*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 XXXXXX's.

United States Department of Energy
Office of Hearings and Appeals

In the Matter of: Personnel Security Hearing	)	
	)	
Filing Date: April 11, 2023	)	Case No.: PSH-23-0073
	)	
	)	

Issued: July 17, 2023

Administrative Judge Decision

Katie Quintana, Administrative Judge:

This Decision concerns the eligibility of XXXXXXXXXXXXXXX (hereinafter referred to as "the Individual") to hold an access authorization under the United States Department of Energy's (DOE) regulations, as set forth at 10 C.F.R. Part 710, "Procedures for Determining Eligibility for Access to Classified Matter and Special Nuclear Material."[1] As discussed below, after carefully considering the record before me in light of the relevant regulations and the *National Security Adjudicative Guidelines for Determining Eligibility for Access to Classified Information or Eligibility to Hold a Sensitive Position* (June 8, 2017) (Adjudicative Guidelines), I conclude that the Individual should not be granted access authorization.

I. Background

The Individual is an applicant for employment with a DOE contractor for a position that would require him to hold a security clearance. In April 2022, as part of the security clearance application process, the Individual completed a Questionnaire for National Security Positions (QNSP). Exhibit (Ex.) 3. In the QNSP, the Individual stated that, in approximately 2013, he had been diagnosed with Bipolar Mood Disorder.[2] *Id.* at 41–42. Subsequently, the Individual underwent an evaluation

[1] The regulations define access authorization as "an administrative determination that an individual is eligible for access to classified matter or is eligible for access to, or control over, special nuclear material." 10 C.F.R. § 710.5(a). This Decision will refer to such authorization as access authorization or security clearance.

[2] The record indicates that the terms Bipolar Disorder and Bipolar Mood Disorder are used interchangeably. For consistency and clarity, this Decision will reference Bipolar Disorder (BPD).

with a DOE consultant-psychologist (DOE Psychologist). Ex. 7. Based on the evaluation, the DOE Psychologist diagnosed the Individual with unspecified Bipolar Disorder.[3] Ex. 7 at 7.

Due to security concerns related to the Individual's psychological condition, the Local Security Office (LSO) informed the Individual, in a Notification Letter, that it possessed reliable information that created substantial doubt regarding his eligibility to hold a security clearance. Ex. 1 at 1. In the Summary of Security Concerns (SSC) that accompanied the Notification Letter, the LSO explained that the derogatory information raised security concerns under Guideline I (Psychological Conditions) of the Adjudicative Guidelines. Ex. 2 at 1.

Upon receipt of the Notification Letter, the Individual exercised his right under the Part 710 regulations to request an administrative review hearing. The Director of the Office of Hearings and Appeals (OHA) appointed me the Administrative Judge in the case, and I subsequently conducted an administrative hearing in the matter. At the hearing, the DOE Counsel submitted nine numbered exhibits (Exs. 1–9) into the record. The Individual introduced five lettered exhibits (Exs. A–E) into the record and presented the testimony of two witnesses, including his own. The hearing transcript in the case will be cited as "Tr." followed by the relevant page number.

II. Regulatory Standard

A DOE administrative review proceeding under Part 710 requires me, as the Administrative Judge, to issue a Decision that reflects my comprehensive, common-sense judgment, made after consideration of all the relevant evidence, favorable and unfavorable, as to whether the granting or continuation of a person's access authorization will not endanger the common defense and security and is clearly consistent with the national interest. 10 C.F.R. § 710.7(a). 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 granting 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) (strong presumption against the issuance of a security clearance).

The individual must come forward at the hearing with evidence to convince the DOE that granting or restoring access authorization "will not endanger the common defense and security and will be clearly consistent with the national interest." 10 C.F.R. § 710.27(d). The individual is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The Part 710 regulations are drafted 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). Hence, an individual is afforded the utmost latitude in the presentation of evidence to mitigate the security concerns at issue.

[3] It should be noted that the DOE Psychologist does not reference the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) in his report of the evaluation. *See* Ex. 7. He does, however, reference it in his testimony. Tr. at 97.

III. Notification Letter and Associated Security Concerns

As previously mentioned, the Notification Letter included the SSC, which sets forth the derogatory information that raised concerns about the Individual's eligibility for access authorization. The SSC specifically cites Guideline I of the Adjudicative Guidelines. Ex. 2. Guideline I indicates that "certain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness." Adjudicative Guidelines at ¶ 27.

