DATE: October 18, 2002

In re:

SSN: ----------

Applicant for Security Clearance

ISCR Case No. 01-15700

DECISION OF ADMINISTRATIVE JUDGE

ROGER C. WESLEY

APPEARANCES

FOR GOVERNMENT

Henry Lazzaro, Department Counsel

FOR APPLICANT

Stephen J. Dunn

SYNOPSIS

Applicant with long history of binge drinking and diagnoses of dependence/problem drinking and emotional disorders, intermixed with relapses in between treatment regimens and periods of abstinence, who provided unreliable information about his treatment history and continued alcohol use until confronted by a DSS agent, fails to mitigate security risks associated with his alcohol and emotional disorders and disclosure deficiencies sufficient to restore him to the level of judgment, reliability and trustworthiness compatible with minimum requirements of clearance eligibility. Clearance is denied.

STATEMENT OF THE CASE

On February 4, 2002, the Defense Office of Hearings and Appeals (DOHA), pursuant to Executive Order 10865 and Department of Defense Directive 5220.6 (Directive), dated January 2, 1992, issued a Statement of Reasons (SOR) to Applicant, which detailed reasons why DOHA could not make the preliminary affirmative finding under the Directive that it is clearly consistent with the national interest to grant or continue a security clearance for Applicant, and recommended referral to an administrative judge to determine whether clearance should be granted, continued, denied or revoked.

Applicant responded to the SOR on March 21, 2002, and requested a hearing. The case was assigned to this Administrative Judge on June 13, 2002, and scheduled for hearing on July 15, 20022. To accommodate evidentiary issues, the hearing was continued. The case was rescheduled for hearing on August 21, 2002 for August 27, 2002. A hearing was convened on August 27, 2002, for the purpose of considering whether it would be clearly consistent with the national interest to grant, continue, deny or revoke Applicant's security clearance. At hearing, the Government's case consisted of eight exhibits and one witness (a DSS agent); Applicant relied on four witnesses (including himself) and two exhibits. The transcript (R.T.) of the proceedings was received on September 6, 2002.

PROCEDURAL ISSUES

Before the close of the hearing, the Government moved to amend the SOR to conform to the evidence presented by Applicant through his psychiatric expert (*see* R.T.,at 104): Specifically, Government sought to add a new Guideline I allegation based on (a) diagnosed panic and anxiety disorders that in the opinion of Applicant's evaluating psychiatrist could have impaired cognitive functioning during a high state of anxiety that could indicate a defect in judgment (at the time), reliability and stability, albeit mostly in situational specific settings when confronted with circumstances of childhood sexual abuse and (b) past failures to follow medical advice relative to to prescribed medications. For good cause shown, after noting Applicant's objection, the requested amendment was granted, subject to affording Applicant the opportunity to recall its psychiatric expert for additional testimony, either live or by telephonic conference, and, if needed, supplemental medical reports (*see* R.T., at 109-121). Applicant was afforded seven (7) days in which to make any request to supplement the record with either medical testimony or reports. Within the time submitted, Applicant confirmed he did not wish to supplement the record. With this confirmation, the record closed.

Official notice is taken of the *DSM-IV* (4th ed. Am. Psych. Assoc. 1994), which was relied on by Applicant's professional evaluator in his written report (ex. A) and implicitly by the Government who embraced the professional's findings with its SOR amendment. Official notice is also taken of the *Physicians' Desk Reference* (1997 ed.), which explains the attributes, type, clinical trials and potential effects of medications, to include the Prozac and Wellbutrin prescribed to Applicant based on the medical reports in evidence.

STATEMENT OF FACTS

Applicant is a 31-year old physicist for a defense contractor who seeks a security clearance.

Summary of Allegations and Responses

Applicant is alleged to have abused alcohol over a seven year period as follows: (a) He consumed alcohol, at times to excess and to the point of intoxication, at times consuming 24 beers in one day, from approximately 1984 to at least February 2001; (b) he sought counseling in 1995 at his university because of concern about his abuse of alcohol, which he used to medicate depression; ©) consumed alcohol (at times two beers at lunch) during work hours from 1995 to at least February 2001; (d) he was involved in an automobile accident in 1997, while driving a company vehicle, and after he consumed alcohol during his lunch hour; (e) he received treatment from December1997 to July 1998 at B Inc., for a condition diagnosed as alcohol dependence, and experienced several relapses of alcohol abuse during this treatment; (f) he asked Dr. O, a general practitioner, in 1998 to prescribe the drug Revia to him to inhibit his alcohol use; (g) he was arrested in August 2000 and charged with DuI, driving with blood alcohol content (BAC) greater than .10 per cent, and speeding; he is alleged to have been fined as to Count One and fined $490.00 plus court costs, and placed on one year of supervised probation with drug/alcohol counseling in accordance with instructions from his probation office, with the other counts dismissed; (h) he attended an alcohol education program from August through November 2000, at a local substance abuse focused education associates group (SAFE); (I) his probation officer required additional alcohol counseling at a local substance abuse treatment center R Center), which he acceded to and began attending counseling in February 2001, where he was diagnosed as problem drinker; and (j) he continues to consume alcohol, notwithstanding his treatment for alcohol dependence, as outlined above.

