DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
	)	ISCR Case No. 20-01838
	)	
Applicant for Security Clearance	)	

Appearances

For Applicant: Maurice Arcadier, Esq.
For Government: Andrea M. Corrales, Esq., Department Counsel

08/22/2022

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Decision

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HARVEY, Mark, Administrative Judge:

In April 2020, Dr. B, a psychologist, diagnosed Applicant with Bipolar II Disorder, Depressive Disorder (moderate, recurrent, in partial remission), Generalized Anxiety Disorder, and Obsessive Compulsive Personality traits. Dr. B said that Applicant's prognosis was poor based on limited insight and absence on ongoing care for psychiatric conditions, which suggested an increased risk for instability that can lead to impairment in judgment, reliability, and trustworthiness. Guideline I (psychological conditions) are not mitigated at this time. Eligibility for access to classified information is denied.

Statement of the Case

On November 16, 2016, Applicant completed and signed an Electronic Questionnaires for National Security Positions (SF 86) or security clearance application (SCA). (Government Exhibit (GE) 1). On October 30, 2020, the Defense Counterintelligence and Security Agency Consolidated Adjudications Facility (DCSA CAF) issued a statement of reasons (SOR) to Applicant under Executive Order (Exec. Or.) 10865, *Safeguarding Classified Information within Industry*, February 20, 1960; Department of Defense (DOD) Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (Directive), January 2, 1992; and Security Executive Agent Directive 4, establishing in Appendix A the *National Security Adjudicative Guidelines for Determining Eligibility for Access to Classified Information or Eligibility to Hold a Sensitive Position* (AGs), effective June 8, 2017. (Hearing Exhibit (HE) 2)

The SOR detailed reasons why the DCSA CAF did not find under the Directive that it is clearly consistent with the interests of national security to grant or continue a security clearance for Applicant and recommended referral to an administrative judge to determine whether a clearance should be granted, continued, denied, or revoked. Specifically, the SOR set forth security concerns arising under Guideline I. (HE 2) On January 14, 2021, Applicant provided a response to the SOR, and he requested a hearing. (HE 3) On February 26, 2021, Department Counsel was ready to proceed. Processing of the case was delayed due to the COVID-19 pandemic.

On April 5, 2022, the case was assigned to me. On April 11, 2022, the Defense Office of Hearings and Appeals (DOHA) issued a notice of hearing, setting the hearing for June 22, 2022. (HE 1) The hearing was held as scheduled.

Department Counsel offered 4 exhibits into evidence, and Applicant offered 11 exhibits into evidence. (Transcript (Tr.) 17-18, 21-23; GE 1-GE 4; Applicant Exhibit (AE) A-AE K) There were no objections, and all proffered exhibits were admitted into evidence. (Tr. 18, 23) Applicant proffered a copy of the security investigative record (226 pages), and it was admitted without objection on July 26, 2022, as AE L. (HE 4) On July 6, 2022, DOHA received a transcript of the hearing. The record was closed on July 26, 2022.

Department Counsel moved for administrative notice of the *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition (*DSM-5*) pages 123-139, 155, and 160-168. (Tr. 18-19; HE 5) There was no objection, and I granted the motion. (Tr. 145; HE 5)

Some details were excluded to protect Applicant's right to privacy. Specific information is available in the cited exhibits and transcript.

Findings of Fact

In Applicant's SOR response, he admitted that he received the diagnoses described in SOR ¶¶ 1.a and 1.b. (HE 3) He also provided mitigating information. His admissions are accepted as findings of fact. Additional findings follow.

Applicant is a 44-year-old senior field test engineer, and he has worked for his current employer, a DOD contractor, managing laboratories developing simulators and fielding manuals for devices for the Army for six years. (Tr. 86-87; GE 1) He served in the Army National Guard from 1996 to 2005, and he was honorably discharged as a Chief Warrant Officer 2 in 2005. (Tr. 81, 84; GE 1) He was an Apache helicopter mechanic and pilot. (Tr. 81) He received a physical and mental evaluation from the Army which did not indicate any mental-health disqualifying issues. (Tr. 81) He injured his knee and received surgeries in 2003 and 2004. (Tr. 83) He is not receiving disability from the Department of Veterans Affairs (VA). (Tr. 129) He has not served in a combat zone; however, he served a tour in Kuwait from 1999 to 2000. (Tr. 129; GE 2 at 2) In 2007, he attended college; however, he did not receive a degree. (GE 1 at 10) In 2010, he married, and he does not have any children. (Tr. 129)

