January 2, 2003
DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case: Personnel Security Hearing

Date of Filing: May 9, 2002

Case Number: VSO-0543

This Decision concerns the eligibility of XXXXXX XXX XXXX (hereinafter referred to as "the Individual") to retain 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." 1/ A local Department of Energy Security Office (DOE) denied the Individual's request to have his access authorization restored under the provisions of Part 710. For the reasons stated below, I find that the Individual's access authorization should be restored.

I. BACKGROUND

The present proceeding involves an Individual who has been diagnosed with a mental illness known as Bi-Polar Disorder I. The record clearly shows that, since 1985, the Individual has suffered from episodes of either mania or major depression with psychotic features. 2/ During these manic episodes and periods of major depression with psychotic features, the Individual's judgment and reliability have been severely impaired. When the Individual's judgment and reliability have been impaired, it is clear that allowing him access to classified information or special nuclear materials

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1/ An "access authorization" is an administrative determination that an individual is eligible for access to classified matter or special nuclear material. 10 C.F.R. § 710.5.

2/ The record indicates that the Individual has apparently suffered four episodes of Bipolar Disorder. Tr. at 45, 90-91. In 1985, the Individual apparently suffered a manic episode. In 1993, the Individual apparently experienced another manic episode. The 1993 manic episode may have been induced by medication. Tr. at 52, 111. In 1999 and again in 2001, the Individual experienced major depressive episodes with psychotic features.

would endanger the common defense and security and would not be clearly consistent with the national interest as required by 10 C.F.R. § 710.27(d). Accordingly, in those instances when the Individual has experienced either a manic episode or a major depression, the DOE has suspended his access authorization until a board certified DOE consultant psychiatrist determined that he was no longer experiencing a significant defect in judgment or reliability.

The Individual's Bipolar Disorder has, by all accounts, responded well to treatment. Apparently, the Individual is not currently experiencing any significant defects in judgment or reliability. The Individual has now applied for restoration of his access authorization. The DOE security office reviewing his application for access authorization correctly determined that the Individual's Bipolar Disorder raises a security concern under 10 C.F.R. § 710.8(h). Section 8(h) provides that a security concern is raised when an individual has:

> An illness or mental condition of a nature which, in the opinion of a psychiatrist or licensed clinical psychologist, causes or may cause, a significant defect in judgment or reliability.

10 C.F.R. § 710.8(h). In order to resolve the security concerns raised by the Individual's mental illness, the DOE arranged for the Individual to be examined by a DOE sponsored psychiatrist (the DOE Psychiatrist). The DOE Psychiatrist conducted an extensive review of the Individual's medical and personnel security records. The DOE Psychiatrist also conducted a forensic psychiatric examination of the Individual. After conducting his review of these records and his examination of the Individual, the DOE Psychiatrist concluded that the Individual was accurately diagnosed with Bipolar Disorder I or possibly Schizoaffective Disorder. Tr. at 48, 52. 3/ The DOE Psychiatrist further opined that either of these disorders causes, or may cause, a significant defect in judgment or reliability. As a result, the Individual's application for an access authorization was placed in administrative review and the present proceeding was commenced. On April 19, 2002, the DOE issued a letter notifying the Individual that the DOE possessed derogatory information that created a substantial doubt concerning his continued eligibility for access authorization (the Notification Letter). Specifically, the Notification Letter notes 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 his judgment or reliability." Notification Letter, Attachment at 1. The Notification Letter

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3/ A Schizoaffective Disorder is characterized by an uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms of Schizophrenia. During the same period of illness, there must have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms. In order to arrive at a diagnosis of Schizoaffective Disorder, the symptoms that meet the criteria for a mood episode must be present for a substantial portion of the total duration of the active and residual periods of the illness. The disturbance must not be due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. *See* DSM-IV.

further contends that the Individual has at least a 25% probability of having another episode occur. If another serious episode were to occur, the Notification Letter reasons, it is highly likely that the Individual would experience a significant defect in judgment and reliability.

In response to the Notification Letter, the Individual filed a request for a hearing. This request was forwarded to the Office of Hearings and Appeals (OHA) and I was appointed as Hearing Officer. A hearing was held under 10 C.F.R. Part 710. At the hearing, the DOE called two witnesses: a DOE Personnel Security Specialist and the DOE Psychiatrist. The Individual called one witness: his treating psychiatrist (the Treating Psychiatrist). 4/ The Individual also testified on his own behalf. The record of this proceeding was closed on October 8, 2002, when OHA received a copy of the transcript of the hearing.

