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September 8, 2004

DEPARTMENT OF ENERGY  
OFFICE OF HEARINGS AND APPEALS

*Hearing Officer's Decision*

Name of Case: Personnel Security Hearing

Date of Filing: April 22, 2004

Case Number: TSO-0104

This Decision considers the eligibility of XXXXXXXXXXXX XXXXXXXXXXXX (hereinafter referred to as "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." As explained below, it is my decision that the individual's access authorization should not be restored.

I. BACKGROUND

The individual is an employee of a Department of Energy (DOE) contractor. In 1999 the individual's employer requested that he be granted a DOE access authorization. The individual's background investigation revealed areas of potential concern to the DOE, and personnel security interviews (PSIs) were conducted with the individual in August and December 1999. In March 2000, a DOE-consultant Psychiatrist conducted a psychiatric evaluation of the individual. In his March 2000 Report, the DOE-consultant Psychiatrist found that in December 1998, the individual was arrested for battery involving his wife and was hospitalized after displaying psychotic and delusional behavior. The March 2000 Report found that the individual suffered from "Major Depression, Single Episode, with Psychotic Features, in Full Remission." March 2000 Report at 7. In a March 2000 Addendum to this Report, the DOE-consultant Psychiatrist altered his diagnosis on the basis of reviewing the notes of the doctor who had treated the individual at a local clinic following his hospitalization (the Clinic Doctor). The DOE-consultant Psychiatrist received these notes from the DOE after he completed his Report. Based on the Clinic Doctor's report that the individual had experienced an "inappropriately euphoric"

mood in February 1999, the DOE-consultant Psychiatrist changed his diagnosis of the individual to "Bipolar Disorder, Most Recent Episode Manic, in Remission." He wrote in the Addendum that the Clinic Doctor's notes

heighten the importance of [the individual's] remaining on Neurontin as a condition of keeping his current good mental state and prognosis.

2000 Addendum at 1. The DOE-consultant Psychiatrist recommended that the individual be told of his need to remain on the Neurontin for the DOE to have adequate assurance of his continued good judgement and reliability. *Id.* at 2. In May 2000, the DOE informed the individual of the DOE-consultant Psychiatrist's recommendation, and the individual agreed to resume taking Neurontin and Prozac. See May 16, 2000 telephone memorandum of the DOE personnel security specialist who contacted the individual. DOE Exhibit 14. Shortly thereafter, the DOE granted the individual an access authorization based upon mitigation of these mental emotional issues. However, at a May 2003 PSI, the individual stated that he stopped seeing the Clinic Doctor and stopped taking his prescriptions of Prozac and Neurontin in the Fall of 2000, and has not received any treatment since. May 2003 PSI at 10-13 and 22. Based on these statements, the DOE directed that the DOE-consultant Psychiatrist reevaluate the individual, which occurred in August 2003.

In February 2004, the Manager for Personnel Security of the DOE area office where the individual is employed (the Manager) issued a Notification Letter to the individual. The Notification Letter states that the individual has raised a security concern under Sections 710.8(h) of the regulations governing eligibility for access to classified material. With respect to Criterion (h), the Notification Letter finds that the individual was evaluated by the DOE-consultant Psychiatrist in August 2003, and it is the DOE-consultant Psychiatrist's opinion that the individual suffers from "Bipolar Disorder, Most Recent Episode Manic, Severe with Psychotic Features, In Remission." The Notification letter states that the DOE-consultant Psychiatrist concluded in his evaluation that (1) the individual has an illness or mental condition that causes or may cause a significant defect in his judgement or reliability, and that (2) the individual showed unreliability and poor judgment when he ignored the medical advice of his treating psychiatrist and the DOE-consultant Psychiatrist, and stopped his psychiatric medications.

The Notification Letter also states that in March 2000, the DOE-consultant Psychiatrist informed the DOE that it is important that the individual remain on his Neurontin as a condition of keeping his good mental state and prognosis, and for the DOE to have adequate assurance of his continued good judgement and reliability. The Notification Letter indicates that at an April 2000 PSI, the individual was informed that both the Clinic Doctor and the DOE-consultant Psychiatrist felt that stopping his medication would cause a defect in reliability, and he would then become a security concern to the DOE.