Regarding Guideline I, the LSO relied upon the DOE Psychologist's August 2022 determination that the Individual met the criteria for unspecified Bipolar Disorder (BPD). Ex. 2 at 1. The LSO cited the DOE Psychologist's conclusion that the condition has no cure and carries "a high risk of recurrence," which was greater for the Individual as he was "not taking a mood stabilizing medication." *Id*. The LSO additionally cited the Individual's self-disclosure that he had been previously diagnosed with BPD as well as his belief that he had been misdiagnosed and had forgone his medication for the practice of yoga. *Id*. at 2. The LSO also noted that the Individual had not been compliant with his medication and was not undergoing any treatment or taking any medication for his condition. *Id*. at 2–3.

IV. Findings of Fact

After reviewing the Individual's responses on the QNSP, in July 2022, the Individual was asked to complete a Letter of Interrogatory (LOI). Ex. 4. In his response to the LOI, the Individual indicated that, after his diagnosis, he began individual counseling and medication. Ex. 5 at 105.[4] He additionally stated that he did not currently have a treatment plan for BPD and was not taking any medication for the BPD. *Id*. at 106.

The Individual also provided his medical records in his response to the LOI. Ex. 6. These records provide a detailed record of the Individual's medical history from December 2014 to May 2015. *Id.* The records show that, in December 2014, the Individual sought a second opinion from a health clinic regarding the diagnosis for his Bipolar condition.[5] *Id*. at 101. The medical provider's (Provider)[6] notes indicate that the Individual was concerned that he had not been properly diagnosed and had stopped taking his medication as he did not like how it made him feel. *Id.* The Provider's notes additionally state that she diagnosed the Individual with BPD, prescribed a new medication, and recommended therapy. *Id.* at 103. Over the treatment period, according to the

[4] The citations to DOE exhibits in this decision are to the red numbers at the bottom right corner of the page, where applicable.

[5] The medical record indicate that the original diagnosis was for Bipolar I; however, the record contains no information regarding the specifics of that diagnosis. As such, this decision will refer to it as a Bipolar condition. *See* Ex. 6 at 101.

[6] Although the medical records show that this provider was a medical doctor, they are unclear as to whether she specialized in psychiatry. *See* Ex. 6.

notes, the Individual was prescribed a number of medications until he and the Provider found a medication that the Individual said made "his mood and anxiety . . . very stable."[7] *Id.* at 38; *see* Ex. 6.

The Individual also provided records from his former therapist. Ex. 6. These records show that the Individual attended at least nineteen therapy sessions from December 2014 to May 2015, failing to attend only one scheduled session. *Id.* In at least one session, the therapist noted that he was concerned that the Individual was displaying symptoms of mania due to impulsive spending, lack of focus, and flight of ideas.[8] *Id.* at 59.

In August 2022, the Individual underwent an evaluation by the DOE Psychologist. Ex. 7. After evaluating the Individual, the DOE Psychologist issued a report (Report), detailing his findings. *Id.* The Report indicates that the DOE Psychologist reviewed the Individual's medical records from the Provider, which noted that the Individual had been diagnosed with Bipolar I in approximately 2013. *Id*. at 3. The DOE Psychologist cited a note in the medical records where the Provider wrote that the Individual "indicat[ed] that he has a long history of bipolar disorder, but [he] has not been compliant with medications." *Id*. According to the Report, the Individual told the DOE Psychologist that "his belief [is] that he may never have had bipolar disorder, but that bipolar disorder was a diagnosis given after medical providers learned that his mother suffered from bipolar disorder." *Id*. at 5. The Individual also told the DOE Psychologist that he stopped taking his BPD medication "when he found that yoga was effective in calming his mood." *Id*.

Based on his evaluation, the Individual's personnel security file, and the medical notes from past providers, the DOE Psychologist diagnosed the Individual with ADHD and unspecified BPD, in the Report. *Id.* 6. He explained that these conditions can impair the Individual's judgment, reliability, and stability. *Id*. at 7. The DOE Psychologist noted that there is no cure for BPD, and "[i]t is considered a lifelong illness." *Id*. He added that "[t]reatment with medication and active monitoring is the best strategy for managing symptoms, but even with good intervention, symptoms can return." *Id*. The DOE Psychologist opined, "[i]n my professional opinion, there is a high risk of recurrence of symptoms . . . at some point in the future and that risk is greater because he is not taking a mood stabilizing medication." *Id*. at 8.