From 2005 to 2013, Applicant worked for DOD contractors training helicopter pilots on simulators. (Tr. 84-85) From 2013 to 2014, he supported engineers in a development environment. (Tr. 85) From 2014 to 2015, he worked with simulators for another DOD contractor. He has held a security clearance since 1997. (Tr. 87) His periodic reinvestigation was in 2007. (Tr. 87) There is no evidence of security violations. He has never received any adverse employment actions such as reprimands or suspensions. (Tr. 88)

Psychological Conditions

Applicant's medical records indicate he first experienced bipolar symptoms when he was six years old. (AE L at 145) Applicant denied any mental-health issues before 2005; however, he was the victim of sexual abuse around age six. (Tr. 107, 129) Applicant's grandmother was schizophrenic. (Tr. 128) Both of his parents have suffered from depression. (GE 3 at 4)

In 2004, Applicant's grandfather died, and friends who were military aviators died in accidents at Fort Hood, Texas and Iraq. (Tr. 89) Applicant was engaged; however, the engagement was not going well. (Tr. 89) He was taking pain medications after his knee surgery. (Tr. 89) He was also dissatisfied with his employment. (GE 2 at 3) In 2005, Applicant sought help from a general practitioner and was diagnosed with depression and Attention Deficit Disorder (ADD), and he was prescribed Cymbalta, an anti-depressant. (Tr. 88, 106-108; GE 2 at 3) He took Cymbalta for a week or two. (Tr. 108) He began to think about committing suicide. (Tr. 90, 130) His father took him back to see his doctor. (GE 2 at 3) He learned when he went back to see his treating physician that he mistakenly received an excessively large dose of Cymbalta. (Tr. 91) A flight surgeon advised him to stop taking Cymbalta and then to see how he felt. (Tr. 91) He complied with the flight surgeon's advice.

In 2006, Applicant was feeling lethargic and tired, and he went to see another general practitioner. (Tr. 91; AE L at 45) He was diagnosed with depression and possibly ADD. (Tr. 91) He was prescribed antidepressants and Ritalin for ADD. (Tr. 91, 110) The side effects of the medications made Applicant feel worse, and despite medication changes, he was not improving.

Later in 2006, Applicant went to see Dr. D, a psychiatrist, who diagnosed him with a Bipolar Disorder. (Tr. 93) Applicant said for the first time he experienced episodes of mania. (Tr. 111-112) He tried multiple mood stabilizers. (Tr. 112) He slept about three hours over a four-day period, and he said his inability to sleep was due to taking Ritalin medication. (Tr. 112-113; GE 2 at 3) Applicant believed the idea that he was manic originated from his reaction to Ritalin. (Tr. 131) He felt "like Superman." (Tr. 131) Dr. D described Applicant as honest, candid, and reliable. (Tr. 92-93; AE L at 45, 154) Dr. D said Applicant does not have a condition or treatment that could impair his judgment or reliability, particularly in the context of safeguarding national security information. (AE L at 154) Dr. D retired in 2008, and Applicant next saw Dr. E for about nine months. (Tr. 93; AE L at 45) The record does not contain Dr. E's diagnosis.

From 2009 to 2010, Dr. F treated Applicant and he continued the Bipolar Disorder diagnosis and prescribed Lamictal. (Tr. 114) Applicant said Dr. F told him he was not really sure the correct diagnosis was Bipolar Disorder. (Tr. 114) Applicant continued to feel tired and lethargic; however, he did not feel depressed. (Tr. 115) Dr. F continued to prescribe Lamictal, and Applicant took the medication because he was doing well with this medication. (Tr. 114; GE 2 at 3) Dr. F recommended follow-up appointments every six months or so to monitor how he was doing, and Applicant complied with this treatment recommendation. (Tr. 115) In November 2010, he stopped seeing Dr. F because he was moved to a different state. Medical records from Dr. F were not introduced into the security record.