The individual requested a hearing to respond to the concerns raised in the Notification Letter. In his response to the Notification Letter, the individual contested the diagnosis of "Bipolar Disorder" made by the Clinic Doctor and the DOE-consultant Psychiatrist. He also contended that he did not ignore medical advice when he discontinued taking Neurontin in 2000. Finally, he asserted that his continued good mental health in the more than three and one half years since he stopped taking this medication proves that it was unnecessary. The requested hearing in this matter was convened in July 2004 (hereinafter the "Hearing"), and the testimony focused chiefly on the concerns raised by the individual's psychiatric diagnosis by the DOE-consultant Psychiatrist and the individual's efforts to mitigate the concerns raised by his decision to stop taking Neurontin and Prozac in 2000.

## II. REGULATORY STANDARD

In order to frame my analysis, I believe that it will be useful to discuss briefly the respective requirements imposed by 10 C.F.R. Part 710 upon the individual and the Hearing Officer. As discussed below, Part 710 clearly places upon the individual the responsibility to bring forth persuasive evidence concerning his eligibility for access authorization, and requires the Hearing Officer to base all findings relevant to this eligibility upon a convincing level of evidence. 10 C.F.R. §§ 710.21(b)(6) and 710.27(b), (c) and (d).

### A. *The Individual's Burden of Proof*

It is important to bear in mind that a DOE administrative review proceeding under this Part is not a criminal matter, where the government would have the burden of proving the defendant guilty beyond a reasonable doubt. The standard in this proceeding places

the burden of proof on the individual. It is designed to protect national security interests. The 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). The individual must come forward at the hearing with evidence to convince 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. § 710.27(d). *Personnel Security Review (Case No. VSA-0087)*, 26 DOE ¶ 83,001 (1996); *Personnel Security Hearing (Case No. VSO-0061)*, 25 DOE ¶ 82,791 (1996), *aff'd*, *Personnel Security Review (VSA-0061)*, 25 DOE ¶ 83,015 (1996). The individual therefore is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The regulations at Part 710 are drafted so as to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. 10 C.F.R. § 710.26(h). Thus, by regulation and through our own case law, an individual is afforded the utmost latitude in the presentation of evidence which could mitigate security concerns.

Nevertheless, the evidentiary burden for the individual is not an easy one to sustain. The regulatory standard implies that there is a presumption against granting or restoring a security clearance. See *Department of Navy v. Egan*, 484 U.S. 518, 531 (1988) ("clearly consistent with the national interest" standard for the granting of security clearances indicates "that security determinations should err, if they must, on the side of denials"); *Dorfmont v. Brown*, 913 F.2d 1399, 1403 (9th Cir. 1990), *cert. denied*, 499 U.S. 905 (1991) (strong presumption against the issuance of a security clearance). Consequently, it is necessary and appropriate to place the burden of persuasion on the individual in cases involving national security issues. In addition to his own testimony, we generally expect the individual in these cases to bring forward witness testimony and/or other evidence which, taken together, is sufficient to persuade the Hearing Officer that restoring access authorization is clearly consistent with the national interest. *Personnel Security Hearing (Case No. VSO-0002)*, 24 DOE ¶ 82,752 (1995); *Personnel Security Hearing (Case No. VSO-0038)*, 25 DOE ¶ 82,769 (1995) (individual failed to meet his burden of coming forward with evidence to show that he was rehabilitated and reformed from alcohol dependence).

*B. Basis for the Hearing Officer's Decision*

In personnel security cases under Part 710, it is my role as the Hearing Officer to issue a decision as to whether granting an 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(a). Part 710 generally provides that "[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 must examine the evidence in light of these requirements, and assess the credibility and demeanor of the witnesses who gave testimony at the hearing.