Additionally, Applicant is alleged to have been cited in January 1999 for failure to stop at a stop light, and later fined $120.00, for which he failed to appear in February 2001 to answer the charges, and is subject to issuance of a failure to appear warrant. Allegedly, Applicant failed to inform his supervising probation officer (re: his conviction of his August 2000 DuI offense) of his prior alcohol treatment. Also, Applicant allegedly, failed to reveal to his SAFE counselors in August 2000 that he had received prior alcohol treatment. And Applicant allegedly falsified material facts in (a) a DSS interview conducted in January 2001 by failing to disclose his prior alcohol counseling in 1995 at his university and 1997-1998 treatment for diagnosed alcohol dependence at A Facility and (b) a DSS signed, sworn statement in January 2001 (falsely denying any post August 2000 drinking) and a DSS signed, sworn statement of February 2001 (falsely denying any alcohol treatment in 1995).

Applicant is alleged to have committed criminal conduct as well by reason of his August 2000 DuI conviction and falsification of facts in his DSS interview and ensuing DSS statements.

For his response to the SOR, Applicant admits some of the allegations: (I) consuming beer at lunch with fellow employees between 1995 and at least February 2001, (ii) consuming alcohol in 1997 just prior to driving a company car and having an auto accident in an unfamiliar area, requesting Dr. O to prescribe Revia to him to help him lessen the effects of his PTSD and panic disorders and inhibit his alcohol use (changed by the provider to Prozac), (iii) attending a SAFE program from August 2000 to November 2000 on his own volition, a course he successfully completed without consuming alcohol, (iv) attending additional alcohol counseling, beginning in February 2001 (this mandated by his probation officer) with R Center, which he successfully completed without consuming alcohol, (v) continuing to consume alcohol notwithstanding his prior treatment for alcohol dependence (save for the periods when he was under treatment), (vi) affirming in a signed sworn DSS statement of January 2001 that he had not consumed alcohol since his August 2000 arrest, affirming in another signed, sworn statement (this one of February 2001) that he had not received any alcohol treatment save for his B Inc. and SAFE treatment, and implicitly omitting his post-August 2000 consumption of alcohol and prior 1995 counseling, and (vii) violating 10 U.S.C. Sec. By his DSS omissions, assuming they can be proven. Applicant denied the balance of the allegations, with explanations.

Relevant and Material Factual Findings

The allegations covered in the SOR and admitted to by Applicant are incorporated herein by reference adopted as relevant and material findings. Additional findings follow.

While just 13 years of age (based on the accepted credible account he furnished B Inc. in 1995), Applicant began consuming alcohol. By the time he reached high college, he was drinking regularly on weekends, on some occasions (but not regularly) consuming as much as 24 beers in a day.

Applicant's alcohol history and record of psychiatric disorders

Concerned enough about his periodic depressed states and self medicating with alcohol while in college (oft-drinking to intoxication), Applicant sought alcohol counseling from school counselors in 1995. By this time, he had already experimented with all types of drugs and classified himself as a binge drinker (*see* ex. 1). He claims to have learned more about himself, including his previously undiagnosed post traumatic stress syndrome (PTSD) traced to a childhood incident of sexual molestation. His binges had become more frequent and prompted him to seek earlier psychiatric counseling and hospitalization with SO: in 1995 (*see* exs 1 and 2), when he was diagnosed with depression and prescribed Prozac (an anti-depressant). Convinced he could work his depression problems without the aid of medication, however, he soon quit using Prozac on his own, without medical authority, and returned to self medicating with alcohol. Briefly, he returned to taking prescribed Prozac in 1996 while under psychiatric treatment with SO, only to quit using the medication once again (*see* ex. 7).

With his return to abusive drinking following counseling (in 1995), Applicant sometimes consumed beer at lunch hours with co-workers (as many as two per setting), a practice he continued through January 2002. His drinking practices included periodic binge drinking (up to 24 beers in a day) up to February 2001 (*see* ex. 2). The evidence is not enough, however, to impute any work deficiencies or impairment as the result of his drinking at lunch.

While attending a Christmas party at work in late 1997,Applicant consumed several drinks with his fellow co-workers. After returning to work from the party, he drove a company vehicle in an unfamiliar area, hit gravel, and panicked. In turn, he hit a barrier, which caused minor damage to the vehicle. He fixed the vehicle and was apparently never reprimanded for the incident. Enough alcohol consumption is attributed to Applicant before the accident, however, to characterize the incident as alcohol-related.