II. STANDARD OF REVIEW

The Hearing Officer's role in this proceeding is to evaluate the evidence presented by the agency and the Individual, and to render a decision based on that evidence. *See* 10 C.F.R. § 710.27(a). Part 710 generally provides

> [t]he decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable and unfavorable, as to whether the granting or continuation of 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 have considered the following factors in rendering this decision: the nature, extent, and seriousness of the concern; the circumstances surrounding the concern, including knowledgeable participation; the frequency and recency of the concern; the Individual's age and maturity at the time of the concern; the voluntariness of the Individual's participation; the absence or presence of rehabilitation or reformation and other pertinent behavioral changes; the motivation for the concern, the potential for pressure, coercion, exploitation, or duress; the likelihood of continuation or recurrence; and other relevant and material factors. *See* 10 C.F.R. §§ 710.7(c), 710.27(a). The discussion below reflects my application of these factors to the testimony and exhibits presented by both sides in this case.

When reliable information reasonably tends to establish the validity and significance of substantially derogatory information or facts about an individual, a question is created as to the individual's eligibility for an access authorization. 10 C.F.R. § 710.9(a). The individual must then resolve that question by convincing the DOE that restoring his access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R.

4/ The Treating Psychiatrist is a former DOE consultant psychiatrist. It was in this capacity that the Treating Psychiatrist first encountered the Individual (in 1993). The Individual first became a patient of the Treating Psychiatrist in May 2001.

§ 710.27(d). In the present case, the record shows that a valid and significant question has been raised about the Individual's eligibility for an access authorization. However, the Individual has convinced me that restoring his security clearance would not endanger the common defense and security and would clearly be in the national interest.

III. FINDINGS OF LAW AND FACT

Although the record indicates that both psychiatrists have previously opined that the Individual may suffer from Schizoaffective Disorder, they now agree that the Individual suffers from Bipolar Disorder I but does not suffer from Schizoaffective Disorder. 5/ Tr. at 47-48, 57, 101-102. Bipolar disorders are among the most common, severe and persistent mental illnesses. 6/ Bipolar disorders are characterized by the presence of at least one manic, mixed, or hypomanic episode. 7/ In addition, both psychiatrists agree that the Individual has significant defects in judgment and reliability when he experiences manic episodes or episodes of major depression with psychotic features. Tr. at 49-50, 56-57. As the Notification Letter correctly notes, the Individual's mental

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5/ The American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) establishes a distinction between Bipolar Disorder I and Bipolar Disorder II, with Bipolar Disorder I being the more severe of the two disorders. Tr. at 48.

6/ Bipolar Disorders affect about 10 to 30 out of every 1000 people (or 1 to 3%) in the United States.

7/ A manic episode is defined by a distinct period of persistently elevated, expansive, or irritable mood lasting at least one week (or less if hospitalization is required). The mood is also accompanied by additional symptoms, such as inflated self-esteem or grandiosity, a decreased need for sleep, pressured speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable and high-risk activities. A hypomanic episode is defined by a distinct period of persistently elevated, expansive, or irritable mood lasting at least 4 days. The mood is also accompanied by additional symptoms, such as inflated self-esteem or grandiosity, a decreased need for sleep, pressured speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable and high-risk activities. In contrast to a manic episode, a hypomanic episode is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization. The presence of a major depressive episode is very common in the lifetime of individuals with Bipolar Disorder (more than 90% of these individuals have at least one major depressive episode in their lifetime), but it is not necessary to experience a depressive episode to be accurately diagnosed with Bipolar Disorder.

disorder raises a serious and significant security concern under 10 C.F.R. § 710.8(h). Consequently, I find that the DOE security office properly invoked Criterion H in processing the Individual's application for restoration of his access authorization under the DOE's administrative review procedures.

Accordingly, my responsibility is to make an independent assessment of the seriousness of the risk under Criterion H. In that connection, I will consider those factors set forth at 10 C.F.R. § 710.7(c) in deciding whether restoration of access authorization to the Individual would not endanger the common defense and security and would be clearly consistent with the national interest. Although the Psychiatrists agree on the Individual's diagnosis, they disagree about both the probability and the likely consequences of any future manic or psychotic episodes.