*III. HEARING TESTIMONY*

At the Hearing, testimony was received from six persons. The DOE presented the testimony of a personnel security specialist and the DOE-consultant psychiatrist. The individual testified and presented the testimony of a psychologist who had evaluated him prior to the Hearing (the Individual's Psychologist), his workplace supervisor, the individual's wife, the individual's father-in-law and the individual's mother-in-law. 1/

*A. The Personnel Security Specialist*

The DOE personnel security specialist explained that the DOE's criterion (h) concerns were based on the individual's decision in 2000 to stop using the medication that he had been prescribed to treat his bipolar illness, and upon the DOE-consultant Psychiatrist's opinion that this decision showed poor judgment and created an unacceptable risk that he would experience a bipolar episode in the future. Hearing Transcript (TR) at 27-28.

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1/ As indicated by the resume and testimony of the DOE-consultant psychiatrist (TR at 29-30) and by the resume of the Individual's Psychologist, both of these medical professionals have extensive clinical experience in diagnosing and treating mental illnesses. They clearly qualified as expert witnesses in this area.

B. *The DOE-consultant Psychiatrist*

The DOE-consultant Psychiatrist testified that his diagnosis and concern about the individual's future mental stability were based on the "very serious disorder" that the individual suffered in 1998.

It included a particular concern, psychotic symptoms. Namely, it appeared that he was delusional; the delusions involved people in the workplace, which, of course, is a concern; the delusions led to acting-out behavior, pushed his wife down and was arrested for battery, which is of concern.

The adjudicative guidelines . . . place special concern on psychotic disorders as far as disorders that will affect a person's judgment and reliability. So any time a person has a past history of being delusional or having hallucinations, it's of particular concern for these types of evaluations.

TR at 31.

The DOE-consultant Psychiatrist testified that the individual did not meet the typical criteria for bipolar disorder because he did not display psychotic symptoms until the age of forty, which he believed improved the individual's prognosis.

Given the fact that he had a late onset disorder, I had hoped and was able to predict, . . . that as long as he kept on his medications, kept in a treatment alliance with a mental health practitioner, that the prognosis was acceptable.

TR at 32. The DOE-consultant Psychiatrist also acknowledged that he had initially diagnosed the individual as suffering from depression, but that he changed in diagnosis after seeing the notes and diagnosis of the Clinic Doctor.

So my diagnosis of single episode depression changed to bipolar disorder after I got good evidence from his currently treating psychiatrist that he'd had a manic episode and that the treating psychiatrist had diagnosed him indeed as bipolar.

TR at 36. He testified that he relied on the observations and diagnosis of the Clinic Doctor in spite of his subsequent legal problems regarding professional licensing and substance abuse because he did not believe that those problems affected the care that he gave to the individual. TR at 65.

He stated that the change in diagnosis strengthened his recommendation that the individual needed to stay on medications and needed to stay in a treatment partnership. TR at 38. He stated that there are different treatment options for an episode of psychosis, and that it was possible for an individual to stop taking medication for the psychosis if he remained in a treatment partnership.

If a person remains in a treatment partnership, the partnership -- the person and his doctor might decide -- might weigh the risks and benefits, for instance, and decide to stop the medicines after six months or a year, and wait and see, follow them for symptoms, set up guidelines, when would you call me, what would be evidence of an episode coming on.

TR at 39. In the individual's case, the DOE-consultant Psychiatrist concluded that since the Clinic Doctor recommended that the individual's medications be continued, that strengthened the DOE-consultant Psychiatrist's initial impression that the individual's judgment and reliability would be most assured if he continued his medicines. TR at 40.

At the Hearing, the DOE-consultant Psychiatrist stated that when he reevaluated the individual in 2003, he concluded that the individual's decision to unilaterally stop his medications elevated his risk of a future psychotic episode to an unacceptable level.

So when I saw him three years later, the fact that he didn't have any episodes was definitely a factor on his side in terms of his good prognosis. I felt that was outweighed, however, by the poor judgment and lack of insight that he showed in just stopping his medications precipitously and on his own.

TR at 46. When asked what treatment the individual could undertake to mitigate the risk of a future psychotic episode, the DOE-consultant Psychiatrist said that a conservative course of treatment would be for the individual to take an FDA approved drug for bipolar disorder such as Zyprexa. TR at 50. However, he

indicated that it would be possible for the individual to mitigate the risk of future episodes without medication by setting up an ongoing treatment plan.