By Applicant's own acknowledgments, he had lost control of his drinking by the time he self-referred himself to B Inc. for substance abuse treatment in December 1997, following his alcohol-related accident (*see* ex. 3). Upon his admission at B Inc., Applicant provided a case history to the facility. In this case history, he related an experience of sexual abuse as a child and described his physical health as in a deteriorating state, without identifying which of his alcohol or diagnosed depression were causative or influential of the other. was diagnosed with alcohol dependence (*see* ex. 1).

To be sure, Applicant takes issue with the pattern of drinking attributed to him by B Inc. (beginning at the age of 13) in its medical history summary of January 1998. Without anything more to corroborate his claims of later introduction to

alcohol, the initiation time attributed to him in B Inc.'s medical history provides the most objective historical description and is accepted. What is clear from the compiled medical history of Applicant by B Inc. is this: By the time he sought counseling from B Inc. in December 1997, he had experienced diagnosed bouts of depression, suspended his prescribed medication, and began to self medicate with alcohol to reduce his emotional pain. He had become so concerned enough about his drinking as to cause him considerable worry about his overall health (ex. 1).

Growing up with caring and supportive parents, Applicant enjoyed a normal upbringing, which was interrupted from time to time with verbal abuse of his family when he didn't get his way. Dedicated to his work, he became a workaholic which tended to seclude him and impair his ability to fashion a healthy social life. With few outlets to vent his episodes of depression, anxieties and stresses, he came to rely on alcohol as a form of self-medication. His alcohol consumption between 1996 and 1997 was for the most part regular, and at times to excess (up to 24 beers in a day). He insists he did enjoy some periods of abstinence during this time span, claims not disputed by any of medical counselors and accepted (*see* exs. 1 and 6).

In its admission diagnosis of December 1997, B Inc. diagnosed Applicant with alcohol dependence on the Axis I diagnostic qualifier, and personality disorders (unspecified) on his Axis 2 qualifier. Noted Axis IV stressors included loss of interest in life's activities, blaming of others for his continued abuse of alcohol, resistance to notions of powerlessness over chemicals and life's unmanageability. He is described in the report as tended to intellectualize his alcohol problem and resistant to recovery network participation, like Alcoholics Anonymous ("AA"), and hindered by "many emotional stuck points" that could pose relapse risks (ex. 1). No real improvement was cited in A Inc.'s discharge summary: Axis I, alcohol dependence; Axis II, depression, currently on Prozac (an anti-depressant, reputed to produce uncertain results over extended periods exceeding six weeks, *see Physicians' Desk Reference, supra,* at 936), Axis III, no current medical pathology, and Axis IV deferred stressors. When discharged from B Inc. in July 1998, Applicant was credited with increased interest in life's pleasure activities and developed interpersonal relationships within the 12 step recovery groups. Still, he was discharged with pronounced difficulties in accepting powerlessness over alcohol, evidenced by several drinking relapses during his treatment regimen, which he always minimized (ex. 1). He is described as leaving the B Inc. Program with some understanding of how to build a recovery network (through the 12 step program, to include AA meetings, a sponsor and developing recovery related activities). However, upon discharge from the program he remained in denial and unreceptive "to the idea of personal powerlessness over alcohol" (ex. 1). Recommendations for Applicant's continued recovery included continued focus on his denial, minimization of his alcoholism, and taking responsibility for his ongoing recovery (rather than relying on his parents to guide or steer him in the right direction).

By all accounts, Applicant did not enroll in AA or any other support group following his July 1998 discharge from B Inc. Rather, he relapsed into resumed drinking and turned his attentions to finding prescription medication to absorb his anxiety and panic attacks, which continued after his discharge. While it is not entirely clear which of his diagnosed disorders were most responsible for causative reactions in the other, inferences warrant that his disorders were co-occurring and interrelated.

At his spouse's urging, Applicant sought counseling from Dr. O (a general practitioner) in August 1998. He asked Dr. O to prescribe Revia to lessen his panic attacks. She declined his request and instead prescribed Prozac (*see* R.T., at 198). With Prozac, Applicant achieved relief from his panic attacks for a brief time. There are no indications in the evidence, though, that Dr. O ever titrated or monitored Applicant's Prozac medication over time to address any side affects he may have experienced from the medication. And by 1999, Applicant had once again voluntarily suspended any further use of Prozac, sans medical authority (*see* ex. A; R.T., at 99, 159).

Applicant continued drinking at various levels of consumption after August 1998. After drinking a number of beers in the evening of August 12, 2000, he was stopped by federal park police for suspected speeding, administered a field sobriety test, and arrested. Back at the police station, he registered .14 per cent blood alcohol content (BAC) on a Breathalyzer back at the station and was charged with DuI (*see* ex. 8). Applicant claims his high BAC level was influenced by chewing tobacco in his mouth at the time. His claims are not supported, however, by scientific proof of a valid correlation between chewing tobacco and registered BAC levels. Applicant's claims are speculative at best and without anything more corroborative cannot be accepted.