Dr. M, a psychiatrist, treated Applicant from April 2011 to October 2016. (Tr. 93; AE L at 45) In April 2011, Dr. M wrote in Applicant's medical records that he

> presented with life long history of episodes of irritable & happy mood, excessive [e]nergy, decreased need for sleep and increase[d] sex drive. [Patient (Pt)] also had episodes of getting depressed and irritable. Pt reported having disturbed sleep and appetite, loss of interest in activity of daily living, lack of motivation, multiple episodes of anxiety attacks, and multiple episodes of crying spells. . . . Pt also presented with history of feeling anxious and having frequent panic attacks. Pt has also a long history of paying attention to details, difficulty completing prolonged tasks, difficulty initiating complex tasks, easily frustrated, and easily bored. (GE 4 at 1)

Dr. M diagnosed Applicant with Bipolar I Disorder (mixed type) in remission, ADD, Generalized Anxiety Disorder, Major Depression in remission, and Obsessive Compulsive Personality (OCP) traits. (Tr. 93-94, 116; AE L at 45; SOR ¶ 1.a) Dr. M prescribed Lamictal for mood stabilization and Vyvanse for Attention-deficit/hyperactivity disorder (ADHD). (Tr. 116)

On July 25, 2013, Dr. M noted that Applicant "is doing well. Anxiety and mood level is great. Illness history of Bipolar course was reviewed with [Applicant] with clear history of manic or hypomanic episodes but ocp traits and anxiety and recurrent depressive episodes. No side effects from meds. Supportive and individual therapy was provided." He changed his diagnosis to Major Depression in remission, ADHD, and Obsessive Compulsive Personality (OCP) traits. (Tr. 95; GE 4 at 17) Dr. M reduced the Lamictal prescription from 150 mg to 100 mg for mood stabilization and Adderall for ADHD. (Tr. 117; GE 4 at 17) Dr. M noted Applicant's judgment was logical and his mood was stable. (Tr. 96; GE 4 at 17) Dr. M advised the OPM investigator that he was not confident about the Bipolar Disorder diagnosis and the correct diagnosis might be Anxiety, Depression, ADD, and OCD traits. (AE L at 45)

Applicant followed all prescribed or recommended treatment from April 2011 to October 2014, and from October 2014 to February 2016. (*Id*. at 46) Applicant did not receive any treatment from October 2014 to February 2016, and Dr. M did not remember why Applicant stopped treatment. (*Id*.) Applicant had the following appointments with Dr. M: six in 2011, eight in 2012, one in 2013, three in 2014, and two in 2016. (*Id*.) Dr. M

believed Applicant would carefully safeguard classified information because he is a perfectionist, anxious, and has OCD. (*Id*.) His last treatment with Dr. M was in October 2016. (Tr. 97; GE 4 at 22)

Medical records generated by Dr. M's recommends follow-up appointments as shown in the following table.

Date of Appointment	Treatment Recommendation Return to Clinic or RTC all indicate return earlier if needed	Cite	Date of Next Appointment	Cite
Apr. 28, 2011	3 weeks	GE 4 at 3	May 31, 2011	GE 4 at 4
May 31, 2011	4 weeks	GE 4 at 4	Jun. 28, 2011	GE 4 at 5
Jun. 28, 2011	4 weeks	GE 4 at 5	July 26, 2011	GE 4 at 6
July 26, 2011	4 weeks	GE 4 at 6	Aug. 23, 2011	GE 4 at 7
Aug. 23, 2011	4 weeks	GE 4 at 7	Sept. 20, 2011	GE 4 at 8
Sept. 20, 2011	4 weeks	GE 4 at 8	Jan. 17, 2012	GE 4 at 9
Jan. 17, 2012	4 weeks	GE 4 at 9	Apr. 18, 2012	GE 4 at 10
Apr. 18, 2012	4 weeks	GE 4 at 10	May 16, 2012	GE 4 at 11
May 16, 2012	2 weeks	GE 4 at 11	May 30, 2012	GE 4 at 12
May 30, 2012	4 weeks	GE 4 at 12	June 25, 2012	GE 4 at 13
June 25, 2012	8 weeks	GE 4 at 13	Aug. 2, 2012	GE 4 at 14
Aug. 2, 2012	8 weeks	GE 4 at 14	Oct. 10, 2012	GE 4 at 15
Oct. 10, 2012	8 weeks	GE 4 at 15	Dec. 21, 2012	GE 4 at 16
Dec. 21, 2012	4 weeks	GE 4 at 16	July 25, 2013	GE 4 at 17
July 25, 2013	24 weeks	GE 4 at 17	Jan. 28, 2014	GE 4 at 18
Jan. 28, 2014	24 weeks	GE 4 at 18	July 7, 2014	GE 4 at 19
July 7, 2014	24 weeks	GE 4 at 19	Oct. 24, 2014	GE 4 at 20
Oct. 24, 2014	24 weeks	GE 4 at 20	Mar. 30, 2016	GE 4 at 21
Mar. 30, 2016	2-3 weeks	GE 4 at 21	Oct. 20, 2016	GE 4 at 22
Oct. 20, 2016	2-3 weeks	GE 4 at 22		

