she "shut down," and at her husband's suggestion consulted a doctor, who diagnosed her with anxiety, prescribed lorazepam, an anti-anxiety medication, and suggested that she obtain counseling. Transcript of Hearing (Tr.) at 23. She took the lorazepam for about a week, and visited a counselor at her worksite. *Id.* at 25-26. By the end of December, she was feeling back to normal. *Id.* On July 13, 2007, the individual started feeling extreme anxiety while at work. *Id.* at 26. The feeling intensified over the weekend that followed, and she began to experience racing thoughts. *Id.* at 27. When she returned to work on Monday, she began to suffer from paranoia, thinking that she was being followed and that her phone was tapped. *Id.* at 29. She stayed home from work on Tuesday, and saw her doctor on Wednesday. *Id.* Her doctor still believed she was suffering from anxiety, but referred her to a psychiatric counselor. *Id.* at 30. Ultimately, she was seen by a psychiatrist, who prescribed Paxil. *Id.* at 31. After a week on Paxil, her symptoms were worse, and at the psychiatrist's recommendation, she voluntarily admitted herself for inpatient treatment. *Id.* at 32. During that 11-day stay, she was diagnosed with bipolar disorder. *Id.* When she was released, she was taking six medications for her condition, including lithium. *Id.* at 33-34. With the help of her treating psychiatrist, she has modified her regimen of medication, so that she now takes lithium, a mood stabilizer, and risperdal, an anti-psychotic, daily, has three sleeping aids available to her as needed, and has eliminated Paxil altogether. *Id.* at 34. She testified credibly that despite the side effects of these medications, she has no inclination to unilaterally stop taking them: "They keep me from having bipolar episodes, but they don't change my core personality. . . . It's going to have to be an awful high barrier for me [to stop taking them], and I haven't come anywhere close to that barrier." *Id.* at 73-74. The individual testified that other than in November 2006 and July 2007, she has had no episodes of anxiety or bipolar disorder in her life. *Id.* at 24, 52.

The individual also testified about her management of the condition. She sees her psychiatrist monthly to adjust medications as necessary. *Id.* at 61. She has biweekly sessions with each of two counselors, one who works with her psychiatrist in her health plan, and one who is onsite at her place of employment, generally alternating weeks so that she sees one counselor each week. *Id.* at 37, 57, 59. Recently, she increased her sessions with her health-plan counselor to weekly, as a precaution to stress she might feel due to the upcoming hearing in this case. *Id.* at 59. In addition to professional treatment, and at the suggestion of her treating professionals, she now exercises on most days of the week and meditates for 20 minutes every evening. *Id.* at 39, 46, 62. On her own initiative, she has charted her moods on a daily basis since September 2007, using a form she found online. *Id.* at 39, 79; Exhibit L. For each day, she records the medication

she has taken, any counseling sessions attended, doctor visits, exercise, hours of sleep, and, most important, her perceptions of her mood: whether she feels within normal limits, or whether her mood is depressed or elevated, and the degree of deviation from the norm. Exhibit L. She shares these charts with her psychiatrist and counselors, and testifies that they have been helpful in spotting trends that need attention. Tr. at 79. As an example, she noted that in January 2008, when her access authorization was suspended, her mood chart indicates that she felt anxious and moderately depressed. *Id.* at 89-90. She raised this concern with her doctors, and within a week of noting the change, she was feeling better due to adjustment in her lithium dosage. *Id.* at 63.

In addition, the individual testified about a network of family, friends, and co-workers who support her through encouragement and vigilance of her moods. She has told them that she suffers from bipolar disorder and has instructed them as to the early warning symptoms. *Id.* at 48. She stated: "Some of them had seen me in these . . . conditions, and I'm like, 'Remember what I looked like on, you know, July 20th when we went out? . . . . If I'm ever that way again, you need to . . . tell me, you need to tell . . . my husband. If we're not around you need to call my doctor or call 911 . . . . I need to get care.'" *Id.* Her network includes her five siblings, of which she speaks with at least two each week, and her mother, with whom she speaks weekly; she maintains they know her well enough to know when she does not "sound right on the phone." *Id.* at 48-49.