In court on DuI/speeding charges arising out of the August 2002 incident, Applicant was found guilty of DuI with BAC greater than .10 per cent and was fined $490.00, plus imposed court costs, and placed on one year of supervised probation with drug/alcohol counseling on the recommendations of his probation office. Counts 2 and 3 of the charges against him were, in turn, dismissed (ex. 8).

Applicant enrolled in the court ordered alcohol education program entitled SAFE in August 2000 and attended regular sessions between August and November 2000. Applicant declined to disclose his prior alcohol and psychiatric treatment history, and his counselors at SAFE, in turn, credited him with no history of alcohol abuse or emotional problems. Based on his having a clean prior record, his SAFE counselors recommended he attend alcohol drug education sessions at SAFE for a period of 12 weeks (one session per week), submit to random urinalyses and attend at least one AA meeting during his SAFE treatment program. This Applicant agreed to do and by all accounts satisfied the conditions imposed by his SAFE counselors, including his attending twice weekly AA meetings during the duration of his treatment program. Applicant was credited with successfully completing his 12-week DuI program with SAFE in November 2000, albeit based on the limited background information Applicant furnished his SAFE counselors (*see* ex. 5).

Besides referring Applicant to alcohol education, Applicant's probation officer required he attend additional alcohol counseling at R Center. Commencing this counseling in February 2001, Applicant was diagnosed by his R Center counselors as a problem drinker (*see* ex. 6). As with his SAFE counselors before, Applicant did not disclose to either his R Center counselors or his probation officer his prior psychiatric counseling and treatment (including his counseling treatment with Dr. O in 1998), or any of alcohol-related /counseling/treatment with his university in 1995, and with B Inc. in 1997 and 1998, respectively.

Since his discharge from SAFE and R Center in 2001, Applicant has continued to consume alcohol, albeit not to any intoxicating levels that can be documented (*compare* ex. A with R.T. at 188-89, 192-93), and reportedly returned to work with alcohol on his breath as recently as January 2002 (*see* R.T., at 130, 183-84). His claims that he can continue to drink responsibly with his current prescribed medication for addressing his various emotional disorders (to include his most recently diagnosed anxiety disorder) must be weighed on the basis of all of Applicant's drinking history (to include continued drinking following his dependence diagnosis, at times up to 24 beers in a day), past treatment, assigned estimates, and common sense qualifiers.

Applicant's pre-hearing psychiatric evaluation

Prior to the scheduled hearing, Applicant was evaluated (in July 2002) by Dr. Z (a board certified psychiatrist). After taking Applicant's alcohol and psychiatric history, including a review of Applicant's treatment records, Dr. Z conducted a psychiatric examination. Finding Applicant neatly groomed and cooperative in his demeanor, Dr. Z identified Applicant as manifestly stressed (appearing for his interview with a full gallon jug of water), most of which he consumed during the interview. Dr. Z found Applicant's mood and affect within normal range, but detected considerable anger in Applicant towards the DSS agent who interviewed him and reportedly cast aspersions on his character (ex. A). Applicant described his attention span as much more limited since the investigation due to loss of motivation and dampening of senses. Dr. Z diagnosed Applicant on the Axis 1 coordinate with anxiety disorder NOS, stable on prescribed medication, and alcohol dependence, in remission. Dr. Z described Applicant's anxiety disorder as longstanding, with features of PTSD (related to childhood sexual abuse), general anxiety disorder, and panic disorder. Noting that Applicant was on prescribed anti-depressant medication (Wellbutrin), however, since June 2002, he opined that he could not detect any current anxiety symptoms in Applicant.

So, too, Dr. Z opined that he could detect no discernible pattern of abusive drinking by Applicant over the past three to four years: nothing on the basis of what either Applicant or his spouse related to him during the course of the interview. Finding Applicant to have taken positive steps since 1997 to reduce his drinking, Dr. Z was able to conclude that Applicant's alcohol dependence disorder was in remission (*see* ex. A). Dr. Z did not indicate any awareness of Applicant's returning to work smelling of alcohol (*see* Ms. C's account, *infra*,), or to his consuming 24 beers in a day at various times between 1995 and January 2001.

Dr. Z could not identify the source of the medical prescriber of Applicant's Wellbutrin; nor did Applicant, other than to

attribute the source of the prescription to his general practitioner (*see* R.T., at 186). Wellbutrin is an anti-depressant, which like Prozac, is reported to produce uncertain results over and extended period exceeding six weeks, and requires physician monitoring. *See Physicians' Desk Reference, supra,* at 1178. No indications of any follow-up monitoring of Applicant are indicated.

