DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
[Name Redacted]	)	ISCR Case No. 18-01755
	)	
Applicant for Security Clearance	)	

Appearances

For Government: Rhett E. Petcher, Esq., Department Counsel
For Applicant: *Pro se*

03/27/2019

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Decision

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MATCHINSKI, Elizabeth M., Administrative Judge:

Applicant was evaluated by a duly-qualified clinical psychologist in February 2018 and found to have a poor prognosis for her mental-health stability because of her chronic borderline personality disorder and minimization of her need for ongoing psychotherapy treatment. She exhibited adequate judgment and insight during a brief assessment for medication management with her treating psychiatrist in January 2019, but it was not established that her condition no longer presents a security risk. Clearance is denied.

Statement of the Case

On July 3, 2018, the Department of Defense Consolidated Adjudications Facility (DOD CAF) issued a Statement of Reasons (SOR) to Applicant, detailing the security concerns under Guideline I, psychological conditions. The SOR explained why the DOD CAF was unable to find it clearly consistent with the national interest to grant or continue security clearance eligibility for her. The DOD CAF took the action under Executive Order (EO) 10865, *Safeguarding Classified Information within Industry* (February 20, 1960), as amended; DOD Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (January 2, 1992), as amended (Directive); and the *National Security Adjudicative*

Guidelines for Determining Eligibility for Access to Classified Information or Eligibility to Hold a Sensitive Position (AG) effective within the DOD on June 8, 2017.

Applicant responded to the SOR on July 16, 2018, and requested a decision on the written record without a hearing. On August 30, 2018, under ¶ E3.1.7 of the Directive the Government requested a hearing before an administrative judge from the Defense Office of Hearings and Appeals (DOHA). On January 8, 2019, the case was assigned to me to conduct a hearing to determine whether it is clearly consistent with the national interest to grant or continue a security clearance for Applicant. On January 15, 2019, I scheduled a hearing for February 14, 2019.

At the hearing, three Government exhibits (GEs 1-3) were admitted in evidence without objection. Department Counsel offered as GE 4 a report of personal subject interview, which I excluded on Applicant's objection because it lacked the authentication required under ¶ E3.1.20 of the Directive. A list of the GEs (HE I) and an August 30, 2018 letter forwarding the proposed GEs to Applicant (HE II) were marked as hearing exhibits (HEs) for the record but not admitted in evidence.[1] Applicant and one of her co-workers testified, as reflected in a transcript (Tr.) received on February 27, 2019.

I held the record open for 30 days after the hearing for documents from Applicant. On February 27, 2019, Applicant timely forwarded documents, which were admitted as Applicant exhibits (AEs A-D) without any objections.[2]

Summary of SOR Allegations

The SOR alleges under Guideline I that Applicant received treatment from 1991 to at least September 2016 for conditions diagnosed as post-traumatic stress disorder (PTSD), bipolar disorder type II, and borderline personality disorder (SOR ¶ 1.a); that Applicant has a history of suicidal ideation and attempts, including in 2011 (SOR ¶ 1.b(i)), in May 2008 after which she was hospitalized on a psychiatric unit (SOR ¶ 1.b(ii), and in August 2003 (SOR ¶ 1.b(iii)); and that Applicant was diagnosed with bipolar disorder, cluster B personality disorder, and histrionic and/or borderline personality disorder in February 2018, and given a poor prognosis (SOR ¶ 1.c).

When Applicant answered the SOR allegations, she admitted the treatment alleged in SOR ¶ 1.a, adding that she continues to receive therapy and medication management for her bipolar disorder. She also acknowledged having suicidal ideation in the past with no suicide attempts since 2010, which she attributed to her alcoholism for which she seeks support on a daily basis. Applicant admitted that she had been diagnosed with borderline personality disorder in the past but denied that the diagnosis is presently valid. She indicated that her bipolar disorder is presently stable, and her recent assessment is that

[1] In the August 30, 2018 discovery letter, then assigned Department Counsel identified 20 potential GEs. At the hearing, the documents identified as GEs 3 through 19 were entered into evidence collectively as GE 3. The hearing exhibit list was annotated accordingly.

[2] AE D consists of six character reference letters, which were admitted as pre-marked D1-D6.

she has an unspecified mood disorder. She denied that she has a poor prognosis and added that she has worked hard to change her mental health. She indicated that she has support systems in place that have enabled her to better handle stress. (Answer.)