. . . I think another acceptable treatment plan would be just regular visits with a psychiatrist or psychologist, forming a good treatment alliance, a good plan for what would be the warning signs of an episode, and then not necessarily even prescribe at first any medications. That wouldn't be my approved plan, but I think it would be a possible, not stupid plan. Almost as important as the medicine is the ongoing treatment alliance.

TR at 61.

After hearing the testimony of the individual and his wife concerning their meeting with the Clinic Doctor, the DOE-consultant Psychiatrist revised his finding that the individual had been noncompliant and had acted unilaterally in stopping his medication.

In hearing the testimony today, [the individual] maybe was going along with the recommendations of the system, but the recommendations were a little minimal and not well expressed.

TR at 194. He stated that the individual's history of no psychotic episodes until age 40 and none since doesn't fit the standard diagnosis for bipolar disorder. TR at 191. He noted that in the time since his 2003 reevaluation of the individual, he has gone another year without a psychotic episode, which makes a diagnosis of classic bipolar disorder less likely.

I don't remember the exact numbers, but with classic bipolar disorder, very high risk per year of having an episode -- I'm guessing 25, 50 percent. So the fact that he's gone another year, and there has been no episodes, makes certainly the diagnosis of a classical bipolar disorder less and less likely.

There was something unusual that happened in 1998 that didn't happen before and didn't happen after.

TR at 196. The DOE-consultant Psychiatrist then stated that he still would recommend psychotherapy for the individual because it would improve his prognosis by helping him to find better ways of coping with anger, to accept and understand the 1998 episode and

the issues underlying his aversion to medication. TR at 193. He indicated that faith-based counseling would be an acceptable alternative to psychotherapy if the individual felt more comfortable with it. TR at 195-196. 2/

C. *The Individual's Psychologist*

The Individual's Psychologist testified that he conducted a comprehensive psychological evaluation of the individual on three different dates in June 2004. He stated that he gave the individual a battery of psychological tests, as well as structured and unstructured interviews. He noted that the DOE-consultant Psychiatrist had administered the MMPI test to the individual in 2000 and 2003, and that he had administered the MMPI to the individual in 2004, and that on all of the tests the individual's clinical scales were within the normal limit. He concluded that it would be highly improbable for the individual to be actually suffering from serious psychopathology that would not be evident on any of three psychometric evaluations given four years apart. TR at 78. He said that research data indicate that if people have repeated MMPIs and continue to be normal, the chance for an eventual psychotic break is reduced significantly. TR at 79. The Individual's Psychologist also described the individual's test results on the Thematic Apperception Test, the Sentence Completion Test, and the Rorschach test. He concluded that the individual's current psychological condition appeared to be normal and that under these circumstances, regular monitoring rather than a regimen of medication would be sufficient to prevent future psychotic episodes.

All of the data indicate that he's not suffering from any form of affective disorder. Aside from the occurrence of a single severe episode in his history, there is no data to support the conclusion that he currently has an affective disorder. While it's certainly true that many persons who have once had serious depressive episodes

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2/ The DOE-consultant Psychiatrist also testified that he would strongly recommend that the individual get a "sleep-deprived EEG" test to detect any temporal lobe abnormalities. He stated that the individual's wife's testimony that the individual had been sleep deprived when he had the psychotic episode in 1998 strongly indicated that the cause may have been a temporal lobe seizure. TR at 190. The Individual's Psychologist also endorsed this test. TR at 112.

continue to suffer from a latent or underlying depressive condition, it's also the case that many do not. The best guide is a comprehensive evaluation of the patient's condition. If there is not objective evidence of an ongoing disorder, regular monitoring, rather than a lifelong regimen of medicine, is also a viable alternative.

TR at 82-83.