At hearing, Dr. Z acknowledged he was not aware of Applicant's participating in any AA program following his discharge from B Inc. in 1998, or of his being currently enrolled in any regular AA or comparable network program (*see* R.T., at 97). Dr. Z could offer no persuasive explanations as to why Applicant discontinued his Prozac medications earlier without medical authority. Left unchecked by his medication, Dr. Z acknowledged in his hearing testimony (*see* R.T., at 89) that attacks produced by Applicant's anxiety/panic disorders could create cognitive dysfunction: defects in judgment and reliability. Because Dr. Z could not detect any active alcohol or panic symptoms, it is difficult to gauge the extent to which he believes Applicant's history of co-occurring disorders are interrelated and causally linked. Dr. Z's assessments are not challenged by any other competent medical authority and are accepted as far as they go. Based on Applicant's prior experiences and uncertainty over the long range efficacy of his prescribed Wellbrutin (which are not accompanied by any evidence of titrating or monitoring by his treating physician), the relapse potential of Applicant's turning to self medicating freshly emergent symptoms of his emotional disorders cannot be ruled out.

Applicant's DSS interviews with Agent A

Applicant was first interviewed by Agent A in January 2001. When asked about prior alcohol treatment or counseling (*see* ex. 4), he admitted only his 2000 counseling with SAFE, and insisted he had not received any other counseling or treatment (*see* 4). In the signed, sworn statement he gave to Agent A at the end of the interview, he not only omitted both his prior university counseling in 1995 and the treatment he received at B Inc. in 1997, but he falsely claimed abstention from alcohol since his 2000 arrest and no intention to consume alcohol in the future (*see* ex. 4; R.T., at 214-16).

Confronted by Agent A in a follow-up DSS interview in February 2001, Applicant admitted treatment for alcohol by B Inc. in 1997, as well as to treatment for depression by SO in 1996, and later from Dr. O, each of whom prescribed Prozac (*see* ex. 7). These admissions came, however, only after Agent A overcame initial Applicant resistance to provide medical releases (over expressed concerns about sexual content in his medical records). To overcome this Applicant resistance, Agent A does recall telling Applicant about other sexually explicit examples: not to intimidate or provoke Applicant, but to demonstrate DSS custom in reviewing such material when examining applicant medical records (*see* R.T., at 38-40). If in hindsight, such illustrations recounted to Applicant in his interview might be considered insensitive and likely to provoke flash backs to early childhood experiences, Agent A by his testimony and hearing demeanor does not appear to have been aware of Applicant's sensitivities to his childhood sexual experience, much less what kind of anxiety and stress it might produce.

In his first follow-up interview in February 2001, Applicant did admit to his consuming alcohol on lunch breaks into January 2001, and to other post-2000 arrest drinking. However, Applicant again omitted his1995 university counseling, later claiming to have forgotten it. Applicant's mental lapse claims cannot be readily accepted without considering both his admissions of falsely swearing to a more limited alcohol consumption and treatment history, his attempted trimming on the extent of his stated drug history to B Inc. counselors in 1997, his omission of his prior treatment and post-2000 DuI drinking to his SAFE and R Center counselors (*see* exs. 5 and 6), and his possible withholding of any further treatment and drinking from his probation officer (*see* R.T., at 204). True, Applicant denies concealing this information from his treatment counselors in his hearing testimony and insists his probation officer never inquired about it (*see* R.T., at 177, 179, 203-04). Without more probative evidence (such as corroboration from SAFE and R Center counselors), however, their reports must be respected as accurate, along with B Inc's report. Further, as against Applicant's response and hearing claims that he was pressured and intimidated by an agitated Agent A into his making admissions just to escape the interview (*see* R.T., at 209-11, 230-31) are his hearing acknowledgments that his admissions in both of his February 2001 signed, sworn statements are line-for-line correct (*see* R.T., at 216-30). Applicant's DSS omissions of his prior treatment and ongoing drinking were preceded by his failure to inform either his SAFE or R Center counselors, or his probation counselor, of his prior alcohol and psychiatric counseling/treatment (*compare* exs. 5 and 6).

Fear of his treatment counselors and probation officer finding out about his more extensive alcohol use and psychiatric

counseling/treatment was confirmed by Applicant to Agent A (*see* R.T., at 31-32) and provides a more convincing explanation of Applicant's DSS omissions than his claims of pressing fears of panic prompted by any lurid references by Agent A in his confronting of Applicant about his alcohol and treatment history. This plausible inference could not be discredited by Dr. Z when asked at hearing. For Dr. Z had not reviewed Applicant's DSS statements with Applicant in his pre-hearing evaluative interview (*see* R.T., at 79) and, consequently, could offer no convincing medical explanation for Applicant's misstating his more extensive alcohol and treatment history.

Moreover, certified DSS agents are presumed to follow established interviewing techniques and cannot be found to have strayed from their high standards without credible, convincing evidence. With so many recorded instances of alcohol abuse, departures from prescribed treatment regimens, and omissions of material information about his alcohol and treatment history from his treatment counselors, probation officer and DSS interviewer, Applicant's insistent claims of an agitated, inciteful Agent A pressing Applicant into making inflated admissions cannot be accepted as credible (*compare* Agent A's contra-assurances of professionalism during each of his interviews of Applicant, R.T., at 33). Inferentially, Applicant's claims that his erratic answers were provoked by Agent A with sexually provocative stories and pejorative comments about his alcohol and marriage designed to exploit his (Applicant's) PTSD and panic disorders cannot under all the circumstances presented be accepted.

