* The original of this document contains information which is subject to withholding from disclosure under 5 U.S.C. 552. Such material has been deleted from this copy and replaced with XXXXXXX's.

November 25, 2003
DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Case Name:	Personnel Security Hearing
Date of Filing:	January 21, 2003
Case Number:	TSO-0031

This Decision concerns the eligibility of XXXXXXXXXXXX (hereinafter referred to as "the individual") for 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/

I. Background

The individual's employer, a Department of Energy (DOE) contractor, sought to place the individual in a job that requires a security clearance. Consequently, the contractor requested access authorization on the individual's behalf. During the ensuing investigation of the individual, information was provided to the local DOE Security Office that raised security concerns. That Office conducted a Personnel Security Interview (PSI) of the individual and referred her to a board-certified psychiatrist (hereinafter referred to as "the DOE psychiatrist"), for an agency-sponsored psychiatric evaluation. The DOE psychiatrist interviewed the individual, reviewed her personnel file and medical records, and provided a written evaluation to the Security Office.

After reviewing the results of the investigation, the Director of the local DOE Security Office determined that derogatory information existed which cast into doubt the individual's suitability for access authorization. On December 11, 2002, the Director informed the individual of this determination in a letter which set forth in detail the DOE's security concerns and the reasons for those concerns. I will hereinafter refer to this letter as the Notification Letter. The Notification Letter also 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.

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. Such authorization will be referred to in this Decision as access authorization or a security clearance.

The individual requested a hearing on this matter. The Director forwarded the individual's request to the Office of Hearings and Appeals and I was appointed the Hearing Officer. A prehearing telephone conference was held, and the hearing was convened at the individual's job site. Five witnesses testified at the hearing. The Human Resources Manager for the DOE contractor and the DOE psychiatrist testified for the DOE. Testifying for the individual were another psychiatrist (hereinafter referred to as "the individual's psychiatrist"), a co-worker of the individual and the individual herself.

II. Statement of Derogatory Information

As indicated above, the Notification Letter included a statement of derogatory information in possession of the DOE that created a substantial doubt as to the individual's eligibility to hold a clearance. This information pertains to 10 C.F.R. § 710.8 (h) of the criteria for eligibility for access to classified matter or special nuclear material. Paragraph (h) defines as derogatory any information indicating that the individual has "[a]n 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 judgement or reliability." The Notification Letter states that the individual was diagnosed by the DOE psychiatrist as suffering from Bipolar Disorder and a possible second illness or mental condition, Dissociative Amnesic Disorder. In the opinion of the DOE psychiatrist, the individual's mental condition has caused significant defects in her judgement and reliability in the past, and more likely than not would do so in the future. DOE psychiatrist's evaluation at 28-31. The Letter also states that during the period from December 28, 1990 through February 15, 1991, the individual was hospitalized on two separate occasions. During her first hospital stay, she was diagnosed with Bipolar Affective Disorder, Hypomanic, and during her second hospitalization, with Bipolar Disorder, Manic. According to the Letter, the individual was prescribed Lithium during each stay.

III. Findings of Fact and Analysis

The criteria for determining eligibility for security clearances set forth at 10 C.F.R. Part 710 dictate that in these proceedings, a Hearing Officer must undertake a careful review of all of the relevant facts and circumstances, and make a "common-sense judgment . . . after consideration of all the relevant information." 10 C.F.R. § 710.7(a). I must therefore consider all information, favorable or unfavorable, that has a bearing on the question of whether granting the individual's security clearance would compromise national security concerns. Specifically, the regulations compel me to consider the nature, extent, and seriousness of the individual's conduct; the circumstances surrounding his conduct; the frequency and recency of the conduct; the age and maturity of the individual at the time of the conduct; the absence or presence of rehabilitation or reformation and other pertinent behavioral changes; the likelihood of continuation or recurrence of the conduct; and any other relevant and material factors. 10 C.F.R. § 710.7(c).

A security clearance hearing is "for the purpose of affording the individual an opportunity of supporting his eligibility for access authorization." 10 C.F.R. § 710.21(b)(6). Once the DOE has made a showing of derogatory information raising security concerns, the burden is on the individual

to produce evidence sufficient to convince the DOE that 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. § 710.27(d). See Personnel Security Hearing, Case No. VSO-0013, 24 DOE ¶ 82,752 at 85,511 (1995) (affirmed by OSA, 1996), and cases cited therein. After careful consideration of the factors mentioned above and of all the evidence in the record in this proceeding, I find that the individual has failed to make this showing, and that she should therefore not be granted a security clearance.