The individual's psychologist stated that he believes that the individual had a manic depressant disorder in 1998 that was "like a bipolar disorder, it was psychotic, but it doesn't fit the label." TR at 86. He emphasized that the current data concerning the individual indicated "no residue of a serious disorder." Under those circumstances, he believed that periodic monitoring of the individual's mental condition would be sufficient to reduce the risk of a relapse. He recommended regular psychological reviews, which may or may not include psychological testing, and also a review of the individual's work record to show whether or not he's exhibiting any symptoms of unreliable behavior. TR at 92.

If it's there, it will show up in the behavior, and we can follow that, and it could be contingent that it's followed up in testing the employee's behavior, and if his behavior at work or anywhere else shows up difficulties, then he has no choice but then to do the medication.

TR at 92-93. He stated that he thought a sufficient monitoring program would involve reviews on a quarterly basis

that would include some psychological testing to see how he was doing with authority, and with someone who has the authority to alert him and other people that if he needed more, if he needed medication, or if he needed to not be in a secure situation.

TR at 100. However, the individual's psychologist indicated agreement with the DOE-consultant Psychiatrist's recommendation that the individual get psychological counseling. The individual's psychologist stated that counseling could serve as a monitoring program.

So I would recommend three to six months of counseling, to begin with on a weekly basis, unless the therapist

feels more is necessary, followed by quarterly visits, and . . . whoever is treating him should have access to be able to report whether or not there are any symptoms that are troublesome, or whether or not that therapist feels that it's time to begin experimenting with a regimen of medication.

TR at 112.

D. *The Individual*

In his response to the Notification Letter and in his testimony at the Hearing, the individual challenged the DOE-consultant Psychiatrist's reliance on the Clinic Doctor's notes concerning his alleged inappropriately euphoric behavior at a February 1999 meeting, and on the Clinic Doctor's subsequent diagnosis of the individual as suffering from Bipolar Disorder. He contended that he was in a good mood that day because he had found a new job the week before the interview and because he had been on Prozac and Neurontin for two months. Response to Notification Letter at 2. At the Hearing, he questioned whether the observations of the Clinic Doctor and his diagnosis should be relied upon by the DOE-consultant Psychiatrist because the Clinic Doctor had had his license removed because it was discovered that he had a substance abuse problem. TR at 64.

The individual testified that he had been more compliant in seeking treatment and following medical advice than was indicated by the DOE-consultant Psychiatrist's 2003 report and the Notification Letter. He stated that in his final meeting with the Clinic Doctor, at which his wife also was present, the Clinic Doctor recommended that he continue his medication but indicated that he did not have to do so.

We were in the meeting, we talked to the [Clinic Doctor], his recommendation was to take the medicine, but he said that . . . if you continue your medicine, come see me in six months, and if you don't continue your medicine, you don't need to come back and see me. That's what he said.

TR at 85. He said that the Clinic Doctor never indicated to him that if he took the medication, he would not have an episode, but if he stopped taking it, he would.

[The Clinic Doctor] said he didn't know . . . what happened in 1998, or if it would ever happen again. He

said it could happen in five years, it could happen in ten years. It could never happen.

TR at 183. The individual testified that the medicines prescribed by the Clinic Doctor made him feel attenuated and reduced his ability to think clearly. TR at 48, 180. Nevertheless, he continued to take the Neurontin for over a year before stopping. After that time, the individual told the Clinic Doctor that he wanted to stop taking the Neurontin and the Clinic Doctor advised him to taper off the drug. TR at 183. He said that he was aware of the DOE-consultant Psychiatrist's recommendation in 2000 that he continue taking the Neurontin but that he disagreed with it because "I had this internal feeling that it was something I needed to avoid." TR at 185. He also testified that he has been off this medication for over three and one half years and has not experienced "a single psychiatric episode" in that time. TR at 10.

He stated that he believed that he would recognize a recurrence of the symptoms that he had in 1998, and pointed out that he was in the process of getting medical help for his symptoms when the incident that led to his arrest took place. TR at 186.

With regard to the expressed opinions of the DOE-consultant Psychiatrist and the Individual's Psychologist that there was a continued need for psychotherapy or psychological monitoring, the individual stated that "I haven't ruled it out. I would definitely consider that, if that is exactly your conclusion." TR at 187.