Findings of Fact

After considering the pleadings, exhibits, and transcript, I make the following findings of fact.

Applicant is 48 years old and has an associate's degree in paralegal studies earned in May 1994. (GEs 1, 3; Tr. 65.) She obtained licenses as a certified nurse assistant in 1995, and as a licensed nurse assistant in 2013. She then attended a technical institute part time at night from September 2013 to December 2013. She has been employed by a defense contractor since late March 2015 and seeks a security clearance for her duties. (GEs 1, 4; AE C.)

Applicant and her first husband married in November 1988, had a daughter in 1989, and then divorced in January 1993. They remarried in August 1996 and had two more daughters before divorcing in May 2003. (GEs 1, 3.) As of February 2019, Applicant's ex-husband was serving a 50-year prison sentence for sexually assaulting their oldest daughter. (GE 3; Tr. 58.) Applicant married her second husband in June 2004, and they divorced in October 2009. In February 2015, Applicant began a cohabitant relationship. (GE 1.) She was no longer in that relationship as of February 2019. (Tr. 66.) None of her three daughters currently live with her. (Tr. 67.)

Applicant was sexually abused by her stepfather as a child. She has received mental-health services from her current provider (clinic X) on and off since age 13, when she overdosed on Tylenol and sleeping pills. She was psychiatrically hospitalized and then placed in foster care. After several hospitalizations for suicidal ideations, she married her first husband. He was abusive, and she was hospitalized at age 18 and then again at age 20 in 1991 following an overdose. In August 2002, a psychiatrist at clinic X prescribed Topamax for Applicant, and he diagnosed her with bipolar disorder, PTSD, and "a substantial" Axis II borderline personality disorder. (GE 3.)

Around the time of her second divorce from her first husband, Applicant was hospitalized for psychiatric reasons. In early September 2003, Applicant intentionally overdosed on her daughter's Vicodin prescription. In April 2004, she returned to treatment at clinic X because of the stress of her ex-husband's upcoming trial on charges of sexual assault and its impact on their oldest daughter. Applicant reported symptoms of depression and anxiety. She was diagnosed with bipolar disorder, and she began cognitive behavioral and interpersonal therapy sessions. (GE 3.)

In May 2005, Applicant was hospitalized for six days for depression and suicidal ideation. At discharge, she was placed on Topamax and amitriptyline and referred to clinic X. On May 16, 2005, Applicant was admitted to clinic X's crisis stabilization program. She reported rapid cycling between depression or isolation and manic episodes as well as

auditory hallucinations. At a session on June 22, 2005, Applicant reported auditory hallucinations and racing thoughts, which she attributed to the stress of her ex-husband's lengthy prison sentence for molesting their daughter. She was diagnosed on Axis I with bipolar disorder and PTSD, and on Axis II with borderline personality disorder, and advised to continue with individual therapy. (GE 3.)

In June 2005, Applicant was on suspension for missed time when she left her job of five years. She then held temporary assignments until April 2006 when she landed an administrative position with a realty company. In September 2006 she went on extended disability after she hurt her wrist. (GEs 1-2.) It is unclear what treatment, if any, she received for her mental health from June 2005 to March 2007.

As of late March 2007, Applicant was living with her two younger daughters and separated from her second husband. Her eldest daughter was living with her parents in another state. Applicant sought support at clinic X, reporting worsening symptoms and increased stress over the previous few months. She described manic behavior, impulsive and risky behavior, rapid speech, and mood swings consistent with bipolar I disorder, and a significant pattern of relationship difficulties, frequent and chronic suicidal ideation and intent, and lack of personal identity consistent with borderline personality disorder. She also reported panic attacks in public places. She indicated that her symptoms were impacting her personal relationships and her ability to work, and she expressed a readiness to engage in treatment. Applicant was diagnosed on Axis I with bipolar I disorder, most recent episode depression, severe; eating disorder; and panic disorder with agoraphobia. On Axis II, she was diagnosed with borderline personality disorder. Treatment recommendations included psychiatric evaluation, medication monitoring, and individual and group therapy. (GE 3.)