Finally, the individual testified that she has learned to manage stress better in her life, and she has learned to recognize symptoms of her illness. In the past, she would feel compelled to complete tasks she had assigned to subordinates in order to meet deadlines, *id.* at 23, but now she realized that it was more appropriate to let her superior know that a deadline cannot realistically be met, and to seek his advice in prioritizing projects. *Id.* at 64. She has reduced the hours she works, and no longer spends more than a half-hour to an hour on work projects during the evening hours at home, whereas before November 2006, she was often sending e-mails to her superior at midnight. *Id.* at 29, 69. She has learned to delegate tasks at home as well as at work. *Id.* at 39, 59. Most important, the individual testified that she would be able to recognize a recurrence of an episode "like the one in July. I mean, that one was very strong, and I think I would immediately get help." *Id.* at 65. She further recognizes that she could have manic and depressive episodes in the future: "It's a chronic recurring illness, but I . . . do things to minimize the risk of it occurring, and I think I have a lot of safeguards in place to catch it, so that it would be [of] low severity and its impact would be very minimum." *Id.* at 66.

b. The Individual's Husband

The individual's husband testified that he had been married to the individual for twelve years. *Id.* at 167. He stated that in the past two years, he has observed a general increase in the demands on his wife, both at work, where she has assumed greater responsibilities, and at home, as their three children have grown older and more active. *Id.* at 168. Although she worked only part-time officially, her actual hours were much closer to those of a full-time employee. *Id.* at 169. By November of 2006, he observed that she was under more stress than before, more

agitated, sleeping less, and suffering from tight muscles. *Id.* at 170. He convinced her to see her physician, who diagnosed her with anxiety. *Id.* at 171. Prescribed medication helped her, but he continued to notice a steady increase in her workload. *Id.* at 172. On Friday, July 13, 2007, when she arrived home from work, the husband observed that his wife was obviously distressed and "really kind of off by herself thinking about something." *Id.* at 173. Over the weekend, she became more agitated, convinced that she had been harassing her supervisor and would be fired. *Id.* at 174-75. The following Monday, his wife returned to work, but when she returned home after work, he realized that her state of mind had deteriorated even further. *Id.* at 176. He convinced her to stay home from work the next day, by which time she was incoherent. *Id.* at 177. The following day, he took her to her physician, who arranged for a psychiatric consultation. *Id.* at 178. His testimony is similar to his wife's regarding her hospitalization, her compliance with prescribed medications, her delegation of household duties, her meditation, her mood charting, and her reduction in the hours she actually works. *Id.* at 179-88. He also pointed out that she has learned to be more assertive, rather than acceding to every request for her help at her children's school and other social activities. *Id.* at 186. He testified that her support system includes family, friends and co-workers, all of whom she has instructed how to observe and report any behavior that may be early warnings of a new outbreak. *Id.* at 189-90. Finally, he stated that she is fully aware of how terrible she felt in July 2007 and how important it is to her to stay in remission. *Id.* at 188-89, 195.

c. The Individual's Neighbor and Long-time Friend

The individual's neighbor testified that she has known the individual for the past nine years, as they live next door to each other. *Id.* at 221. She stated that she and the individual walk for exercise at least five days a week, and share other pastimes as well. *Id.* at 221-22. They spend a lot of time together and, as a result, the neighbor is quite aware of the individual's moods. *Id.* at 222. She knew her to be a cheerful and active person in general, and observed the change in behavior in both November 2006 and July 2007. *Id.* at 223-25. She is part of the individual's support system, which she stated includes the individual's extensive family and other friends, and knows to watch for both excessive sleepiness and hyperactivity. *Id.* at 226-28. She said that since the July 2007 episode, the individual has achieved a better balance between home and work, can now delegate responsibilities, and has learned to say "no." *Id.* at 229. She also stated that the individual will do everything in her power to avoid a recurrence of the July 2007 episode. *Id.* at 230.