Applicant said that even though the medical records in some instances said to see Dr. M every couple of weeks, Dr. M told Applicant that he needed to see him when needed or to renew a prescription. (Tr. 117-118) Dr. M kept him on Lamictal even after Applicant told Dr. M that he was taking vitamins and Chinese medicine. (Tr. 118) Dr. M never told him to stop taking Lamictal. (Tr. 118) In 2017, Applicant saw Dr. M's spouse because Dr. M was out of the office; however, he did not provide the dates when he saw Dr. M's spouse. (Tr. 119)

In November 2017, Applicant went to Europe with his spouse, and he forgot his medications. (Tr. 97) He discovered he felt better without his medications. (Tr. 97; SOR response, ¶ D.II) Without his medications, he felt stable and less groggy. (Tr. 98) He believes his mental health can be stable through a low carbohydrate diet and exercise.

(Tr. 99, 127; GE 2 at 2) When he cheats on his diet, symptoms of tiredness and lethargy return, which has occurred five or six times. (Tr. 127-128)

The DOD CAF asked Dr. B, a licensed clinical psychologist, to evaluate Applicant for continued access to classified information. (GE 2 at 1) In April 2020, Dr. B generated a psychological report for the DOD CAF. (GE 2) Dr. B considered Applicant's background information, her clinical interview and observations of Applicant, and Applicant's Personality Assessment Inventory (PAI). Dr. B provided a detailed mental-health history of Applicant, and she diagnosed him with Bipolar II Disorder, Depressive Disorder (moderate, recurrent, in partial remission), Generalized Anxiety Disorder, and Obsessive Compulsive Personality traits. (SOR ¶ 1.b; GE 2 at 5) Dr. B did not interview Applicant's spouse or coworkers. (Tr. 99-101) Dr. B explained the reasons for her diagnosis as follows:

> Applicant's presentation was inconsistent with his psychological test results, as he certainly is quite anxious, ruminative, and possibly hypomanic at this time. His insight is clearly lacking and his fixation on "blood sugar issues" and diet as opposed to voicing awareness of his psychiatric diagnoses is concerning. He describes a history of at least one hypomanic episode that he claims was the result of taking Ritalin as prescribed, although that is highly unlikely. He also describes numerous episodes of depression. Therefore, I find that the prior diagnosis of bipolar disorder is appropriate. It does not seem plausible that he has ADHD in my opinion, as he does not describe his attention as being problematic until adulthood. I suspect his attentional issues are related to his other psychiatric conditions. GE 2 at 5-6.

Dr. B's prognosis is as follows:

> The [A]pplicant's prognosis is poor, based on his limited insight and the absence of ongoing care for psychiatric conditions. This suggests increased risk for instability, which can lead to impairment in judgment, reliability, and trustworthiness. (GE 2 at 5-6)

Dr. S assessed Applicant's mental-health at Applicant's request. (Tr. 25-31) Dr. S is a licensed clinical social worker who has a Ph.D. in psychology. He has never held an active license in psychology "because I can't make [any] money doing that." (Tr. 32) His only testimony involved cases about the need for longer stays in hospitals. (Tr. 32) He said he has seen Applicant regularly about once a week since December 1, 2020, or perhaps it was about 20 times over 18 months. (Tr. 28-29) From December 1, 2020, to January 6, 2021, he said "[s]even sessions have been completed and no symptoms of Bipolar Disorder have been detected during this time. Neither have any other serious symptoms been uncovered during our sessions." (AE F) Applicant said Dr. S's sessions were about every two to four weeks. (Tr. 126) Dr. S did not review Applicant's past medical records. (Tr. 36, 41) He was unaware that Applicant experienced symptoms of Bipolar and Major Depressive Disorder for several years. (Tr. 38) Applicant told Dr. S about a depressive episode in 2005 and suicidal thoughts. (Tr. 39) He was aware

Applicant went four days with only three hours of sleep. (Tr. 40) In response to Department Counsel's question about not sleeping much for four days, Dr. S said he was aware of this fact "but I don't see that – I've done that, nobody is labeling me bipolar." (Tr. 40)