The Individual provided documentation in connection with the present proceeding showing that he was currently being treated for ADHD. Ex. A. He also presented written documentation of a psychological evaluation that he underwent by a personal psychologist (Personal Psychologist) in

[7] The Provider also noted in her records that the Individual endorsed cyclical moods, spending sprees, rapid speech, and sleeping issues. Ex. 6 at 101. The notes also state that the Individual informed the Provider he had intermittently been cutting himself since approximately 2012, including on one occasion during the period the Provider was treating him. *Id.* at 73, 101.

[8] The day following this concerning behavior, the Individual visited another healthcare professional in the practice his doctor and therapist worked at, who noted that, at the time of the appointment, the Individual displayed no signs of mania. *Id.* at 55.

April of 2023. Ex. C. The Personal Psychologist stated that the records he reviewed in completing his evaluation did "not conclusively indicate bipolar disorder." *Id.* at 1. However, the Personal Psychologist did not specifically address any of the symptoms that led to the Individual's original diagnosis. *See* Ex. C. The Personal Psychologist noted that the Individual had not been on medication for BPD since approximately 2015 or 2016, and there was no record of "subsequent mania/hypomania or other severe outcomes." *Id.* Further, he explained that stimulants, like the type used by the Individual to treat ADHD, can sometimes trigger mania/hypomania, but he noted that the Individual's use of "stimulant medication . . . did not apparently lead to any such episodes." *Id.* The Personal Psychologist also stated that "[u]nless a history of mania or hypomanic episode can be conclusively established, bipolar disorder should not be reintroduced to the [Individual's] active diagnoses." *Id.* at 2. Ultimately, he concluded that the Individual's treatment for ADHD should be continued with periodic monitoring for mania/hypermania symptoms "to ensure the accuracy of the decision to remove the bipolar unspecified diagnosis." *Id.*

V. Hearing Testimony

At the hearing, the Individual's wife (Wife) testified on the Individual's behalf. Tr. at 13. The Wife testified that she had been married to the Individual for a little over ten years. *Id.* at 14. She explained that her husband had been diagnosed with BPD around 2013 or 2014, when she noticed that the Individual seemed "kind of off," and they had been "fighting more." *Id.* at 16–17. The Wife recalled that she told the Individual: "[Y]ou need to go seek some kind of therapy. You need to go figure out what's going on with you because something just doesn't seem to be okay with you." *Id*. at 16. She elaborated, stating that, for a period of around eight months, the Individual left their family and acted like a "completely different person." *Id.* at 30–31. The Wife testified that the Individual did seek out therapy and the help of a psychiatrist, which led to the BPD diagnosis. *Id.* at 17. She noted that when the Individual "acted out," she classified his behavior as him being "manic" as "it fit the narrative of, oh, he's bipolar." *Id.* at 36–37.

The Wife estimated that, around 2015, the Individual was prescribed medication to treat the BPD, but he stopped taking it because he did not feel it was helping, and it made him gain weight. *Id.* at 23. She further testified that, when the Individual was taking medication for BPD, it was "like [he] was a machine," but she noted that she feels that the Individual's ADHD medication helps him to be less "sporadic" and "flamboyant." *Id.* at 27–28. The Wife opined that, in comparing the Individual's past behaviors to the present time, the Individual was "more stable, cognitively, . . . more here with [the] family." *Id.* at 24–25.

The Individual testified on his own behalf. *Id.* at 38. He stated that he was first diagnosed with BPD, around 2013, when he went to a medical clinic and told the healthcare professional that his

mother had BPD. *Id.* at 44–45.[9] That healthcare professional prescribed the Individual medication for the condition, but the Individual testified that he felt that the medication "didn't do anything" and made him feel "off." *Id.* at 44. He testified that, after a month of being on the medication, the Wife told him that he "was acting weird" on the medication, "and so she dumped it down the drain." *Id.* at 46, 73. The Individual explained that, within a year of having started the medication, he began coping with childhood trauma and managing family conflict. *Id*. at 46– 47. The Individual testified that he began "acting . . . in a way that everybody thought was manic," which led him to seek out a second healthcare clinic where he saw the Provider. *Id.* at 47. The Individual also recalled that he wanted a second opinion regarding the BPD diagnosis. *Id*. at 53.