On April 20, 2007, Applicant began seeing her current psychiatrist at clinic X. A friend was managing her Topamax and amitriptyline medications for her so that she did not overdose. Applicant indicated that she had significant depression, but she was reluctant to try mood stabilizers because of their side effects. Her psychiatrist assessed her judgment and insight as adequate, although her affect was restricted. He diagnosed her on Axis I with bipolar disorder, not otherwise specified, and PTSD, delayed onset, chronic type, and on Axis II with borderline personality disorder. She agreed to a trial of Lamictal medication for her bipolar disorder, and was advised to return to the clinic in four to five weeks. (GE 3.)

From August 2007 until July 2008, Applicant lived in another state. She was hospitalized for two weeks in May 2008 following an intentional overdose on Elavil. Applicant moved back to her current locale in July 2008, and on September 5, 2008, she returned to clinic X for treatment of diagnosed bipolar disorder, PTSD, and borderline personality disorder. She reported current symptoms of depression and anxiety with panic attacks, sometimes with no identifiable precipitant. She denied any current suicidal ideation or intention, although she acknowledged thinking about self-harmful behavior in response to stressors and to changes in her environment. Applicant indicated that she was feeling very stressed due to the pressure to find a job after being unemployed for 2.5 years. She acknowledged that alcohol and other drugs (marijuana) were having severe effects on her

life. Therapeutic behavioral services and weekly individual psychotherapy were recommended to improve her overall functioning. During a session with her psychiatrist in October 2008, Applicant reported her mood as stable, and she denied a history of substance use requiring treatment. (GE 3.)

Applicant continued in treatment with clinic X. Over the next year, she exhibited tangential speech and needed redirection in therapy. As of September 2009, she reported increased symptoms of mania and difficulty managing activities of daily living. She was given diagnoses on Axis I of bipolar disorder, currently hypomanic, and on Axis II borderline personality disorder. Applicant was well-engaged with her service providers and showed good insight into her current symptoms of hypomania. (GE 3.)

In June 2010, Applicant was hospitalized for suicidal ideation with plan and intent. She self-reported her fear that she might harm her daughters, and as a consequence, the Department of Children, Youth, and Families (DCYF) placed her daughters in foster care. That summer, Applicant began attending Alcoholics Anonymous (AA) for a social environment free of alcohol. In August 2010, social workers at clinic X noted that Applicant continued to attend her therapy appointments, but she had difficulty following through with treatment recommendations. During a medication-management session with her psychiatrist on November 4, 2010, Applicant reported sobriety of 2.5 months with AA attendance. She acknowledged that she had been withholding information from him about her substance use over the years. She stated that she relapsed after nine years of sobriety into drinking from two to six drinks per day until 2.5 months ago. She reported increased anxiety related to a plan for her children to be placed back with her in December 2010. Applicant agreed to a short-term use of Vistaril in lieu of Lamictal. She was given diagnoses on Axis I of bipolar disorder type II, PTSD, and alcohol abuse in early full remission, and on Axis II of borderline personality disorder. (GE 3.)

Applicant resumed working in April 2011, although her schedule as a factory worker made it difficult for her to attend her therapy appointments. By May 2011, Applicant was using Ativan prescribed by her primary care physician as a sleep aid. During a session with her psychiatrist in early May 2011, she reluctantly agreed that she was hypomanic, but she declined to take prescribed risperidone. Her insight and judgment were assessed as adequate. She was advised that should her manic symptoms worsen, she should consider the use of mood-stabilizing medications. (GE 3.)

As of August 2011, Applicant was experiencing emotional dysregulation and anger, including at DCYF, although one of her children had returned home from foster care. Through AA's support, Applicant was able to stay sober for the past year. She reported suicidal ideation in the past year, but not in recent months. (GE 3.)

In April 2012, Applicant hit her head in an automobile accident, which exacerbated her mental health issues. Her psychiatrist diagnosed her with post-concussion syndrome. By August 2012, her two teenage daughters were living with her, which was a source of stress. Applicant reported an increase in anxiety, moods "all over the place," and a difficulty focusing. She experienced panic attacks and had auditory hallucinations, but she had been

sober for over two years and had no suicidal or homicidal ideations. Borderline personality disorder remained her primary diagnosis with a secondary diagnosis of bipolar I disorder, moderate. (GE 3.)