Dr. S most recently saw Applicant for a 50-minute clinical appointment on May 11, 2022, or May 13, 2022. (Tr. 34) He also saw Applicant on April 15, 2022, and on May 5, 2022. (Tr. 51) He based his diagnosis of "almost perfectionistic" on his interview of Applicant, his spouse, and his coworkers. (Tr. 33, 36) He noted in his report that Applicant "discontinued his prescriptions for bipolar three years ago due to visiting out of country and, serendipitously, having forgotten to bring his medications. No symptoms of bipolar appeared when the medications were not taken. This is attested to by his above average performance and being symptom free at work and at home." (Tr. 44; AE F) Dr. S suggested that Applicant was inconsistent about going to his appointments from 2011 to 2016 because Applicant "thinks he's found the cause and a solution. He stopped the meds, I know that . . . I don't know the details of why he would do that, I have no idea. I didn't know that, but I can't imagine being worried about it when you're doing fine." (Tr. 46)

Dr. S's diagnosis is that Applicant does not meet the criteria for Bipolar Disorder. (AE F) He is almost perfectionistic. (Tr. 35, 46-47) He did not talk to anyone who previously diagnosed Applicant. (Tr. 34) He does not provide "a serious diagnosis like bipolar or schizophrenic, [he] always asks for a second opinion." (Tr. 35) Applicant is not taking any medications. (Tr. 28) Applicant is "doing beautifully." (Tr. 29) He recommended that Applicant continue with talk therapy and psychotherapy because he believes "all folks could continue with talk therapy." (Tr. 34-35) He recommended that Applicant see a mental-health provider every 15 to 30 days "for his own mental growth, if he chooses, not because he really needs it, because he's trying to grow, to understand himself." (Tr. 49) His recommendation is that Applicant see a mental-health provider whenever Applicant deems it necessary or "as needed." (Tr. 50) He believes Applicant is trustworthy. (Tr. 29) Applicant received inconsistent diagnoses over the years, and bipolar disease is frequently incorrectly diagnosed. (Tr. 30) Incorrect prescriptions can have adverse medical effects. (Tr. 30) Cymbalta is prescribed for depression; however, it can trigger suicidal tendencies. (Tr. 31)

Dr. S was focused on Applicant's current behavior and how he was performing at work, and not on his mental-health history. (Tr. 41) He said he did not care about Applicant's diagnosis from three years ago. (Tr. 41) He acknowledged that "there's a possibility that they [will] fall back to where they were, but there's somebody trying to survive now. That's what I'm concerned with is now and the behavior." (Tr. 41)

Applicant does not have any concerns about his mental health, and he has not taken any medications for his mental health since November 2017. (Tr. 104, 119; SOR response, ¶ D.III) He does not believe he has Post Traumatic Stress Disorder. (Tr. 130) He does not believe he has a chronic mental illness, and he does not believe he needs psychiatric care. (Tr. 106, 120) He decided not to return to see Dr. M in 2017 after consulting with his spouse who does not have any training in psychology. (Tr. 120) If

problems develop, he plans to seek help from a mental-health practitioner. (Tr. 105) He is willing to see a mental-health provider once a month if it will satisfy security requirements. (Tr. 132)

Applicant said security officials told him the security issue was the Bipolar Diagnosis, and he believed his security issue was resolved when Dr. M changed his diagnosis from Bipolar to Depression. (Tr. 121-122) He wanted to do whatever he needed to do to resolve security concerns. (Tr. 122) He told his facility security officer (FSO) when the issue of his mental health first arose, and Applicant said "[e]ssentially that before he had a diagnosis that he later attributed to blood sugar and not the diagnosis he was given." (Tr. 60) Applicant told his FSO that he stopped following treatment recommendations and taking his medications without communicating with his treatment provider. (Tr. 61-62) The FSO did not recommend whether he should follow medical advice or tell him that he needed to communicate with his treatment provider about not taking his medications. (Tr. 62) He relied upon his FSO for advice on security matters. (Tr. 122) His FSO did not consider him a threat to national security. (Tr. 62-63)

Applicant did not know what to do when he received the SOR. (Tr. 123) He sought advice from supervisors in his company. (Tr. 123-124) They suggested he seek an opinion from a third party, and he sought assistance from Dr. S. (Tr. 124) He provided his medical records to Dr. S. (Tr. 125) Dr. S told Applicant he might have situational depression in 2005 because of stress. (Tr. 125-126)

Character Evidence

Applicant presented three character witnesses at his hearing and 16 written statements from his coworkers, friends, pastor and spouse. (Tr. 53-79; AE G) The general sense of their statements is that Applicant is friendly, reliable, diligent, professional, responsible, detail oriented, and trustworthy. (*Id*.) They did not provide any negative information about his mental health, work performance, and disciplinary actions. (*Id*.) He is a valued asset to his company who makes important contributions to his company. (*Id*.) He supports his spouse and his community. (*Id*.) His work performance is outstanding. (*Id*.) Their statements support his continued access to classified information. (*Id*.)