At the second clinic, he was specifically diagnosed with "bipolar unspecified," and he started cognitive behavioral therapy in addition to being prescribed medications. *Id.* at 48, 75. He noted that the medications did not help him and would cause side effects that, then, resulted in him taking another medication to treat the unwanted side effects. *Id*. at 66–67. The Individual testified that he eventually "lost [his] health insurance" and "just stopped all the medication." *Id*. at 68. He stated that despite the medical records stating that one of the medications stabilized his mood, he "recall[ed] none of the medications working." *Id.* at 76.

The Individual testified that he disagreed with some of the Provider's conclusions, such as her determination that he suffered from "cyclical mood cycles," and he opined that his symptomology was more reflective of post-traumatic stress disorder (PTSD) and ADHD than BPD. *See id.* at 47, 54, 56, 59–60. As such, he went to his general practitioner, around 2016, who told the Individual "let's just try ADHD meds," and according to the Individual, "it worked." *Id*. at 69, 82. The Individual claimed that this general practitioner told him that, if the ADHD medication was effective, then the BPD was a "misdiagnosis."[10] *Id*. at 82–84. The Individual explained that he also uses yoga and meditation to allow himself to assess his moods and cope with anxiety. *Id.* at 90–91.

The DOE Psychologist was the final witness to testify. He noted that the Individual's medical records conclusively showed that two mental health providers diagnosed the Individual with BPD in a period of approximately one year. *Id.* at 105. He also explained that, pursuant to "the DSM", there are seven symptoms of BPD, three of which must be present to meet the criteria for a diagnosis. *Id*. at 97–98. The DOE Psychologist noted that the Provider clearly documented that

[9] The medical records indicate that the Individual was specifically diagnosed with Bipolar I. Ex. 6 at 101. However, it should be noted that there are no medical records available from the first clinic. Information about the initial diagnosis is contained in the medical records from a second clinic he visited for a second opinion. *See id.*

[10] The Individual's testimony was slightly convoluted in that he then said he never saw this general practitioner, but he was seeing one of his physician's assistants or nurse practitioner and any reference he made to this general practitioner was actually a reference to the physician's assistant or nurse practitioner. Tr. at 84–85. According to the letter from his general practitioner's office, the nurse practitioner opined that "it is possible that the patient was misdiagnosed." Ex. A.

the Individual had complained of all seven symptoms, thus supporting a diagnosis of BPD. *Id.* at 98–99.

The DOE Psychologist noted that the Provider's notes appeared to indicate that she "rul[ed] . . . out" ADHD. *Id*. at 99. He stated that, although there are "a lot of similarities" between ADHD and BPD, "the episodic or cyclical nature of" BPD differentiates it from ADHD. *Id*. at 99–100. The DOE Psychologist noted that another differentiating factor is grandiosity or inflated self-esteem, a symptom that is present with BDP, but not with ADHD, PTSD, or anxiety. *Id*. He pointed out that the Provider noted grandiosity as part of the Individual's symptomology. *Id*. at 97.

In analyzing the Individual's medical records with regard to his medications, the DOE Psychologist noted that, at the first clinic, the Individual was first prescribed an anti-depressant. *Id*. at 102. He testified that anti-depressants are not prescribed to people with BPD as "it often triggers a manic episode, which could be agitation [or] irritability." *Id*. The DOE Psychologist indicated that the medical records indicate that the Individual became "very agitated" after taking the anti-depressant. *Id*. The DOE Psychologist further testified that BPD medication the Individual was taking in early 2015 "helped" as the medical records stated that "his moods and anxiety have been very stable on" the medication, and the Individual denied any manic symptoms. *Id*. at 104.

The DOE Psychologist testified that it is recommended that a person who has been diagnosed with a bipolar condition to "take a mood stabilizing medication . . . for life." *Id*. at 107. Additionally, he stated that the medication should be combined "with therapy that helps them to appreciate, I do have this condition, I do need to take my medication, and then to self-monitor for stressors." *Id.* He further explained that "the DSM specifies that once [a person has] a manic episode, [that person is] 90 percent likely to have another mood episode." *Id*. at 108. The DOE Psychologist added that people with BPD who do not take mood stabilizers are at higher risk for manic or hypomanic episodes. *Id.* at 123. The DOE Psychologist testified that there are many potential triggers for manic and hypomanic episodes, including stressors, a fall, or weather. *Id.* at 120. He emphasized that "we don't know all the things that can trigger [the episodes]." *Id*.