Every individual with a DOE access authorization presents a security risk. 8/ That risk includes the possibility that an individual will experience a bipolar episode. 9/ However, an individual who has been accurately diagnosed with Bipolar Disorder presents a greater security risk of experiencing a bipolar episode in the future than a randomly chosen member of the general population. In order to consider whether this increased risk is unacceptable, I must consider two factors: (1) the probability of a future bipolar episode occurring, and (2) the expected consequences if the Individual experiences a future bipolar episode.

A. Probability of Future Episodes

Turning to the first factor, the two psychiatrists who testified before me at the hearing used different approaches in estimating the probability that the Individual would experience another bipolar episode in the future. The DOE Psychiatrist, citing his own survey of the medical literature, opines that 25% percent of all those persons diagnosed with bipolar disorder and treated with lithium will experience further episodes. 10/ The DOE Psychiatrist uses this statistic to deduce that the Individual has a 25% chance of experiencing another bipolar episode. In contrast, the Treating Psychiatrist has considered the Individual's specific circumstances, including the Individual's

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8/ A certain percentage of the general population possesses a trait which will eventually cause them to experience a manic episode. Tr. at 122. *See* fn. 6.

9/ Every person presenting with bipolar disease will have a first episode sometime and there is no scientifically validated way of determining who those persons are until they begin exhibiting symptoms.

10/ At the time of the hearing, the Individual was not undergoing lithium treatment. Tr. at 99. The Treating Psychiatrist explained that the Individual had been undergoing Electroconvulsive Treatment (ECT) for his last episode (which was a major depressive episode). *Id.* However, the Treating Psychiatrist indicated that the Individual would be starting lithium therapy in the near future. Tr. at 99, 111, 121. The DOE Psychiatrist opined that the Individual had about a 25% risk of experiencing a bipolar episode during the course of his ECT. Tr. at 63.

support system, the high quality and intensity of the Individual's current mental health care, and the Individual's intelligence, exceptional compliance, insight into his disorder, and responsiveness to treatment. He has concluded the probability of the Individual experiencing a future bipolar episode is less than that predicted by the DOE Psychiatrist.

Common sense and the DOE Personnel Security Regulations support the Treating Psychiatrist's probability determination methodology. The DOE Personnel Security Regulations provide:

> The decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable and unfavorable, as to whether the granting or continuation of 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). The regulations further provide:

> In resolving a question concerning an individual's eligibility for access authorization, all DOE officials involved in the decision- making process shall 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). This language mandates that an access authorization determination must be made after due consideration of the individual circumstances present in each case, rather than relying upon categorically based bright-line tests. In previous cases, OHA hearing officers have considered the individual circumstances present in each case involving Bipolar Disorder and have issued some decisions in favor of individuals with Bipolar Disorder and in other cases have issued decisions against individuals with Bipolar Disorder. *Compare Personnel Security Decision, Case No. VSO-0467*, 8_,__ (January 31, 2002) *VSO-0441* (restoring clearance); *Personnel Security Decision, Case No.*, 8_,__ (November 23, 2001)(restoring clearance) with *Personnel Security Decision, Case No. VSO-0421*, 28 DOE ¶ 82,800 (June 8, 2001) (denying clearance); *Personnel Security Decision, Case No. VSO-0381*, 28 DOE ¶ 82,771 (November 7, 2000) (denying clearance); *Personnel Security Decision, Case No. VSO-0358*, 28 DOE ¶ 82,755 (August 1, 2001) (denying clearance); *Personnel Security Decision, Case No. VSO-0355*, 28 DOE ¶ 82,759 (August 30, 2000) (denying clearance); *Personnel Security Decision, Case No. VSO-0253*, 27 DOE ¶ 82,804 (May 26, 1999) (denying clearance); *Personnel Security Decision, Case No. VSO-0205*, 27 DOE ¶ 82,776 (October 1, 1998) (denying clearance); *Personnel Security Decision, Case No. VSO-0150*, 26 DOE ¶ 82,789 (August 7, 1997) (denying clearance); *Personnel Security Decision, Case No. VSO-0082*, 25 DOE ¶ 82,800 (April 22, 1996) (denying clearance).