In July 2012, Applicant left her factory job by mutual agreement following notice of unsatisfactory performance. She had been having trouble performing her duties after her car accident. (GE 4.) Between August 2012 and August 2013, Applicant had a number of changes and losses in her life, including loss of her driver's license, ending her relationship with her then fiancé, and the death of a friend from AA. Applicant attended therapy and medication-management appointments at clinic X, but she was not consistent in her attendance with therapy after her therapist retired. Over the year, Applicant presented for treatment with increased mood dysregulation, lability, anxiety, decreased energy, sleep disturbances due to panic symptoms and intrusive thoughts. She reported one incident of suicidal ideation with plan and intent, but she did not require psychiatric hospitalization. Applicant maintained sobriety throughout the year with ongoing, regular participation in AA with a sponsor. (GE 3.)

Applicant was rehired by her former employer in October 2013. In February 2015, she was involuntarily terminated after she did not report for two shifts when she was ill. After she proved that she had reported her absence, she was offered her old job, but she chose instead to work for her current employer. (GEs 1, 4.)

On March 12, 2015, Applicant completed and certified to the accuracy of a Questionnaire for National Security Positions (SF 86). In response to an inquiry concerning any counseling for an emotional or mental health condition in the last seven years, Applicant indicated that she has had treatment from 1991 to present at clinic X. (GE 1.) Applicant began working for her current employer on March 30, 2015. (AE C.)

A clinic X staff-activity log covering June 16, 2015, through September 25, 2018, shows that Applicant had 45-minute individual therapy sessions at the clinic approximately every two weeks from June 2015 to April 2016 and from August 2016 through mid-February 2017. She attended one therapy session in the spring of 2017. From June 2017 through November 2017, she attended therapy once every three months. There is no evidence of any therapy sessions in December 2017 and January 2018. She was absent from a service scheduled for January 24, 2018. (AE B.)

At the request of the DOD CAF, Applicant was evaluated by a licensed clinical psychologist on February 12, 2018. The assessment included a clinical interview; review of documentation showing a history of long-term mental health treatment for bipolar disorder and borderline personality disorder since 1991; and testing consisting of the Substance Abuse Subtle Screening Inventory (SASSI-3), and the Million Clinical Multiaxial Inventory (MCMI-III).[3] The psychologist noted Applicant's ongoing medication management with Topamax under the care of her psychiatrist at clinic X and her individual therapy with a social worker at clinic X, but also that Applicant had discontinued her use of Ativan and had

[3] The MCMI-III is a self-report psychological-assessment tool intended to identify personality traits and any presence of psychopathology. (GE 2.)

stated that she no longer needs psychotherapy. Applicant indicated that she only sees her therapist "sometimes for support." Applicant denied any current suicidal or homicidal ideation. In the opinion of the psychologist, Applicant "dramatically minimized her history of such [ideation]." Applicant reported that she was attending five to ten AA meetings a week, and she insisted that it was AA that was keeping her stable. The psychologist diagnosed Applicant on Axis I with alcohol dependence, full remission, most recent relapse in October 2015, and bipolar disorder, by history. No present symptoms of bipolar disorder were evidenced in the assessment. She gave Applicant a diagnosis on Axis II of cluster B personality disorder, histrionic and/or borderline personality disorder.[4] The psychologist summarized her assessment, as follows:

> Clinical psychopathology is present in [Applicant's] presentation, her dramatic minimization and unwillingness to be forthcoming and realistic with regard to both her history of symptoms and her vulnerability to experiencing negative emotions certainly is evidence that her judgment, reliability, and trustworthiness is impaired with regard to the protection of national security. . . . Ongoing prognosis for [Applicant] is Poor. Her status is very likely to be negatively impacted by the presence of stressful life events and any alcohol use. She is likely to struggle with emotional lability, with bouts of angry outbursts and periods of isolation. She insisted that her relationship with AA is what keeps her stable and reported that she does not feel she is in need of individual psychotherapy "anymore." Her minimization of need for ongoing treatment and her reliance on AA as her sole source of stability renders her highly vulnerable to episodes of emotional dysregulation. These personality characteristics undermine [Applicant's] ability to maintain with certainty the judgment, reliability, and trustworthiness necessary to protect national security.

The psychologist subsequently concluded that Applicant is "likely unable to consistently and reliably remain stable and well over the long term." (GE 2.)