A. Findings of Fact

Based on the record in this proceeding, I make the following findings of fact. In October 1990, the individual was taken into custody by the local police department after allegedly becoming abusive toward her grandmother. PSI at 16, DOE psychiatrist's report at 5. After allegedly becoming involved in an altercation at the jail, the individual was referred to a local facility for a psychiatric evaluation. PSI at 17. 2/ On December 28, 1990, the individual was admitted to a local hospital after a week of unusual behavior, including "acting increasingly agitated, irritable and inappropriately." Hospital record, DOE Exhibit 9. During the period of time leading up to this initial hospitalization, she was also "hitch-hiking and getting in trouble," having difficulty sleeping, experiencing hyperactivity, eating little, and using her credit cards to charge irresponsibly for Christmas gifts. *Id.*, PSI at 20; 40. She joined a local religious group and tried to give away her truck, stating that she needed to donate everything to the poor. During her stay at the local hospital, she was administered Thorazine and Lithium, and was discharged on January 3, 1991 with a diagnosis of Bipolar Disorder, Hypomanic. DOE Exhibit 9. The individual also impulsively set out on a somewhat lengthy trip in the middle of the night and ran out of gasoline. She was rescued by several soldiers in a van and ended up at a local armory. After allegedly being "groped" by a soldier, she got into an altercation and was again taken into custody by local law enforcement. PSI at 27. On January 21, 1991, the individual was admitted to the psychiatric unit of another local medical facility. DOE Exhibit 10. During her stay, she was again administered Lithium, and was discharged on February 15, 1991 with a diagnosis of Bipolar Affective Disorder, Manic. *Id.*

B. The Mitigating Evidence

At the hearing, the individual attempted to show that what she termed the "nervous breakdown," Hearing Transcript (Tr.) at 20, that she suffered as a teenager and that led to her hospitalizations in December 1990 and January 1991 was the result of a chaotic childhood and several very stressful events. She testified that her parents divorced when she was three years old, and that her mother's drug and alcohol addiction caused the individual to be constantly shuttled back and forth between her mother's residence and that of her grandparents. Tr. at 24-25. She testified that she "grew up fast" and "saw a lot of things I shouldn't have seen," such as "my mom shooting my stepfather. I saw a lot of drug use . . . ." Tr. at 25. While in her mid-teenage years, she turned her mother in to the

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2/ The record does not indicate the result of this evaluation or whether she received treatment there.

police, believing that her mother "had to change or [illegal drug usage] was going to take her life." Tr. at 27. At around this time, she stated, her father relinquished all parental rights in order to avoid having to pay child support, which caused her great pain. Tr. at 26.

During the period of time leading up to her hospitalizations, she met the man who was to become her first husband, and became pregnant by him. Tr. at 27. She was living with her grandparents at the time, she testified, and because she believed that they would not approve of her pregnancy out of wedlock, she got married. *Id*. Shortly after their marriage, she testified, he began drinking heavily and became abusive. He struck her, and she lost her baby. Tr. at 28. She added that she was "17, 18, approximately" at the time. Shortly afterwards, her grandfather, to whom she was very close, was diagnosed with terminal lung cancer, and her marriage broke up when she found that her husband had impregnated another woman. *Id*. After her grandfather died, the individual's father re-entered her life. Since the time he had relinquished all parental rights over her, he had become a "born again" Christian, and he began to influence her to adopt what he considered to be a more "Christian" lifestyle by forsaking country music and giving her possessions away. Tr. at 30-31. The individual testified that all of these events led up to her "nervous breakdown" in 1990, at the age of "18 or 19." Tr. at 31. She stated that she was taken into custody in October 1990 at the behest of her grandmother because she "was acting different" and was depressed. Tr. at 32.

The individual also testified about what has transpired in the years since her 1991 hospitalization. She said that she has been married for ten years and has four children, has a residential and commercial cleaning business, and has been employed with a DOE contractor since 2000. The individual added that she has not taken or been prescribed any medication for mental or emotional problems since 1991, and that she has not had any manic episodes, periods of depression or periods of time in which she was not in touch with reality during those years. Tr. at 35-36.