It is important to note, that in those cases where an OHA Hearing Officer has denied an individual with Bipolar Disorder's request for a clearance, the individual's case has generally been complicated by additional circumstances with have reflected negatively on the individual's ability to safeguard classified information or special nuclear materials. In *Personnel Security Decision, Case No. VSO-0421*, 28 DOE ¶ 82,800 (June 8, 2001), the individual had been convicted of child abuse. In *Personnel Security Decision, Case No. VSO-0381*, 28 DOE ¶ 82,771 (November 7, 2000), the individual had (1) been diagnosed with alcohol abuse, (2) been found to have abused cocaine, and (3) not responded well to therapy. In *Personnel Security Decision, Case No. VSO-0358*, 28 DOE ¶ 82,755 (August 1, 2001) the individual failed to comply with his treatment plan and lacked the insight to see that he suffered from a Bipolar Disorder. In *Personnel Security Decision, Case No. VSO-0355*, 28 DOE ¶ 82,759 (August 30, 2000) the individual had a history of marijuana use, had been diagnosed with alcohol abuse, failed to comply with his treatment plan and lacked the insight to see that he suffered from a Bipolar Disorder. In *Personnel Security Decision, Case No. VSO-0253*, 27 DOE ¶ 82,804 (May 26, 1999) the individual lacked the insight to see that he suffered from a bipolar disorder and would not accept the validity of his diagnosis. In *Personnel Security Decision, Case No. VSO-0205*, 27 DOE ¶ 82,776 (October 1, 1998) the individual was found to have been dishonest in reporting information to DOE security officials. In *Personnel Security Decision, Case No. VSO-0150*, 26 DOE ¶ 82,789 (August 7, 1997), the individual suffered from a co-morbid diagnosis of Paranoid Personality Disorder, failed to accept the validity of his diagnosis and refused to implement his treatment. In *Personnel Security Decision, Case No. VSO-0082*, 25 DOE ¶ 82,800 (April 22, 1996), the individual was found to be still experiencing mood swings and instability, had not been taking his medication consistently, and had a co-morbid diagnosis of Mixed-type Personality Disorder.

In this case, we have a wealth of information regarding the Individual. Moreover, we are fortunate to have detailed testimony form the treating Psychiatrist. The Treating Psychiatrist is more familiar than the DOE Psychiatrist with the specific circumstances of the Individual's case. The DOE Psychiatrist's familiarity with the Individual's case is limited to a single forensic psychiatric examination of the Individual as well as, an exhaustive review of the Individual's medical records and personnel security case file. The Treating Psychiatrist's familiarity with the Individual's case is much more extensive. The Treating Psychiatrist's first encounter with the Individual occurred in 1993, when he conducted a forensic psychiatric evaluation of the Individual on behalf of the DOE. Tr. at 87-88. In May of 2001, the Individual was referred to the Treating Psychiatrist by another psychiatrist who was treating the Individual at that time. Tr. at 90. At that time, the Treating Psychiatrist began treating the Individual. Accordingly, the Individual has been the Treating Psychiatrist's patient for over a year. The Individual currently sees the Treating Psychiatrist on a bi-weekly basis. Tr. at 93.

The DOE Psychiatrist contends that, even if the Individual is treated with lithium, he has "about" a 25% chance of having another manic or psychotic episode during the next five years. 11/ Tr. at

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11/ The DOE Psychiatrist opined that Lithium therapy is the most effective available treatment for Bipolar Disorder. Tr. at 61-62. According to the DOE Psychiatrist, 50% of (continued...)

49. The DOE Psychiatrist testified that he arrived at this figure by searching the medical literature for longitudinal studies of patients with Bipolar Disorder. Tr. at 65, 71. After reviewing many such studies, the DOE Psychiatrist concluded that since approximately 25% of the Bipolar patients (followed in the studies he reviewed) who were treated with lithium experienced at least one more psychotic or manic episode, the Individual has a 25% chance of experiencing a manic or psychotic episode, assuming he is undergoing lithium therapy. Tr. at 72. 12/