Policies

The U.S. Supreme Court has recognized the substantial discretion of the Executive Branch in regulating access to information pertaining to national security emphasizing, "no one has a 'right' to a security clearance." *Department of the Navy v. Egan*, 484 U.S. 518, 528 (1988). As Commander in Chief, the President has the authority to control access to information bearing on national security and to determine whether an individual is sufficiently trustworthy to have access to such information." *Id*. at 527. The President has authorized the Secretary of Defense or his designee to grant applicant's eligibility for access to classified information "only upon a finding that it is clearly consistent with the national interest to do so." Exec. Or. 10865.

Eligibility for a security clearance is predicated upon the applicant meeting the criteria contained in the adjudicative guidelines. These guidelines are not inflexible rules of law. Instead, recognizing the complexities of human behavior, these guidelines are applied in conjunction with an evaluation of the whole person. An administrative judge's overarching adjudicative goal is a fair, impartial, and commonsense decision. An administrative judge must consider all available, reliable information about the person, past and present, favorable and unfavorable.

The Government reposes a high degree of trust and confidence in persons with access to classified information. This relationship transcends normal duty hours and endures throughout off-duty hours. Decisions include, by necessity, consideration of the possible risk 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. Clearance decisions must be "in terms of the national interest and shall in no sense be a determination as to the loyalty of the applicant concerned." *See* Exec. Or. 10865 § 7. Thus, nothing in this decision should be construed to suggest that it is based, in whole or in part, on any express or implied determination about applicant's allegiance, loyalty, or patriotism. It is merely an indication the applicant has not met the strict guidelines the President, Secretary of Defense, and DNI have established for issuing a clearance.

Initially, the Government must establish, by substantial evidence, conditions in the personal or professional history of the applicant that may disqualify the applicant from being eligible for access to classified information. The Government has the burden of establishing controverted facts alleged in the SOR. *See Egan*, 484 U.S. at 531. "Substantial evidence" is "more than a scintilla but less than a preponderance." *See v. Washington Metro. Area Transit Auth.*, 36 F.3d 375, 380 (4th Cir. 1994). The guidelines presume a nexus or rational connection between proven conduct under any of the criteria listed therein and an applicant's security suitability. *See* ISCR Case No. 95-0611 at 2 (App. Bd. May 2, 1996).

Once the Government establishes a disqualifying condition by substantial evidence, the burden shifts to the applicant to rebut, explain, extenuate, or mitigate the facts. Directive ¶ E3.1.15. An applicant "has the ultimate burden of demonstrating that it is clearly consistent with the national interest to grant or continue his security clearance." ISCR Case No. 01-20700 at 3 (App. Bd. Dec. 19, 2002). The burden of disproving a mitigating condition never shifts to the Government. *See* ISCR Case No. 02-31154 at 5 (App. Bd. Sep. 22, 2005). "[S]ecurity clearance determinations should err, if they must, on the side of denials." *Egan*, 484 U.S. at 531; *see* AG ¶ 2(b).

Analysis

Psychological Conditions

AG ¶ 27 articulates the security concern for psychological conditions:

> 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 to 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.

AG ¶ 28 provides conditions that could raise a security concern and may be disqualifying in this case:

> (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 behaviors;
>
> (b) an opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness;
>
> (c) voluntary or involuntary inpatient hospitalization; and
>
> (d) failure to follow a prescribed treatment plan related to a diagnosed psychological/psychiatric condition that may impair judgment, stability, reliability, or trustworthiness, including, but not limited to, failure to take prescribed medication or failure to attend required counseling sessions.

The record establishes AG ¶¶ 28(b) and 28(d); however, AG ¶¶ 28(a) and 28(c) are not established. Further details will be discussed in the mitigation analysis, *infra*.

Five mitigating conditions under AG ¶ 29 are potentially applicable:

> (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.

The DOHA Appeal Board concisely explained Applicant's responsibility for proving the applicability of mitigating conditions as follows:

> Once a concern arises regarding an Applicant's security clearance eligibility, there is a strong presumption against the grant or maintenance of a security clearance. *See Dorfmont v. Brown*, 913 F. 2d 1399, 1401 (9th Cir. 1990), *cert. denied*, 499 U.S. 905 (1991). After the Government presents evidence raising security concerns, the burden shifts to the applicant to rebut or mitigate those concerns. *See* Directive ¶ E3.1.15. The standard applicable in security clearance decisions is that articulated in *Egan*, *supra*. "Any doubt concerning personnel being considered for access to classified information will be resolved in favor of the national security." Directive, Enclosure 2 ¶ 2(b).