The individual's psychiatrist also testified. He said that there are there are many conditions that can be confused with Bipolar Disorder, such as plain depression, major depressive disorder, schizophrenia, adjustment disorders, or brief psychotic episodes, and that, in certain circumstances, even a well-qualified psychiatrist could make an erroneous diagnosis of Bipolarity. Tr. at 189-190. It would be rare, he stated, for a Bipolar person to have only one manic episode or subsequent depression, adding that 95 percent of people who have one manic episode have recurrences. Tr. at 191. However, he went on to say that most people who have a manic episode have a recurrence "pretty quickly," and that frequently, the manic episode is followed by a depression. *Id*. "[Bipolar] individuals tend to have cycles, so . . . most of the people I've seen have this history of fairly frequent episodes . . . certainly having episodes every few years." Tr. at 192. When someone diagnosed with Bipolar Disorder does not fit that pattern, he testified, he tends to question that diagnosis. Tr. at 193. Of the many Bipolar patients he has seen, he could not recall one who had gone more than 10 years without an episode. *Id*. The individual's psychiatrist then discussed factors which he believes can contribute to the onset of a manic episode. He said that the use of antidepressant drugs, sleep deprivation, and external stressors such as troubled marriages can trigger manic episodes. Tr. at 193-194.

The individual's psychiatrist then discussed his evaluation of the individual, and his reasons for disagreeing with the DOE psychiatrist's diagnosis. The individual's psychiatrist diagnosed her as having suffered from a Mood Disorder, Not Otherwise Specified during the period of her hospitalizations. He stated that the primary reason for his disagreement

> is the lack of recurrence, not only of a manic episode, not even of a brief – these milder forms of the condition, which we call hypomanic, no suggestion that we have, but we also don't have any suggestion of a clinical depression.
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> So we've gone 12-and-a-half years. Again, no treatment. We then look at possible stressors which might have set this off, and there have been several. Her life in the last 12-and-a-half years has not been totally without stressful events.

Tr. at 196. He added that among those events was a domestic dispute (in 2001) during which the individual was struck by her current husband, periods of sleep deprivation caused by work requirements, and two pregnancies. Tr. at 197. Given the records available and the stresses to which she was subject at the time, he indicated that it was impossible to tell whether she was exhibiting manic-like features in late 1990-early 1991 because she was not sleeping and was upset, or whether she was truly manic. Tr. at 198-199. He therefore estimated the individual's chances of being Bipolar at 10 to 20 percent.

He then went on to state that, even if the individual did have a manic episode during the time of her hospitalizations, he believed a recurrence to be unlikely. He indicated that, while he did not disagree with the generally-accepted estimation that 95 percent of people who have a manic episode would have another, he did not think that that statistic necessarily applied to people, such as the individual, who had gone over ten years without having a recurrence. Tr. at 201. Because of this lack of a recurrence, and especially because of the absence of subsequent depressive episodes, the individual's psychiatrist estimated that the individual's chances of having another manic episode were "somewhere between 10 and 15 percent." Tr. at 206. Even if the individual is Bipolar and had a recurrence, he testified, it is likely that its onset would be gradual enough so that the individual or her friends and family would notice, and seek help. Tr. at 206-207. The individual's psychiatrist concluded that she "most likely does not have a Bipolar condition and most certainly does not constitute a significant risk of creating a security risk by virtue of impaired judgement or reliability." Tr. at 208.

The individual's co-worker testified that the individual is an honest and reliable person who has exercised good judgement in the performance of her duties. He added that she is an emotionally strong woman who can be trusted not to divulge confidential information. Tr. at 236-243. 3/

3/ The individual also submitted exhibits, including written evaluations from her psychiatrist and from her physician. In two separate evaluations, her physician stated "It is difficult for me to place that evaluation [Bipolar Disorder] on her at this point because I have never seen

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C. Analysis

After carefully considering the evidence described above, and the record as a whole, I believe that the individual experienced a manic episode during the latter part of 1990 and the beginning of 1991. I therefore believe that the DOE psychiatrist's diagnosis of Bipolar Disorder is accurate. 4/

3/ (...continued)
or heard of the diagnostic criteria presenting in this patient in particular . . . currently, she is well adjusted and not experiencing any problems" (January 13, 2003 evaluation); and "I have not seen any evidence during my time as her physician to support [a diagnosis of Bipolar Disorder]. In fact, she has been under stress during the time that I have known her, and . . . seems to have handled it adequately" (October 3, 2002 evaluation). The individual's psychiatrist's report is substantially the same as his testimony at the hearing.