#### *E. The Individual's Wife*

The individual's wife testified that since the individual had discontinued his medications, he had exhibited no alarming behavior. TR at 144. She said that she was impressed by the stress and anger management techniques that he had learned at the clinic following the 1998 psychotic episode. She stated that she was confident that she would recognize the symptoms of any future episode, and the individual would listen to her or to her parents or his boss and get the assistance he needed. TR at 145.

She testified that prior to the 1998 episode, she had realized that the individual was acting strangely, and that at her urging he had seen his family doctor for a physical and visited a psychiatrist. However, the episode took place before he could take the prescribed medication. TR at 146, 148.

She stated that the individual's hospital admission in 1998 was voluntary in that the individual readily agreed to enter a hospital as a condition for his release from jail. TR at 166-168.

With regard to the medication prescribed by the Clinic Doctor, she stated that it made him behave like a "zombie", that he'd didn't smile or seem happy. TR at 155. She said that she and the individual discussed his getting off the medication right after their last meeting with the Clinic Doctor. She said that the Clinic Doctor told them he was not sure what happened to the individual in 1998 and if he'd ever have an episode again. She said he recommended staying on the medicine but suggested other options.

He recommended staying on the medicine, but if you don't, then, you don't need to see me anymore, and if you do, come back in six months. Then he talked about the support system of listening . . . to your wife, if she points out that something is going on, that kind of thing.

TR at 148. She stated that she did not believe the individual needed psychotherapy because he was now able to cope with stress.

He's had the management tools, the anger management tools, the stress classes, and he knows that you can feel a little bit upset every once in awhile and it's not that you're a bad person.

TR at 159.

*F. The Individual's Workplace Supervisor*

The Individual's Workplace Supervisor testified that he has worked with the individual for a little more than five years and has been his immediate supervisor for about three years. He stated that the individual is an exceptionally good employee who functions well as part of a project team. TR at 121. He stated that he has socialized with the individual at some parties over these years and that they have gone biking together a few times. He testified that he has never noticed any unusual behavior by the individual in any of these settings. TR at 122. He described the individual's work as occasionally involving servicing multiple clients and deadlines, and that he performs quite well under stressful conditions. TR at 128-129.

*G. The Individual's Father-in-Law*

The Individual's father-in-law stated that he and his wife moved near the individual before the individual's 1998 episode. He said that he and his wife see the individual and his family about four times a week. He said that he noticed nothing unusual before the individual's 1998 episode and has observed nothing unusual since. He said that he had "nothing but good to say about [the individual]". He said that if he warned the individual that his behavior was unusual, he's pretty sure that the individual would pay attention to the warning. TR at 133-139.

*H. The Individual's Mother-in-Law*

The Individual's mother-in-law testified that she had a close relationship with her daughter and that within the last five years she had not observed or been told of any abnormal behavior by the individual toward his wife and children. She described the individual as "the best son-in-law I could ask for." TR at 140-141.

*IV. THE INDIVIDUAL'S POST-HEARING ACTIVITY*

At the Hearing, both the DOE-consultant Psychiatrist and the Individual's Psychologist advised the individual to get a sleep-deprived EEG as a means of determining whether he suffered from a frontal-lobe abnormality. In a facsimile letter dated July 15, 2004, the individual stated that his medical doctor had scheduled a sleep-deprived EEG for July 17, 2004. Along with a facsimile letter dated July 29, 2004, the individual attached a note from a physician stating "your EEG was normal." In that letter, the individual stated that

I would like to make it clear that I do not want to participate in any monitoring program if it involves the use of my personal monetary funds. If the DOE feels it is necessary and wants to sponsor such a program I will be open to it.