Applicant attended therapy once in February 2018, and approximately every two weeks from April through mid-July 2018. There is no indication of any therapy sessions in August 2018. She had a 45-minute session on September 10, 2018, and had reportedly "confirmed" for September 25, 2018. (AE B.) No information was provided about her clinical presentation or progress in staff logs. She testified that she now sees her therapist

[4] Under the Diagnostic and Statistical Manual of Mental Disorders (DSM), borderline personality disorder is defined by a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity. Histrionic personality disorder is a pattern of excessive emotionality and attention seeking. Personality disorders are grouped into three clusters based on similarities. Cluster B includes the antisocial, borderline, histrionic, and narcissistic personality disorders. Persons with these disorders often appear dramatic, emotional, or erratic. Personality disorders are diagnosed when there is an enduring pattern present in a variety of contexts that appeared before early adulthood, and they are typical of an individual's long-term functioning. Impulsive behavior in at least two areas and recurrent suicidal behavior are characteristics of borderline personality disorder. There is considerable variability in the course of borderline personality disorder. The risk of suicide gradually wanes with advancing age, although the tendency towards intense emotions, impulsivity, and intensity in relationships is often lifelong.

every three months and that her most recent session was in December 2018. (Tr. 56.) She provided no documentation to corroborate that she had therapy.

Applicant testified that she goes to a psychologist, a psychiatrist, and a therapist, and has them available to monitor her,[5] but she then stated, "I just take care of myself really well these days." (Tr. 48.) Applicant indicated that she is able to manage her mental health by taking her medication, eating right, and not drinking alcohol or using illegal drugs. She explained that it took her some time to change her negative thought process, and that AA is a daily reminder for her to work on her "thinking problem" on a daily basis. (Tr. 51-53.) Applicant denied any panic attacks in the last year, although she admitted that "there probably was an instance within the last year" when she felt really overwhelmed. She did not tell her therapist about it. She would not tell her therapist "unless it gets bad." She copes with panic attacks by "just breathing, just meditating and relaxing." (Tr. 62-64.)

Documents submitted after her hearing included a progress note of a 15-minute medication-management session with her psychiatrist at clinic X in mid-January 2019. Applicant reported doing well on her Topamax medication. She had some stressors over the recent holidays and some work stressors, but she reported that she was able to manage them. She exhibited no psychotic or suicidal symptoms, no lability or constriction of mood, and adequate insight and judgment. Her psychiatrist assessed her with unspecified bipolar disorder, in remission; alcohol use disorder, in remission; and unspecified personality disorder with cluster B features by history. She was continued on Topamax medication and advised to return to the clinic in three months. (AE A.) Applicant testified that she takes her medication regularly. (Tr. 69.)

Applicant did not provide the February 2018 report of the psychologist to her psychiatrist for his review, even though she had a copy. She apparently mentioned the assessment to her psychiatrist because she was "very upset about it." She claims that some information in the psychologist's report to the DOD was inaccurate, although she did not elaborate about any errors. (Tr. 72-74.)

Applicant has not consumed any alcohol since 2015. She attends between seven and ten AA meetings a week and learned in AA some coping skills that she "can use" in every aspect of her life. (Tr. 48, 50-51.)

Applicant has had no disciplinary issues with her current employer. (AE C.) She has enjoyed her work over the last four years and considers it an honor to work there. In late 2015, she transferred to a more stressful position, which she held for almost three years. It helped her learn how to remain calm and cope with difficult situations. She has been in her current assignment since November 2018. (Tr. 47-48, 71.)

[5] Available records show that Applicant has had her present therapist since June 2017 (AE B), but she has been under the care of her psychiatrist since April 2007. (GE 3.)

Work and Character References

A co-worker, who serves as a union steward and was previously employed in the same department as Applicant, has always known Applicant to be calm at work. She managed a situation that could have been very stressful for her. She had counted on a union official to represent her at her hearing. He had the documentation she intended to present at her hearing but then called that morning and indicated he would be unable to accompany her.[6] Traffic issues led Applicant and her witness to change their plans and take public transportation, which was delayed. Applicant remained "in good spirits." (Tr. 33-40.) The witness is aware that Applicant was "a heavy drinker at one time." Yet, he would like to see her obtain a security clearance. He considers her to be "a great American." When asked whether his opinion would change if he knew that of her mental health diagnoses, he responded that he had never seen any evidence of those issues. (Tr. 41-43.)