Applicant is reputed to be hard working and responsible by a Government colleague (Ms. C) with knowledge of his work ethics. The stress of addressing his clearance investigation caused him to be replaced by his company in February 2002 after missing much of the month of January (*see* R.T., at 127-28). How much drinking contributed to his missing work during this period is less than clear, but Ms. C detected alcohol on his breath on at least once occasion in January 2002 (R.T., at 130): an observation Applicant does not deny (*see* R.T., at 183-84). Applicant assures he remains in his company's employ (*see* R.T., at 184-85, 204-05), subject to call back pending resolution of his clearance investigation. Just what are Applicant's employment terms and status at this time is less than certain. The most that can be factually inferred are his claims that he is still in his company's employ, but moved to occasional status pending completion of his current clearance proceedings due to his taking off in January 2002 without clearing it with his supervisor. Terms and conditions of his return to work are too sketchy to draw any reliable inferences.

POLICIES

The Adjudicative Guidelines of the Directive (Change 4) list "binding" policy considerations to be made by Judges in the decision making process covering DOHA cases. The term "binding," as interpreted by the DOHA Appeal Board, requires the Judge to consider all of the "Conditions that could raise a security concern and may be disqualifying" (Disqualifying Conditions), if any, and all of the "Mitigating Conditions," if any, before deciding whether or not a security clearance should be granted, continued or denied. The Guidelines do not require the Judge to assess these factors exclusively in arriving at a decision. In addition to the relevant Adjudicative Guidelines, judges must take into account the pertinent considerations for assessing extenuation and mitigation set forth in E.2.2 of the Adjudicative Process of Enclosure 2 of the Directive, which are intended to assist the judges in reaching a fair and impartial common sense decision.

Viewing the issues raised and evidence as a whole, the following adjudication policy factors are pertinent herein:

Alcohol Consumption

Concern: Excessive alcohol consumption often leads to the exercise of questionable judgment, unreliability, failure to control impulses, and increases risk of unauthorized disclosure of classified information due to carelessness.

Disqualifying Conditions:

DC 1 Alcohol-related incidents away from work, such as driving while under the influence, fighting, child or spouse abuse, or other criminal incidents related to alcohol use.

DC 2 Alcohol-related incidents at work, such as reporting for work or duty in an intoxicated or impaired condition, or drinking on the job.

DC 3 Diagnosis by a credentialed medical professional (*e.g.,* physician, clinical psychologist, or psychiatrist) of alcohol abuse or alcohol dependence.

DC 5 Habitual or binge consumption of alcohol to the point of impaired judgment.

Mitigating Conditions:

MC 1 The alcohol-related incidents do not indicate a pattern.

MC 2 The problem occurred a number of years ago and there is no indication of a recent problem.

MC 3 Positive changes in behavior supportive of sobriety.

Personal Conduct

Concern: Conduct involving questionable judgment, untrustworthiness, lack of candor, dishonesty, unreliability, or unwillingness to comply with rules and regulations could indicate that the person may not properly safeguard classified information.

Disqualifying Conditions:

DC 3 Deliberately providing false or misleading information concerning relevant and material matters to an investigator, security official, competent medical authority, or other official representative in connection with a personnel security or trustworthiness determination.

DC 5 A pattern of dishonesty or rule violations.

Mitigating conditions:

MC 1 The information was unsubstantiated or not pertinent to a determination of judgment, trustworthiness, or reliability.

Criminal Conduct

Concern: A history or pattern of criminal activity creates doubt about a person's judgment, reliability, and trustworthiness.

Disqualifying Conditions:

DC 1 Allegations or admission of criminal conduct.

DC 2 A single serious crime or multiple lesser offenses.

Mitigating Conditions:

MC 1 The criminal behavior was not recent.

MC 2 The crime was an isolated incident.

Emotional, Mental and Personality Disorders

Concern: Emotional, mental, and personality disorders can cause a significant deficit in an individual's psychological, social and occupational functioning. These disorders are of security concern because they may indicate a defect in judgment, reliability, or stability.

Disqualifying Conditions:

DC 1 An opinion by a credentialed mental health professional that the individual has a condition or treatment that may indicate a defect in judgment, reliability, or stability.

DC 2 Information that suggests that an individual has failed to follow appropriate medical advice relating to treatment of a condition, *e.g.,* failure to take prescribed medication.

DC 4 Information that suggests that the individual's current behavior indicates a defect in his or her judgment or reliability.

Mitigating Conditions:

MC 1 There is no indication of a current problem.