July 29, 2004 facsimile letter from the individual to the Hearing Officer. The individual then stated his belief that he has "demonstrated that there are no acute mental illness problems with myself." *Id.*

## V. ANALYSIS

The individual presented four arguments for the purpose of mitigating the security concern. The first is an assertion that the DOE-consultant Psychiatrist did not have a sufficient basis for his diagnosis of "Bipolar Disorder, Most Recent Episode Manic, Severe with Psychotic Features, In Remission" and that the diagnosis is therefore erroneous. The second contention is that the individual acted in accordance with the guidance of the Clinic Doctor when he stopped taking his medications in 2000, so that his action in stopping his medication does not constitute a security concern to the DOE. The third contention is that his current refusal to take medication or to seek counseling does not pose a security concern because he has had no symptoms of manic or psychotic behavior since the 1998 episode, and recent psychiatric tests show his psychological behavior to be entirely normal. Finally, he contends that he has stress management skills and a family support system that are sufficient to cope with any future episode of unusual behavior. For the reasons stated below, I conclude that these arguments do not resolve the security concern.

### A. *Alleged Errors in the DOE-consultant Psychiatrist's Diagnosis of Bipolar Disorder*

In his Response to the Notification Letter and in his Hearing testimony, the individual argues that the DOE-consultant Psychiatrist did not have a sufficient basis for arriving at his diagnosis of bipolar disorder. The individual does not dispute that he suffered a severe psychotic episode in December 1998 when he was arrested for battery of his wife and hospitalized after displaying psychotic and delusional behavior. Rather, he questions whether the Clinic Doctor properly diagnosed him with Bipolar Disorder due to an "inappropriately euphoric" mood during a February 1999 interview and whether the DOE-consultant Psychiatrist should have changed his diagnosis to Bipolar Disorder based on the Clinic Doctor's diagnosis and notes. The individual contends that he was not inappropriately euphoric or manic during this interview, but displayed upbeat behavior because he recently had found a new job. His wife also testified that she had never seen the individual euphoric.

At the Hearing, both the DOE-consultant Psychiatrist and the Individual's Psychologist acknowledged that the individual's single episode of psychotic behavior posed problems for diagnosis and treatment. The DOE-consultant Psychiatrist acknowledged that the individual did not meet the typical criteria for bipolar disorder

because he apparently did not display psychotic symptoms until the age of forty. He also acknowledged that he changed his initial diagnosis of depression based on the Clinic Doctor's revised diagnosis and interview notes. He believed that these notes did indicate a manic or hypomanic episode, and supported the bipolar diagnosis. He stressed that whether the diagnosis was depression or bipolar disorder, the main concern for the DOE was the individual's psychotic symptoms. The individual's psychologist indicated that the individual had a manic depressant disorder in 1998 that "was like a bipolar disorder, it was psychotic, but it doesn't fit the label." TR at 86. 3/

Under these circumstances, I find that the individual has not shown that the Clinic Doctor's observations and diagnosis were erroneous, and that they should not have been relied upon by the DOE-consultant Psychiatrist. The DOE-consultant Psychiatrist considered all of the relevant information and made a proper diagnosis based on his clinical judgment. In previous cases, the DOE has accepted a diagnosis based on a psychiatric evaluation, diagnostic impressions and other tests notwithstanding the fact that the individual did not meet the usual or specific DSM-IV criteria for a particular diagnosis. See *Personnel Security Review, Case No. VSA-0298*, 28 DOE ¶ 83,001 (2000). Nor did the Individual's Psychologist opine that the diagnosis of bipolar disorder was unreasonable or erroneous. Accordingly, I find that the DOE properly invoked Criterion (h) in suspending the individual's access authorization.

*B. The Individual's Decision to Stop His Medication*

The individual and his wife testified that the individual acted in accordance with the guidance of the Clinic Doctor when he stopped taking his medications in 2000. They contend that although the Clinic Doctor recommended that the individual continue taking his medication, he did not indicate strong objections to the individual stopping the medication, and presented it as one option that the individual could choose. They also state that the Clinic Doctor provided guidance on "tapering off" the medication if the individual chose that option. After hearing this testimony, the

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3/ Both of these doctors were open to the idea that the individual's 1998 behavior may have been the result of temporal lobe epileptic seizure. However, the normal results of the individual's sleep-deprived EEG provide no support for this theory.

DOE-consultant Psychiatrist revised his opinion that the individual was noncompliant and acted unilaterally when he stopped his medication, and concluded that the individual was probably going along with recommendations of the Clinic Doctor when he decided to stop his medications. TR at 194. The DOE-consultant Psychiatrist also revised the recommendation in his 2003 evaluation that the individual must remain on medication in order to mitigate the risk of future episodes. He indicated that counseling may be sufficient to mitigate future risks.