ISCR Case No. 10-04641 at 4 (App. Bd. Sept. 24, 2013).

There is no evidence that Applicant engaged in any problematic behavior or was hospitalized for a mental-health issue. He followed all prescribed or recommended treatment from April 2011 to October 2014, from October 2014 to February 2016, and from January 2020 to present. However, AG ¶¶ 29(b) and 29(c) do not fully apply because there is no evidence Dr. S was acceptable to and approved by the U.S. Government, and he did not establish he is "a duly qualified mental health professional." Dr. S did not review Applicant's medical records and showed little interest in his mental-health history. His diagnosis of "almost perfectionistic" was inconsistent with the other diagnoses of multiple mental-health experts who treated Applicant from 2005 to 2017.

On July 25, 2013, Dr. M said Applicant "is doing well. Anxiety and mood level is great. *Illness history of Bipolar course was reviewed with [Applicant] with clear history of manic or hypomanic episodes* but ocp traits and anxiety and recurrent depressive episodes. No side effects from meds. Supportive and individual therapy was provided." (GE 4 at 17 (emphasis added))

DSM-5 states:

Bipolar II disorder, requiring the lifetime experience of at least one episode of major depression and at least one hypomanic episode, is no longer thought to be a "milder" condition than bipolar I disorder, largely because of the amount of time individuals with this condition spend in depression and because the instability of mood experienced by individuals with bipolar II disorder is typically accompanied by serious impairment in work and social functioning.

* * *

A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with manic-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced bipolar and related disorder and bipolar and related disorder due to another medical condition. (DSM-5 at 123)

The Diagnostic Criteria for Bipolar I disorder is as follows:

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic/episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.
Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.
Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder. (DSM-5 at 123-124)

The Diagnostic Criteria in DSM-5 for Major Depressive Disorder is as follows:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note**: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

(**Note**: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition. (DSM-5 at 160-161)

A manic or depressive episode may result in behavior that casts doubt on an individual's judgment, stability, reliability, or trustworthiness, and it may result in an emotional, mental, or personality condition, including, but not limited to, irresponsible behavior or self-harm. A person in the throes of a manic or depressive episode might jeopardize national security. See DSM-5.

In ISCR Case No. 19-00151 (App. Bd. Dec. 10, 2019) the Appeal Board affirmed the grant of a security clearance in a case involving conflicting expert mental-health witness opinions, and cogently explained the necessity of reconciling opposing expert witness opinions stating:

> A Judge is required to weigh conflicting evidence and to resolve such conflicts based upon a careful evaluation of factors such as the comparative reliability, plausibility, and ultimate truthfulness of conflicting pieces of evidence. *See, e.g.,* ISCR Case No.05-06723 at 4 (App. Bd. Nov. 4, 2007). A Judge is neither compelled to accept a DoD-required psychologist's diagnosis of an applicant nor bound by any expert's testimony or report. Rather, the Judge has to consider the record evidence as a whole in deciding what weight to give conflicting expert opinions. *See. e.g.,* ISCR Case No. 98-0265 at 4 (Mar. 17, 1999) and ISCR Case No. 99-0288 at 3 (App. Bd. Sep. 18, 2000).

After a careful review of the evidence, I believe Dr. M's initial diagnosis and Dr. B's diagnosis and prognosis are the most accurate and reliable diagnoses and prognosis. The record documents a history of multiple depressive episodes and at least one manic episode. Dr. S's diagnosis of "almost perfectionistic" and the resulting prognosis are unreliable because he did not review Applicant's mental-health records, consult with previous treatment providers, or perform psychological testing. Moreover, he was an evasive witness. For example, one of the criteria for a manic episode is "Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)." (DSM-5 at 123-124) In response to Department Counsel's question about this symptom, Dr. S said he was aware of this fact "but I don't see that – I've done that, nobody is labeling me bipolar." (Tr. 40) He did not explain how he factored in this symptom in his diagnosis in light of the DSM-5 criteria.

Dr. B opined, "The [A]pplicant's prognosis is poor, based on his limited insight and the absence of ongoing care for psychiatric conditions. This suggests increased risk for instability, which can lead to impairment in judgment, reliability, and trustworthiness." (GE 2 at 6) Applicant did not go to any appointments with Dr. M from October 24, 2014, to March 30, 2016, and from 2017 to December 2020. He did not seek mental-health treatment advice before stopping his use of Lamictal. In December 2020, he started seeing Dr. S, who supported his notion that his mental-health problems related to diet, and he did not have bipolar disorder or any other serious mental-health disorder. I am not convinced that Dr. S was providing sound medical advice to Applicant about treatment of his mental-health disorders.