MC 2 Recent opinion by a credentialed mental health professional that an individual's previous emotional, mental, or personality disorder is cured, under control, or in remission, and has a low probability of recurrence or exacerbation.

Burden of Proof

By virtue of the precepts framed by the Directive, a decision to grant or continue an Applicant's request for security clearance may be made only upon a threshold finding that to do so is clearly consistent with the national interest. Because the Directive requires Administrative Judges to make a common sense appraisal of the evidence accumulated in the record, the ultimate determination of an applicant's eligibility for a security clearance depends, in large part, on the relevance and materiality of that evidence. As with all adversary proceedings, the Judge may draw only those inferences which have a reasonable and logical basis from the evidence of record. Conversely, the Judge cannot draw factual inferences that are grounded on speculation or conjecture.

The Government's initial burden is twofold: (1) It must prove any controverted fact[s] alleged in the Statement of Reasons and (2) it must demonstrate that the facts proven have a nexus to the applicant's eligibility to obtain or maintain a security clearance. The required showing of nexus, however, does not require the Government to affirmatively demonstrate that the applicant has actually mishandled or abused classified information before it can deny or revoke a security clearance. Rather, consideration must take account of cognizable risks that an applicant may deliberately or inadvertently fail to safeguard classified information.

Once the Government meets its initial burden of proof of establishing admitted or controverted facts, the burden of persuasion shifts to the applicant for the purpose of establishing his or her security worthiness through evidence of refutation, extenuation or mitigation of the Government's case.

CONCLUSION

Applicant presents as a hard working engineer for a defense contractor who brings a history of security significant co-occurring and interrelated alcohol abuse/dependence and psychiatric induced anxiety disorders, in addition to security concerns raised by his failure to provide reliable and trustworthy answers about his alcohol and treatment history when interviewed by Agent A. Applicant's problems with alcohol and stress/panic date to at least his adolescent years and involved him in several encounters with counseling and treatment providers to stabilize and wean him away from self-medicating his depression and related emotional stresses with alcohol.

Applicant's alcohol problems

A binge drinker for much of his adolescence and early adulthood, oft-using alcohol to self-medicate his depression and anxiety problems, Applicant sought repeated help from psychiatric and substance abuse health providers over an eight-year period spanning 1994 and 2002. Despite being diagnosed with alcohol dependence (in 1995 by B Inc.) and interrelating depression and anxiety disorders (by SO in 1995 and again in 1996 and by Dr. O in 1998), Applicant shunned professional advice to abstain and associate with AA, and repeatedly suspended taking of his prescribed Prozac medications designed to control his depression and anxiety disorders. Each time he stopped his medications sans any professional advice, he returned to drinking as a way of self-medicating, with self-destructive results: an alcohol-related

accident following a company Christmas party in 1997, and a DuI incident in 2000. In between incidents, he oft-consumed two beers on lunch hours before returning to work, was diagnosed as a problem drinker by R Center as recently as February 2001, and reportedly appeared for work smelling of alcohol as recently as January 2002, apparently concerned over his security clearance.

While there are no indications (although not fully developed) that his binge drinking and continued drinking in the face of an alcohol dependence diagnosis impacted his work, his drinking manifestly contributed to two alcohol-related incidents away from work and deterred him from any constructive addressing of his alcohol and emotional disorders. To his credit, he did successfully complete his SAFE education course in 2000: His completed program included 12-weeks of AA participation. Regrettably, he did not see the need to find an AA chapter to participate in after completing his SAFE course. Without a support network to draw from, he soon relapsed into drinking and self medicating his other emotional disorders, at least until he could find a mental health provider to prescribe Wellbrutin for him in June 2002, which by Dr Z's accounts, has provided some relief for him.

Based on Applicant's alcohol and counseling/treatment history to date, the Government may invoke several disqualifying conditions of the Adjudicative Guidelines for alcohol : DC 1 (alcohol incidents away from work, based on both his 1997 and 2000 incidents), DC 3 (diagnosis of alcohol dependence), DC 5 (habitual or binge drinking) and DC 6 (consumption of alcohol subsequent to a diagnosis of alcoholism).

Applicant's earlier medical history is open to little reasonable dispute. No question but that Applicant abused alcohol frequently between 1984 and 2000. Becoming addicted to alcohol, he made numerous attempts at treatment between 1994 and 2000, none producing any meaningful success that might enable him to claim sustainable treatment and rehabilitation. Depression, anxiety and related symptoms of panic, and even PTSD, were generally attributed to much of his drinking excesses, and realistically account for much of his problem drinking. Unreformed, but periodically abstinent between 1996 and 2000, Applicant slipped once in 1997 driving home from a Christmas party, and again returning home in August 2000. Medicating on alcohol to supplant other prescribed medications to address his emotional disorders, Applicant has missed out on some very valuable therapy recommendations to help stabilize his drinking problems and strengthen him against any risks of future relapses.