A friend who has known both the individual and her husband for over 20 years also testified. *Id.* at 233. She sees the individual and her family about twice a week through school activities and frequent visits on the weekend. *Id.* at 234. During the summer of 2007, the individual's mother, who lives 2,000 miles away, called the friend to ask her to check in on her daughter. *Id.* at 236. The friend did so, and the individual was able to convince her at that moment that she was doing fine. *Id.* at 237-38. Later in the summer, the friend learned that the individual had been hospitalized. *Id.* at 238. The individual explained her condition to the friend in great detail, and elicited a promise that the friend would tell the individual's husband about any significant

behavior she observed: ". . . if I notice something, I was to take action." *Id.* at 238, 244. She did, in fact, notice a change in January 2008, which coincided with the suspension of the individual's access authorization, and challenged the individual at the time. *Id.* at 245. The friend also testified that the individual has learned to step back from her work and adjust her commitments at home to leave some time for herself. *Id.* at 240-41.

d. The Individual's Manager and Co-Workers

The individual's manager testified that the individual was "the star" of his group. *Id.* at 251. She was extremely successful in her position, which he acknowledged was very stressful by nature, and all the more so in the individual's case, because she was quick to "overtask" herself. *Id.* at 250, 261. He was out of town when the individual was hospitalized in July 2007, and it came as a shock to him. *Id.* at 251-52. When she was cleared to return to work, the two of them met with the site physician, who instructed him regarding signs of stress and how to respond. *Id.* at 253; *see also id.* at 152-53 (testimony of site physician). He observed that since her return to work, she is exceeding his expectations and is more outgoing. *Id.* at 256.

One co-worker has shared an office with the individual since her access authorization was suspended. *Id.* at 202. He attested to her success at her position, which involves interaction with many co-workers, even though she is excluded from being physically present in their work area. *Id.* at 204-05. He also stated that she has instructed him on the warning signs of her illness, and what action to take if he were to observe any of them. *Id.* at 203. He clarified that he has not observed any, despite the many stresses she currently faces in her job. *Id.* at 208-10. A second co-worker testified that the individual was an excellent worker and that, since her return to work, he has observed that her more relaxed attitude and improved ability to delegate makes her more suited to the project on which they are working. *Id.* at 215, 218-19.

2. Expert Testimony as to the Individual's Progress in Recovery and the Risk of Relapse

The regulatory factors discussed above, both as to the severity of the individual's illness and the steps that that the individual has taken thus far to overcome her illness, need to be taken into account in evaluating the "likelihood of recurrence," in this case the likelihood that the individual will have acute episodes of bipolar disorder in the future. While the lay witnesses at the hearing demonstrate that the individual is doing everything in her power to prevent a recurrence, I give more weight on this issue to the opinions of the experts who testified at the hearing, the individual's treating psychiatrist, her on-site counselor, and the DOE psychiatrist.

a. The Treating Psychiatrist

The individual's psychiatrist began treating her in October 2007. Prior to October, the individual saw a different psychiatrist in the same health plan but located in a more distant city. *Id.* at 95-96. Since then, the treating psychiatrist has been managing the individual's medication regimen.

In addition, she confers regularly with the health plan counselor who provides psychotherapy to the individual. *Id.* at 93-94, 115. She stated that the individual has very good insight into her illness, is compliant with her appointments and medications, is well informed about the symptoms of her illness, maintains a mood chart, works diligently in therapy, uses meditation, exercises regularly, and is proactive about her medical care and her progress. *Id.* at 97-98, 105-09. It was the individual who first noted a low mood in January 2007, which the psychiatrist managed by increasing the individual's lithium dosage after tests confirmed that her earlier dosage was no longer providing a therapeutic benefit. *Id.* Since she began seeing the psychiatrist, the individual has dealt with stress by limiting her commitments and delegating responsibilities. *Id.* at 99-100. The psychiatrist is aware of the individual's extensive support network of family, neighbors, co-workers, and friends. *Id.* at 100. In addition, she is available to the individual at all times through the health plan. *Id.* at 106-07. Her prognosis for the individual is good, notwithstanding that bipolar disorder is a chronic condition, and given the individual's compliance with medication and therapy, her support system, her lack of symptoms since July 2007, and her good care, the risk of further recurrences is low. *Id.* at 103-04, 111. She considers the individual's condition to be stable, and will continue to see her on a monthly basis. *Id.* at 119-20.

b. The On-Site Counselor

The on-site counselor saw the individual in November 2006, on two occasions, to discuss managing the stresses of work and home life. *Id.* at 128. She then saw her once in July 2007, when the individual's management team expressed concern about her level of stress, at which time she understood that the individual already had an appointment with her physician. *Id.* at 130-31. Since the individual's return to work in September 2007, the on-site counselor sees her on a biweekly basis, to monitor her feelings and progress. *Id.* at 135. The counselor stated that the individual is candid with her, understands and accepts her illness, is fully compliant with her medications, has set limits for herself and learned to delegate, and has alerted a select group of people at work to warning signs to watch for and encouraged them to notify her or the site physician if they have any concerns. *Id.* at 135-37. In her opinion, as long as the individual continues to be compliant with her treatment plan, the risk of relapse is very low. *Id.* at 138. She considers the individual's condition to be stable, and anticipates continuing to check in with the individual, eventually reducing the frequency to once monthly. *Id.* at 143, 146.