The Treating Psychiatrist disagreed with the DOE Psychiatrist's assertion that there is a 25% likelihood that the Individual would have another manic or psychotic episode. Tr. at 95, 107, 110. 13/ The Treating Psychiatrist did not disagree with the DOE Psychiatrist's contention that roughly 25% of Bipolar patients treated with lithium would experience a manic or psychotic episode. Tr. at 95, 110. However, the Treating Psychiatrist correctly noted that the statistical characteristics of an aggregate group cannot always be accurately attributed to individual members of the aggregate group. 14/ Tr. at 112, 114, 116. Noting that "there are a number of prognosticators that put [the individual] in the excellent range of a good prognosis," the Treating Psychiatrist testified that the Individual had several important attributes that decrease the likelihood that he would experience another manic or psychotic episode. Tr. at 96-97. These attributes, the Treating Psychiatrist testified, distinguish him from the aggregate population of persons suffering from Bipolar Disorder from which the 25% probability figure is derived. Tr. at 110, 112. Specifically, the Treating Psychiatrist testified that the Individual's excellent support system, compliance, response to therapy, and treatment plan as well as the availability of new medications all decrease the likelihood that the Individual will suffer a future manic or psychotic episode. Tr. at 111. Accordingly, the Treating Psychiatrist repeatedly testified that the Individual's prognosis is "excellent." Tr. at 95-96, 110, 120, 125.

The Treating Psychiatrist described the Individual as a "model patient." Tr. at 93. The Treating

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11/ (...continued)
patients suffering from Bipolar Disorder could be expected to have an episode within 5 years if they were not treated, while only 25% percent of those patients receiving lithium therapy would experience another episode within 5 years. Tr. at 49, 60.

12/ The DOE Psychiatrist described the 25% and 50% probabilities as "ballpark figures that are in my opinion consensus figures." Tr. at 70, 71.

13/ The Treating Psychiatrist characterized the Individual's risk of experiencing a further manic or psychotic episode as "low." Tr. at 95-96.

14/ For example, roughly half of the human population is male. So one could roughly infer that there is about a 50% chance that any one human individual would be male. However, if we had knowledge of an additional characteristic of a particular individual that had predictive value, the presence of ovaries for example, the statistical presumption would be highly inaccurate.

Psychiatrist further testified that the Individual is "an exceptional patient . . . [whose] compliance is among the best compliance that I have in my practice." Tr. at 100; *see also* Tr. at 120.

The Treating Psychiatrist testified that the Individual maintains significant insight even when he is experiencing symptoms. Tr. at 103, 104. The Treating Psychiatrist described the Individual as "exceptionally sensitive about his symptoms. He complains to me about each and every symptom that he has, and in my opinion, I would trust that [he] would continue in the future." Tr. at 97.

The Treating Psychiatrist testified that the Individual is "exceptionally intelligent." Tr. at 96. The Treating Psychiatrist further noted that the Individual was observant and knowledgeable about his disorder. Tr. at 98. The Treating Psychiatrist opined that "intelligent bipolar patients have a better prognosis." Tr. at 108.

Another prognostic factor which favors the Individual is the high quality of the treatment he is currently receiving. Tr. at 66. By all accounts, the Individual is currently receiving excellent and intensive care and is well monitored. Tr. at 63-64, 66, 83. The Treating Psychiatrist notes that the Individual has had an excellent response to treatment. Tr. at 108. The Individual currently sees either the Treating Psychiatrist or a clinical psychologist on a weekly basis. Tr. at 93, 100. The Treating Psychiatrist notes that the Individual has never had consistent treatment until recently, which is important with bipolar illness. Tr. at 108.

The Treating Psychiatrist also testified that the Individual, unlike some other bipolar patients, does not have any additional psychiatric diagnoses or substance abuse problems. Tr. at 119-20. The absence of substance abuse and any co-morbid psychiatric diagnoses improves the Individual's prognosis. Tr. at 119-120.

The Treating Psychiatrist testified that the Individual has a strong support system. Tr. at 100. The Individual sees either the Treating Psychiatrist or a clinical psychologist on a weekly basis. Tr. at 93, 99-100. The Individual (as well as the Individual's wife) have easy access to the Treating Psychiatrist if needed. Tr. at 108. Moreover, the Individual has an excellent family support system. Tr. at 100. The Treating Psychiatrist testified that the Individual's "support system includes his wife's support, her intelligence, her observations about him, her willingness to be involved in his treatment and his three daughters." Tr. at 112. The Treating Psychiatrist indicates that the Individual's wife has been involved in his treatment and accompanies the Individual to therapy sessions. Tr. at 98. Additional support is provided by the Individual's "stable job environment" which the Treating Psychiatrist noted provides the Individual with structure and self-esteem. Tr. at 98. The Treating Psychiatrist further testified that social support insulates people with mental illness and improves their prognosis. Tr. at 119. 15/

15/ The DOE Psychiatrist notes the more support a patient has, the better chance there is that an episode will be diagnosed at an early stage. Tr. at 70.