Three co-workers provided character reference letters for Applicant. A co-worker who has known Applicant for almost four years described her "a kind and caring soul who is always thinking of others." In their time together outside of work, Applicant has acted very responsibly. Applicant takes her sobriety seriously and "attends meetings regularly as required." At work, Applicant has been very focused and dependable. The co-worker believes that it would be detrimental to their employer as well as to Applicant's well-being if she is not allowed to continue her work. (AE D1.) The other co-workers have known her for less than two years. In their experience, Applicant is committed to her work, and she is willing to help when needed. Applicant works overtime on a regular basis. They consider her to be an asset. (AEs D2-D3.)

Applicant's AA sponsor, who has been in the AA program for 30 years, has known Applicant for three years. She attests that Applicant attends daily meetings and volunteers in AA, going above and beyond what is asked of her. The sponsor has not known Applicant to relapse in the past three years. In her opinion, Applicant "handles difficult situations with grace and dignity." She is well respected and trusted by her peers in AA, and she is always seeking new ways to improve herself. (AE D4.)

Two friends who have known Applicant through a women's group provided positive reference letters. They have witnessed Applicant become a leader in planning and organizing group outings. A friend of eight years described Applicant's temperament as "always balanced even with chaos around her." (AE D5.) A friend of the past four years, who has also been involved in the planning and organization of their group's activities, admires Applicant's "quiet and self-confident demeanor." Applicant has shown herself to be a reliable and dependable friend. (AE D6.)

[6] Applicant confirmed that this union official was supposed to act as her personal representative. I advised her that I would not continue with the hearing and that we would reconvene at some future date. Alternatively, she could continue to represent herself and submit documentation after the hearing. Applicant chose the latter.

Policies

The U.S. Supreme Court has recognized the substantial discretion the Executive Branch has in regulating access to information pertaining to national security, emphasizing that "no one has a 'right' to a security clearance." *Department of the Navy v. Egan*, 484 U.S. 518, 528 (1988). When evaluating an applicant's suitability for a security clearance, the administrative judge must consider the adjudicative guidelines. In addition to brief introductory explanations for each guideline, the adjudicative guidelines list potentially disqualifying conditions and mitigating conditions, which are required to be considered in evaluating an applicant's eligibility for access to classified information. These guidelines are not inflexible rules of law. Instead, recognizing the complexities of human behavior, these guidelines are applied in conjunction with the factors listed in the adjudicative process. The administrative judge's overall adjudicative goal is a fair, impartial, and commonsense decision. According to AG ¶ 2(a), the entire process is a conscientious scrutiny of a number of variables known as the "whole-person concept." The administrative judge must consider all available, reliable information about the person, past and present, favorable and unfavorable, in making a decision.

The protection of the national security is the paramount consideration. AG ¶ 2(b) requires that "[a]ny doubt concerning personnel being considered for national security eligibility will be resolved in favor of the national security." In reaching this decision, I have drawn only those conclusions that are reasonable, logical, and based on the evidence contained in the record. Under Directive ¶ E3.1.14, the Government must present evidence to establish controverted facts alleged in the SOR. Under Directive ¶ E3.1.15, the applicant is responsible for presenting "witnesses and other evidence to rebut, explain, extenuate, or mitigate facts admitted by applicant or proven by Department Counsel. . . ." The applicant has the ultimate burden of persuasion to obtain a favorable security decision.

A person who seeks access to classified information enters into a fiduciary relationship with the Government predicated upon trust and confidence. This relationship transcends normal duty hours and endures throughout off-duty hours. The Government reposes a high degree of trust and confidence in individuals to whom it grants access to classified information. Decisions include, by necessity, consideration of the possible risk that the applicant may deliberately or inadvertently fail to safeguard classified information. Such decisions entail a certain degree of legally permissible extrapolation about potential, rather than actual, risk of compromise of classified information. Section 7 of EO 10865 provides that decisions shall be "in terms of the national interest and shall in no sense be a determination as to the loyalty of the applicant concerned." *See also* EO 12968, Section 3.1(b) (listing multiple prerequisites for access to classified or sensitive information).