I have lingering concerns that Applicant's mental-health condition may impair his judgment, stability, reliability, and trustworthiness. He may miss future appointments, not accept the diagnosis of competent mental-health practitioners, elect to stop taking prescribed medication, and a depressive or manic episode may result with an adverse impact on national security. Security concerns under Guideline I are not mitigated at this time.

Whole-Person Analysis

In all adjudications, the protection of our national security is the paramount concern. A careful weighing of a number of variables in considering the "whole-person" concept is required, including the totality of Applicant's acts, omissions, and motivations. Each case is decided on its own merits, taking into consideration all relevant circumstances and applying sound judgment, mature thinking, and careful analysis. Under the whole-person concept, the administrative judge and the PSAB should consider the nine adjudicative process factors listed at AG ¶ 2(d):

> (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 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.

Under AG ¶ 2(c), "[t]he ultimate determination" of whether to grant a security clearance "must be an overall commonsense judgment based upon careful consideration of the guidelines" and the whole-person concept. My comments under Guideline I are incorporated in my whole-person analysis. Some of the factors in AG ¶ 2(d) were addressed under that guideline but some warrant additional comment.

Applicant is a 44-year-old senior field test engineer, and he has worked for his current employer, a DOD contractor managing laboratories developing simulators and fielding manuals for devices for the Army for six years. From 2005 to 2015, Applicant worked for DOD contractors training helicopter pilots on simulators, supported engineers in a development environment, and worked with simulators for another DOD contractor. He served in the Army National Guard from 1996 to 2005, and he was honorably discharged as a Chief Warrant Officer 2 in 2005. He was an Apache helicopter mechanic and pilot. He served a tour in Kuwait from 1999 to 2000. He has held a security clearance since 1997. There is no evidence of security violations. He has never received any adverse employment actions such as reprimands or suspensions.

The general sense of his character statements is that Applicant is friendly, reliable, diligent, professional, responsible, detail oriented, and trustworthy. They did not provide any negative information about his mental health, work performance, and disciplinary actions. He is a valued asset to his company. He supports his spouse and his community. His work performance is outstanding. Their statements support his continued access to classified information.

Applicant received mental-health counseling and was prescribed drugs to stabilize his mood from 2005 to 2017. In 2017, he unilaterally decided that he would stop taking prescribed medications and he would stop attending appointments with Dr. M. He did not communicate about these decisions with Dr. M. On October 30, 2020, the SOR was issued, and in December 2020, he elected to see Dr. S to help him present favorable evidence to improve his chances of maintaining his security clearance. Dr. M, Dr. S, and Applicant do not believe he has a mental-health diagnosis that raises security concerns.

Dr. B provided a detailed mental-health history of Applicant, and she diagnosed him with Bipolar II Disorder, Depressive Disorder (moderate, recurrent, in partial remission), Generalized Anxiety Disorder, and Obsessive Compulsive Personality traits. Dr. B opined that "The [A]pplicant's prognosis is poor, based on his limited insight and the absence of ongoing care for psychiatric conditions. This suggests increased risk for instability, which can lead to impairment in judgment, reliability, and trustworthiness." (GE 2 at 5-6) Dr. B's diagnosis and prognosis are given greater weight than the other diagnoses and prognoses of record.

It is well settled that once a concern arises regarding an applicant's security clearance eligibility, there is a strong presumption against granting a security clearance. *See Dorfmont*, 913 F. 2d at 1401. "[A] favorable clearance decision means that the record

discloses no basis for doubt about an applicant's eligibility for access to classified information." ISCR Case No. 18-02085 at 7 (App. Bd. Jan. 3, 2020) (citing ISCR Case No. 12-00270 at 3 (App. Bd. Jan. 17, 2014)).

I have carefully applied the law, as set forth in *Egan*, Exec. Or. 10865, the Directive, the AGs, and the Appeal Board's jurisprudence to the facts and circumstances in the context of the whole person. Guideline I security concerns are not mitigated.

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 and 1.b:	Against Applicant

Conclusion

In light of all of the circumstances presented by the record in this case, it is not clearly consistent with the interests of national security to grant Applicant's eligibility for access to classified information. Eligibility for access to classified information is denied.

_____
Mark Harvey
Administrative Judge