After considering the testimony and reports of both psychiatrists, I find that the probability that this specific individual will experience a full-blown manic or psychotic episode in the future is considerably lower than the probability opined by the DOE Psychiatrist. Taking this finding into consideration along with my findings concerning the expected security consequences of a future manic or psychotic episode, which I will discuss in greater detail below, I am convinced that the security risks associated with the Individual's Bipolar Disorder are acceptable.

B. Expected Consequences of Possible Future Episodes

In addition to the differing opinions concerning the probability that the Individual would experience a future manic or psychotic episode, the psychiatrists disagree about the expected consequences for security if the individual were to experience a future manic or psychotic episode.

The DOE Psychiatrist strongly emphasized the potential danger to security interests posed by an individual experiencing a manic episode, testifying that: "when somebody is manic even when you catch it early and he's in the hospital, he's at great risk for divulging things that are classified." Tr. at 131. In contrast, the Treating Psychiatrist is confident that any future manic episodes would be detected at an early enough point in time to allow sufficient treatment to prevent this scenario from occurring.

The Treating Psychiatrist testified that even if the Individual were to begin experiencing a manic or psychotic episode, he is confident that such an episode would be detected and treated before it would significantly affect the Individual's judgment and reliability. Tr. at 109, 119. The Treating Psychiatrist noted that the Individual is seen by a mental health professional on a weekly basis, has a well-informed and observant wife and family, and is himself likely to bring any symptoms to the Treating Psychiatrist's attention. Tr. at 97. The Treating Psychiatrist noted that Bipolar Disorder is "one of the most treatable illnesses [mental health professionals] encounter." Tr. at 104. The Treating Psychiatrist further emphasized the cyclical nature of Bipolar Disorder, noting that "many bipolar patients can function well in between their episodes." Tr. at 104. The Treating Psychiatrist testified that this is true of the Individual. *Id.* The DOE Psychiatrist also testified to the cyclical nature of Bipolar Disorder noting that

> The people with pure bipolar disorder usually can be managed on just medication like Lithium and between episodes, they're really completely 100 percent normal. They can practice law, they can practice medicine. They don't appear ill in any way.

Tr. at 54-55.

I find the opinion of the Treating Psychiatrist to be compelling. The Treating Psychiatrist notes that the security risks presented by the possibility that the Individual might experience a manic or psychotic episode in the future are substantially mitigated by the high probability that any such episode would be detected and treated rapidly and could be expected to respond to treatment expeditiously and thoroughly.

The DOE Psychiatrist, asserting that "manic episodes can start very abruptly," implied that the Individual's admittedly excellent support system does not provide sufficient mitigation of the security risks associated with the Individual's Bipolar Disorder. Tr. at 51. The Treating Psychiatrist noted that rapid onset manic episodes "are the exception rather than the rule." Tr. at 96. The Treating Psychiatrist further noted that the Individual was an unlikely candidate for experiencing a rapid onset manic episode, noting that he expected that the Individual would not experience a future episode without a warning. Tr. at 97-98.

Finally, I note one other consideration. The Individual already has had access to a great deal of classified information. Tr. at 146. Given the high level of the Individual's intellect, it is reasonable to conclude that he has already retained a great deal of this classified information in his long term memory. Tr. at 146. Therefore, most of the risks associated with the Individual's Bipolar Disorder have already been incurred. Thus, the DOE's paramount interest would be in preventing the Individual from experiencing future manic episodes or ensuring that the Individual would receive prompt and effective treatment if he were to begin to experience a manic episode. Stable employment would be an important factor in preventing future episodes. Tr. at 99. The ability of the DOE to continue monitoring the Individual's Bipolar Disorder might also serve to reduce the already existing risks due to the combination of the Individual's acquired knowledge of classified information and Bipolar Disorder.

Accordingly, I find that the derogatory information discussed above has been resolved.

IV. CONCLUSION

For the reasons set forth above, I conclude that the Individual has presented evidence that warrants restoration of his access authorization. Since the Individual has resolved the DOE's allegations under Criterion H, the Individual has demonstrated that restoring his security clearance would not endanger the common defense and would be clearly consistent with the national interest. Therefore, the Individual's access authorization should be restored. The DOE may seek review of this Decision by an Appeal Panel under the regulation set forth at 10 C.F.R. § 710.28.

Steven L. Fine
Hearing Officer
Office of Hearings and Appeals

Date: January 2, 2003