Analysis

Guideline I: Psychological Conditions

The security concerns about psychological conditions are articulated in AG ¶ 27:

> Certain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness. A formal diagnosis of a disorder is not required for there to be a concern under this guideline. A duly qualified mental health professional (e.g. clinical psychologist or psychiatrist) employed by, or acceptable and approved by the U.S. Government, should be consulted when evaluating potentially disqualifying and mitigating information under this guideline and an opinion, including prognosis, should be sought. No negative inference concerning the standards in this guideline may be raised solely on the basis of mental health counseling.

Applicant began receiving mental health treatment at age 13. Progress records of her treatment at clinic X show longstanding diagnoses on Axis I of bipolar disorder (secondary) and on Axis II of borderline personality disorder with cluster B features (primary). She was hospitalized for psychiatric reasons several times over the years for suicide attempts or suicidal ideation, although not since June 2010.[7] She had an instance of suicidal ideation with plan and intent at one point between August 2012 and August 2013, but she informed her therapist and services were added to address her "increased needs." The evidentiary record contains no information about her condition or treatment over the next four to five years. Available staff logs from the clinic show the dates and times when she had some therapy and medication-management sessions. When assessed by a duly-qualified psychologist for the DOD in February 2018, Applicant exhibited no present symptoms of bipolar disorder, but her personality disorder was seen as negatively impacting her judgment, reliability, and trustworthiness with regard to protecting national security. The psychologist opined that Applicant's mental health is likely to be negatively impacted by stressful life events and that she is likely to struggle with emotional lability with bouts of angry outbursts and periods of isolation. The psychologist gave Applicant a poor prognosis and found her to be highly vulnerable to future episodes of emotional dysregulation. The following disqualifying conditions under AG ¶ 28 apply:

> (a) behavior that casts doubt on an individual's judgment, stability, reliability, or trustworthiness, not covered under any other guideline and that may indicate an emotional, mental, or personality condition, including, but not limited to, irresponsible, violent, self-harm, suicidal, paranoid, manipulative, impulsive, chronic lying, deceitful, exploitative, or bizarre behavior;

[7] The psychologist who evaluated Applicant for the DOD stated in her report, "There are records of several suicide attempts, the most recent being in 2011." Available records of Applicant's annual treatment and progress at clinic X from August 12, 2010, through August 12, 2012, show that she presented with symptoms of depressed mood, agitation, dissociation, mood dysregulation, anxiety, and panic attacks, but there is no mention of psychiatric hospitalization during those two years. The clinical review for the period September 16, 2009, to August 18, 2010, indicates that Applicant was hospitalized for suicidal ideation with plan and intention in June 2010.

(b) an opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness; and

(c) voluntary or involuntary inpatient hospitalization.

Applicant has the burden of establishing one or more of the following mitigating conditions under AG ¶ 29:

(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; and

(e) there is no indication of a current problem.

Regarding AG ¶ 29(a), Applicant is credited with seeking treatment for her mental health when she was having difficulty controlling her symptoms. She has had a therapeutic relationship with her current psychiatrist since April 2007, and with some exceptions, she has been compliant with her medications. Available records indicate that she has also attended therapy sessions, although she has not always been fully forthcoming with her psychiatrist or therapist. She hid her alcohol abuse from clinicians in the past. She did not tell her current therapist when she felt very overwhelmed in the last year because she did not consider it bad enough to report.

AG ¶ 29(b) is partially satisfied in that Applicant's bipolar condition is in remission. Her treating psychiatrist and the DOD-approved psychologist who evaluated Applicant found no current indication of her bipolar disorder. While neither clinician rendered an opinion on the risk of recurrence of Applicant's bipolar disorder, it has always been a secondary mental health issue for her.

Concerning Applicant's primary diagnosis, borderline personality disorder is not a temporary psychiatric condition of the type contemplated within AG ¶ 29(d). Given the

DOD-approved clinical psychologist's opinion that Applicant's personality disorder is a condition that impairs her judgment, reliability, and trustworthiness with regard to handling classified information, and that she has a poor prognosis with regard to recurrence of her symptoms in times of stress, it is difficult to find mitigation under any of the mitigating conditions.