4/ The criteria for a manic episode, as set forth in The Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, (DSM-IV) are as follows:

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a mixed episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in

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Accordingly, I am not persuaded by the individual's psychiatrist's diagnosis of Mood Disorder, Not Otherwise Specified.

I base this finding in part on the two diagnoses that the individual received as the result of her hospitalizations during the period of time in question. The psychiatrist who examined the individual during her hospitalization in December 1990 took a history of the individual's then-recent behavior, which included (i) acting increasingly agitated and irritable, inappropriately, (ii) hitch-hiking and getting into trouble, (iii) difficulty sleeping, (iii) experiencing "significant downs recently with much crying and tearing," and (iv) excessive spending using her credit cards. DOE Exhibit 9. The examining psychiatrist stated that the individual "appeared to be hypomanic or manic and she was clearly in need of medication . . . ." He went on to observe that she "was irritable and agitated, focused on details, hyperactive, [and] showed some tangentiality of thinking. . . . She seemed to be depressed and angry." *Id*. He started her on Thorazine and Lithium. 5/ The examining psychiatrist's discharge diagnosis was Bipolar Disorder, Hypomanic.

As indicated by the individual's psychiatrist at the hearing, a Hypomanic episode is less severe than a Manic episode. However, according to the DOE psychiatrist, under the DSM III-R, the criteria for a Hypomanic episode specify that Criterion C has not been satisfied. 6/ Criterion C in the DSM III-R says "Mood disturbance sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others." The DOE psychiatrist concluded that the individual's mood disturbance satisfied this requirement, and therefore qualified as a Manic, and not a Hypomanic, episode. DOE psychiatrist's report at 5, fn 6. This conclusion is supported by the individual's decisions to quit her job and to drop out of college because of her illness, which are clear indications that her occupational functioning had become impaired. PSI at 58, DOE psychiatrist's report at 25. Indeed, the discharge diagnosis from the individual's January 21st to February 15th, 1991 hospitalization was Bipolar Affective Disorder, Manic. DOE Exhibit 10.

4/ (...continued)
occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism)

5/ According to the DOE psychiatrist, Lithium is "the treatment of choice for a manic episode and almost the only use of Lithium is to treat Bipolar Disorder." DOE psychiatrist's report at 8, fn.22.

6/ The DSM III-R was the diagnostic manual in use in 1991.

In his written evaluation, the individual's psychiatrist indicated that a diagnosis made using "a longitudinal history with accurate data," such as the one that he was able to make regarding the individual, was more likely to be accurate than a diagnosis based on "an observation at one moment in time," such as those made during the individual's hospitalizations. Individual's Exhibit A at 4. He relied largely on the individual's history of no severe emotional disturbances in the last 12 years, despite the occurrence of various stressful events during that time, in reaching his conclusion that the individual does not suffer from Bipolar Disorder. *Id.*, Tr. at 196.

However, at the hearing, the individual's psychiatrist indicated that, in at least some respects, he and the DOE psychiatrist were at a disadvantage because, unlike the doctors who examined her during her hospitalizations, they "did not [see the individual] when she was in the midst of her problem, whatever it was." Tr. at 203. Moreover, the DOE psychiatrist, who, like the individual's psychiatrist, had the benefit of 12 years' perspective on the individual's condition, concluded that the individual does, in fact, suffer from Bipolar Disorder. After interviewing the individual and her grandmother and examining the medical records from the period in question and the individual's security file, the DOE psychiatrist found that the individual's illness during the latter part of 1990 and the first part of 1991 met all of the criteria for a manic episode set forth in the DSM-IV. Tr. at 49-50. He also disagreed with the contention of the individual's psychiatrist that the individual's 12 years without further manic or depressive episodes made it unlikely that she suffers from Bipolar Disorder. While admitting that this is not the average course of the disorder, Tr. at 112, he testified that he has encountered "many people" who "have had 10, 15, 20 years between episodes." Tr. at 133. He further stated that "the average age of onset of Bipolar Disorder is between 30 and 33," Tr. at 132, and that "it is very possible that the [individual's] first episode at age 19 was just a pre-cursor of what is to come." DOE psychiatrist's report at 31, fn. 111. 7/ For the reasons set forth above, I agree with the DOE psychiatrist that the individual suffered a manic episode, and that she has Bipolar Disorder.