Regarding the diagnosis made by the Provider, the DOE Psychologist noted that the Provider "clearly document[ed] the symptoms," which he noted as particularly important given the cyclical nature of the condition. *Id*. at 106; *see id*. at 107. He noted that it would not be uncommon for the Individual to be asymptomatic as he was when the DOE Psychologist evaluated him. *Id*. at 106. Conversely, the DOE Psychologist testified that he did not agree with the Personal Psychologist's conclusion that ADHD was a more likely diagnosis and that the Individual's symptoms did not conclusively indicate BDP. *Id*. at 104–105. He noted that the Personal Psychologist did not reference either of the two diagnoses of a bipolar condition in his report despite BPD being a lifelong condition and despite reviewing the Individual's records. *Id*. at 105. The DOE Psychologist also took issue with the Personal Psychologist's failure to discuss any of the symptoms that led to the BPD diagnosis or the symptoms that differentiate BPD from ADHD. *Id*.

VI. Analysis

I have thoroughly considered the record of this proceeding, including the submissions tendered in this case and the testimony of the Individual during the hearing. In resolving the question of the Individual's eligibility for access authorization, I have been guided by the applicable factors prescribed in 10 C.F.R. § 710.7(c) and the Adjudicative Guidelines. After due deliberation, I have determined that the Individual has not sufficiently mitigated the security concerns cited by the LSO under Guideline I of the Adjudicative Guidelines. Therefore, I find that the Individual should be denied access authorization. The specific findings that I make in support of this decision are discussed below.

Regarding Guideline I, "[a]n opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness" may raise a security concern and may disqualify an individual from receiving a security clearance. Adjudicative Guidelines at ¶ 28(b). An individual may be able to mitigate the concerns if he shows:

> (a) The identified condition is readily controllable with treatment, and the individual has demonstrated ongoing and consistent compliance with the treatment plan;
>
> (b) The individual has voluntarily entered a counseling or treatment program for a condition that is amenable to treatment, and the individual is currently receiving counseling or treatment with a favorable prognosis by a duly qualified mental health professional;
>
> (c) Recent opinion by a duly qualified mental health professional employed by, or acceptable to and approved by, the U.S. Government that an individual's previous condition is under control or in remission, and has a low probability of recurrence or exacerbation;
>
> (d) The past psychological/psychiatric condition was temporary, the situation has been resolved, and the individual no longer shows indications of emotional instability;
>
> (e) There is no indication of a current problem.

Id. at ¶ 29.

Here, the Individual has been twice diagnosed as having a bipolar condition, diagnoses that were affirmed by the DOE Psychologist. *Id*. at ¶ 28(b). According to the DOE Psychologist, this is not a temporary condition, but a condition that the Individual will need to manage for the rest of his life, and although there is no evidence of a current symptoms the DOE Psychologist testified to

the cyclical nature of the condition, with a 90 percent chance of recurrence. *Id*. at ¶ 29 (d), (e). Furthermore, the Individual does not believe that the BPD diagnosis is accurate and, therefore, is not undergoing treatment for the condition. *Id*. at ¶ 29(a), (b). Although the Individual received treatment from the Provider, the record indicates that he did not demonstrate "ongoing and consistent compliance with the treatment plan" as he did not stay on the BPD medication or continue with therapy once he left the Provider's practice for his general practitioner. *Id*.

Although the Individual presented a report from his Personal Psychologist indicating that the Individual's records "do not conclusively indicate bipolar disorder" and ADHD was the "most likely diagnosis," as the DOE Psychologist noted, the Personal Psychologist does not discuss of the symptoms that led to the original diagnosis or appear to consider the cyclical nature of the condition. Furthermore, it should be noted that the Personal Psychologist does not entirely rule out a BPD condition as he recommended monitoring symptoms of mania to ensure the accuracy of his recommendation to remove the BPD diagnosis. As such, I cannot find that the Individual has sufficiently mitigated the security concern in this regard. *Id*. at ¶ 29(c).

For the foregoing reasons, I cannot find that the Individual has mitigated the security concerns arising under Guideline I.

VII. Conclusion

After considering all of the relevant information, favorable and unfavorable, in a comprehensive, common-sense manner, including weighing all of the testimony and other evidence presented at the hearing, I have found that the Individual has not brought forth sufficient evidence to resolve the security concerns associated with Guideline I. Accordingly, I have determined that the Individual should not be granted access authorization. This Decision may be appealed in accordance with the procedures set forth in 10 C.F.R. § 710.28.

Katie Quintana
Administrative Judge
Office of Hearings and Appeals