To dispute that negative prognosis, Applicant submitted a January 2019 progress note of a session with her treating psychiatrist for medication management, Applicant told her psychiatrist that her current dose of Topamax was effective, and that she was able to manage recent holiday and work stressors. She exhibited no psychotic or suicidal symptoms, no lability or constriction of mood, and adequate insight and judgment. Her psychiatrist assessed her with unspecified bipolar disorder, in remission; alcohol use disorder, in remission; and unspecified personality disorder with cluster B features, by history. She also presented character assessments from co-workers, who have found her to be calm and helpful at work, and from friends, who have found her to be organized.

By all accounts, Applicant has been able to function in an acceptable manner in her present job. She has not had any disciplinary infractions in her current employment. She credits her involvement with AA as giving her the skills needed to manage daily stressors. While I do not doubt that AA has been of great benefit to Applicant, deference is afforded the opinions of mental health providers in light of their education and experience in recognizing and treating psychological conditions. The DOD-approved psychologist has ongoing concern for Applicant's mental health because of Applicant's primary reliance on AA in preference to psychotherapy as the means of controlling her conditions. Applicant testified that she has her psychiatrist and therapist available when she needs them, and that she "just take[s] care of [herself] really well these days." Applicant did not share the report of the February 2018 evaluation with her psychiatrist, although she testified that she told her psychiatrist about the DOD-approved psychologist's diagnosis of borderline personality disorder. Her psychiatrist does not appear to be concerned about her personality disorder at present because the diagnosis was "by history." Even so, I do not have a favorable assessment from a duly-qualified medical professional attesting that Applicant's psychological conditions do not present a security risk. Absent a favorable prognosis, and in light of Applicant's history of serious psychological symptoms with some display of minimization of those symptoms, I cannot conclude with confidence that the psychological conditions security concerns are fully mitigated.

Whole-Person Concept

In the whole-person evaluation, the administrative judge must consider the totality of an applicant's conduct and all relevant circumstances in light of the nine adjudicative process factors in AG ¶ 2(d).[8]

[8] The factors under AG ¶ 2(d) are as follows:

> (1) the nature, extent, and seriousness of the conduct; (2) the circumstances surrounding the conduct, to include knowledgeable participation; (3) the frequency and recency of the conduct; (4) the individual's age and maturity at the time of the conduct; (5) the extent to

Applicant's ability to maintain consistent employment with a calm demeanor over the past four years shows that she has made considerable strides in managing her mental health issues. Even so, I cannot ignore the opinion of a DOD-approved clinical psychologist that Applicant has impaired judgment, reliability, and trustworthiness with regard to the protection of national security. There is no assessment from a duly-qualified medical professional that classified information would not be at risk should Applicant be placed in a particularly stressful situation in the future. A co-worker believes it would be detrimental to Applicant's well-being if she cannot continue in her current job, which suggests the importance of Applicant's job to her, but also that she may still have difficulty coping with change. The Appeal Board has repeatedly held that the government need not wait until an applicant mishandles or fails to safeguard classified information before denying or revoking security clearance eligibility. *See*, *e.g*., ISCR Case No. 08-09918 (App. Bd. Oct. 29, 2009) (citing *Adams v. Laird*, 420 F.2d 230, 238-239 (D.C. Cir. 1969)). It is well settled that once a concern arises regarding an applicant's security clearance eligibility, there is a strong presumption against the grant or renewal of a security clearance. *See Dorfmont v. Brown*, 913 F. 2d 1399, 1401 (9th Cir. 1990). For the reasons noted, I am unable to conclude that it is clearly consistent with the national interest to grant security clearance eligibility for Applicant.

Formal Findings

Formal findings for or against Applicant on the allegations set forth in the SOR, as required by section E3.1.25 of Enclosure 3 of the Directive, are:

Paragraph 1, Guideline I:	AGAINST APPLICANT
Subparagraphs 1.a-1.c:	Against Applicant

Conclusion

In light of all of the circumstances, it is not clearly consistent with the national interest to grant eligibility for a security clearance for Applicant. Eligibility for access to classified information is denied.

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Elizabeth M. Matchinski
Administrative Judge

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which participation is voluntary; (6) the presence or absence of rehabilitation and other permanent behavioral changes; (7) the motivation for the conduct; (8) the potential for pressure, coercion, exploitation, or duress; and (9) the likelihood of continuation or recurrence.