In light of this testimony, I find that the individual has resolved the security concern that he acted unreliably and with poor judgment when he stopped taking the Prozac and Neurontin prescribed by the Clinic Doctor.

### *C. The Risk of Future Episodes*

The individual contends that the possibility that he will have a future violent and/or psychotic episode is so remote that it does not pose a security risk to the DOE. The evidence presented at the hearing indicates that he has had no symptoms of manic or psychotic behavior since the 1998 episode, and that recent psychiatric tests show his psychological behavior to be entirely normal. He also testified that his clinic visits in 1999 provided him with stress management skills. He and his family members testified that their interactions constitute a family support system that is sufficient to identify and to cope with any future episode of unusual behavior before it becomes extreme or dangerous. Under these circumstances, he does not believe that any other measures, such as medication or counseling are necessary to reduce or eliminate the risk of future episodes.

I do not agree. Both the DOE-consultant Psychiatrist and the Individual's Psychologist testified that there is a significant risk of recurrent episodes of manic or psychotic behavior associated with bipolar disorder. The Individual's Psychologist stated that for persons like the individual, who test normally on MMPIs over a four year period, the chance of an eventual psychotic break is reduced significantly. However, he did not rule out a future episode. The DOE-consultant Psychiatrist also stated that the fact that the individual had had no episodes in five years reduced the annual risk of a recurrent episode well below the 25% or 50% rate of individuals with classic bipolar disorder.

While a reduced risk of recurrence is a positive finding, it does not fully mitigate the DOE's security concern. The possibility of

a single future episode similar to the one that the individual experienced in 1998, during which his functioning, judgment and reliability were all significantly impaired, poses a security risk to the DOE. I do not accept the individual's assertion that any future episode could be detected by his family in time to seek help before a security concern would arise. Moreover, both the DOE-consultant Psychiatrist and the Individual's Psychologist recommend that the individual be professionally monitored as a means of mitigating the risk that a future psychotic episode will develop. In his testimony, the DOE-consultant Psychiatrist indicated that ongoing psychological or pastoral counseling would establish the necessary ongoing treatment alliance. The individual currently has no therapeutic relationship for his Bipolar disorder that would serve these functions. I conclude that under the circumstances present in this case, the individual has not demonstrated that the probability of his suffering a relapse and the consequences of such a relapse do not pose a significant security risk to the DOE. 4/

#### VI. CONCLUSION

For the reasons set forth above, I find that the DOE properly invoked Criterion (h) in suspending the individual's access authorization. After considering all the relevant information, favorable or unfavorable, in a comprehensive and common-sense manner, I find that the evidence and arguments advanced by the individual do not convince me that he has sufficiently mitigated the security concerns accompanying that criterion. In view of Criterion (h) and the record before me, I cannot find that restoring the individual's access authorization would not endanger the common defense and would be clearly consistent with the national interest. It therefore is my conclusion that the

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4/ See *Personnel Security Hearing (Case No. TSO-0031)*, 28 DOE ¶ 82,950 (2003) (possibility of relapse was too great for individual with Bipolar Affective Disorder to retain her access authorization); *Personnel Security Hearing (Case No. VSO-0358)*, 28 DOE ¶ 82,755 (2000) (possibility of relapse was too great for individual with Bipolar I Disorder to retain his access authorization); and *Personnel Security Hearing (Case No. VSO-0150)*, 26 DOE ¶ 82,789 (1997) *aff'd Personnel Security Review, Case No. VSA-0150*, 27 DOE ¶ 83,002 (1997) (*aff'd OSA 1998*) (possibility of relapse was too great to allow an individual with Bipolar I Disorder to retain his access authorization).

individual's access authorization should not be restored. The individual may seek review of this Decision by an Appeal Panel under the regulation set forth at 10 C.F.R. § 710.28.

Kent S. Woods  
Hearing Officer  
Office of Hearings and Appeals

Date: September 8, 2004