The individual's psychiatrist testified that, even if the individual has Bipolar Disorder, the chances of a recurrence of a manic or a depressive episode are so small as to represent a negligible threat to national security. Tr. at 206, 208. He estimated those chances to be "somewhere between 10 to 15 percent." Tr. at 206. He further indicated that, in the event of a recurrence, the onset of the episode would almost certainly be slow enough to allow the individual's friends and family sufficient time to seek help on her behalf before she could commit any breach of security. *Id.* For the reasons that follow, I do not find this testimony to be convincing.

Regarding the likelihood of a recurrence, the individual's psychiatrist did not cite any empirical data in reaching his conclusions. Instead, he based his estimate primarily on the individual's 12 year history of no manic or depressive episodes despite the occurrence of various stressful events during that period. Tr. at 211. However, he acknowledged that while "initial episodes have a higher likelihood of being provoked by external stressors," subsequent episodes may come on spontaneously. Individual's Exhibit A at 4. The DOE psychiatrist described the link between life

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7/ The individual is currently 32 years old.

stressors and the onset of manic episodes as "controversial,"while admitting that "there is evidence that stressors' "association [with manic episodes] may be more common in the first versus future episodes." DOE psychiatrist's report at 31.I therefore do not believe that the individual's ability to endure stressful events during the past 12 years without experiencing further manic or depressive episodes is compelling evidence that she will not experience such episodes in the future. Indeed, as the individual's psychiatrist notes, "in the DSM-IV description of Bipolar I Disorder, it is noted that more than 90 percent of individuals who have a single manic episode go on to have further episodes." Individual's psychiatrist's report at 4. The individual's psychiatrist contends that the 90 percent-plus relapse figure should be considered inapplicable to the individual because she has not experienced a manic or depressive episode within the last 12 years. However, in the absence of empirical evidence, I am not willing to conclude that this factor reduces the individual's chances or relapse from a near certainty to the 10 or 15 percent chance estimated by the individual's psychiatrist. Instead, I find the conclusion of the DOE psychiatrist to be more convincing, *i.e.*, that, based on his review of the relevant literature, the individual's chances of experiencing another manic episode at some time in her life is greater than 50 percent. Furthermore, the DOE psychiatrist stated that any future manic episodes by the individual would almost certainly be similar to the one that she suffered 12 years ago, during which her occupational functioning, judgement and reliability were all significantly impaired. I therefore find the risk of another manic episode on the part of the individual to be unacceptably high, and that during such an episode, the individual would be prone to acting in a way that is inconsistent with the best interests of national security.

Furthermore, I find problematic at best the individual's psychiatrist's assertion that the onset of any future episode would almost certainly be slow enough to allow the individual's friends and family time to seek help on her behalf before any breach of security caused by her illness could occur. The record indicates that the individual has informed her friends, family and co-workers of her condition. PSI at 77. However, with the passage of time, the number and the identities of the people with whom we interact on a daily basis changes. It is by no means certain that the individual would inform future associates of her illness, or that they would be willing or even able to readily discern changes in the individual's behavior and obtain help on her behalf before any security breach could occur. In this regard, I agree with the DOE psychiatrist that "a slow onset, an insidious onset, . . . probably creates more problems than a rapid onset. . . . [S]omebody who has an insidious onset might have subtle errors in judgement or reliability coming on slowly over days or weeks before it's actually realized." Tr. at 233. I am not willing to place the interests of national security on so uncertain a foundation.

IV. Conclusion

As I previously stated, it is incumbent upon the individual to produce evidence sufficient to convince the DOE that granting her access authorization would not endanger the common defense and security

and would be clearly consistent with the national interest. For the reasons set forth in this Decision, I conclude that she has not met this burden. Accordingly, I find that the individual should not be granted acess authorization.

Robert B. Palmer
Hearing Officer
Office of Hearings and Appeals

Date: November 25, 2003