c. The Testimony of the DOE Psychiatrist

The DOE psychiatrist was present during the entire hearing and heard all of the hearing testimony. Testifying last, he described the preceding testimony as "very comprehensive," in that he had the opportunity to hear from the individual, "from her professional treaters, from her spouse, from her co-workers, from her friends, from her neighbors . . . ." *Id.* at 267. He stated that he was able to observe that the individual's behavior during the hearing was entirely appropriate and that she "presented herself as emotionally stable," *id.* at 267-68, "despite the anxiety-provoking nature of this whole process." *Id.* at 270. Confirming that the individual has

a chronic illness, Bipolar Disorder Type I, that causes or may cause a defect in her judgment or reliability, he nevertheless described the following factors that were significant in his assessment of her status at the time of the hearing. The individual has a tendency to be perfectionistic which, while beneficial particularly in her field of endeavor, has worked against her by making her "overly conscientious," preoccupied with details, and willing to assume "excessive responsibility for others." *Id.* at 269-70. "All of this has seemed to soften and be modified of late, which is both to her credit and also going to be beneficial in terms of whether she may have a relapse someday." *Id.* at 270. In addition, she has voluntarily reduced her working hours, exhibited "very good self-awareness," is complaint with her treatment plan and has responded well to it, meditates nightly, has a good support system, is vigilant of early symptoms of a relapse, and is "very properly and highly motivated to avoid a further breakdown . . . [and] to remain well." *Id.* at 270-73, 279. Given this "safety net that's quite impressive," he expressed the opinion that the individual "is at low risk to have a relapse." *Id.* at 273. He stated his belief that her condition is stable. *Id.* at 275. Although he stated that it is possible the individual will experience only this single manic episode of July 2007, he acknowledged that he could not guarantee she will not suffer a relapse at some point in her life. *Id.* at 273-74. Nevertheless, he concluded:

> . . . [S]he is doing all she can do. I can't ask – I couldn't ask anything more of her with regard to managing her illness. Basically, the proper treatment for this illness is a combination of medication management, and the medicines she's receiving are appropriate, and stress management, and the psychotherapy she's receiving is appropriate in that regard.

Id. at 274.

D. Hearing Officer Evaluation of Evidence

As noted above, the decision of a Hearing Officer in a Part 710 case is a predictive assessment, in this case an assessment of the likelihood that the individual will experience a recurrence of a manic episode similar to the one that occurred in July 2007. The evidence in this case points nearly universally toward a good prognosis, *i.e.*, that it is quite unlikely that the individual will suffer a relapse.

The experts who testified at the hearing were in accord on this prognosis. These opinions were based at least in part on the same facts that I find compelling in this case. First, the individual has been fully compliant with treatment plan established by her doctors and therapists. *See Personnel Security Hearing* (Case No. TSO-0189), 29 DOE ¶ 82,820 (June 10, 2005). Second, she has developed significant insight into her illness and is extremely capable to recognize early warning signs and react appropriately to them. *See, e.g., Personnel Security Hearing* (Case No. TSO-0303), 29 DOE ¶ 82,900 (March 13, 2006). Third, she has created remarkable support network of family, neighbors, friends, and co-workers to help her manage her illness and live her life fully. *See Personnel Security Hearing* (Case No. TSO-0189). Considering all of the

evidence in this case, I am thoroughly convinced that the individual has a sufficiently low risk of experiencing a manic episode in the future that might cause a defect in her judgment or reliability.

IV. Conclusion

For the reasons set forth above, I find that there is evidence that raises a substantial doubt regarding the individual's eligibility for access authorization. However, I find that the concern raised by that evidence has been more than sufficiently mitigated in this case. I therefore conclude, "after consideration of all the relevant information, favorable and unfavorable," that restoring the individual's "access authorization would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. §§ 710.7(a), 710.27(a).

William M. Schwartz
Hearing Officer
Office of Hearings and Appeals

Date: September 30, 2008