Both Applicant and his evaluating psychiatrist (Dr. Z) characterize his alcohol dependence as in remission, now, citing over four years of avoidance of abusive drinking (the 2000 DuI incident excepting) and the positive affects his newly prescribed medication (Wellbrutin) have had on his attraction to alcohol. To his credit, Applicant does appear to be making progress in the controlling of his drinking. Still, the interrelated links of Applicant's alcohol and emotional disorders, while manifestly in evidence, are never brightly demarcated, and only complicate efforts to accurately assess his relapse potential for returning to self-medicating with alcohol for so long as he remains on his prescribed anti-anxiety medication.

At issue is how to reconcile the favorable prognosis of Dr. Z (the only available substance abuse/mental health provider)to enlist professional assessments of Applicant's current alcohol rehabilitation status) with the explicit mitigation requirements of persons previously diagnosed with abuse or dependence. On this score, our Appeal Board has not been especially helpful in the past in charting acceptable recovery guidelines for applicants in assessed dependence remission, but who bring histories of failed recoveries and relapses. Faced with somewhat similar guideline situations, the Board has from time to time substituted new more restrictive mitigation guidelines that correlate prior slips with heightened relapse potential over the more definitive assessments and prognoses of medical experts. *Compare, e.g.,* DISCR OSD No. 93-1050 (December 20, 1994) with ISCR OSD No. 94-1081 (August 7, 1995). If anything, the Board has, of late, suggested even more stringent mitigation proofs for persons with histories of alcohol-related incidents, without regard to gauging the quality of the person's latest reform efforts. Here again, the Board fails to chart any coherent path for making quantity/quality distinctions, so essential to making fair and reliable predictive risk assessments in alcohol abuse/dependence cases. *See* ISCR OSD Case No. 01-22403 (September 5, 2002)

To be sure, standing by precedent is not meant to convey impressions that legal rules and interpretations should stand still for their own sake. This does not mean that precedents need never be replaced when their underlying policies have yielded to more desired policies. To do so would only advance a system of mechanical jurisprudence that forestalls needed changes. *Cf. Pound, Mechanical Jurisprudence,* 8 *Colum. L. Rev.* 605, 614-22 (1908). Similarly, legal

interpretations of Adjudication Policy factors that are betrayed by logic and fairness and/or discredited by actual experience (such as drinking and causing an accident without being cited and convicted) need not be retained for precedent's sake. And our Board is right to make the point. *See* ISCR OSD Case No. 01-22403, *supra* (*see* concurring opinion) Precedential changes should not be lightly adopted, though, and should be carefully explained when they are. *See Helvering v. Griffiths,* 318 U.S. 371, 403 (1943). *Compare, Pound, The Theory of Judicial Decision II,* 36 *Harv. L. Rev.* 802, 825 (1923) *with* Traynor, *Reasoning in a Circle of Law,* 56 *Va. L. Rev.* 739, 745 (1970). What is important for guiding our trial judiciary is when our Appeal Board determines to adopt more restrictive interpretations of mitigating conditions (both express and using whole person analysis), it should remember its precedents and explain its reasons for any shifts. Appeal Board failure to adhere to its precedents or carefully explain its departures complicates and ultimately weakens the hearing process for both sides.

Faced with uncertain Appeal Board charting of the /dependence/relapse/remission/relapse conundrum, Applicant's mitigation efforts to date must start with the available mitigation guidelines and pick a course through the mitigation framework that best assesses Applicant's current risk status and practical probabilities of his being able to avert future relapses in the foreseeable future. Given his history of binge drinking and dependence, the combining of both his alcohol-related incidents of 1997 and 2000 cannot in fairness be concluded to be isolated and sans any pattern. Nor is it safe to conclude there are no indications of any recent problem in the face of his latest 2000 DuI incident, failures to follow up with AA participation, and latest returning to work with alcohol on his breath.

Applicant can and should be credited with positive changes in behavior supportive of sobriety (assigning considerable credit to the assessments of Dr. Z and Applicant's general avoidance of any drinking to intoxication since his 2000 DuI conviction). Thus, he may take advantage of MC 3 (changes supportive of sobriety) of the Adjudicative Guidelines for alcohol. He may avail himself as well of MC 1 (no pattern to alcohol-related incidents): Both his 1997 accident and 2000 DuI incidents are sufficiently few in number, qualitatively differentiated and sufficiently spaced and removed from the present to support Dr. S's expert opinion of the absence of any current pattern of incidents: albeit, two such incidents might technically qualify as pattern incidents within the parameters of MC 1 under certain definitions of the term.

But Applicant's availing himself of MC 1 and MC 3 by themselves are not enough to carry his mitigation burden. Far more pertinent for making a whole person common sense assessment are the conditions contained in MC 4 (following abuse or dependence diagnosis, successful treatment, participation in AA meetings or similar organization, abstention for at least 12 months, and receipt of a favorable prognosis) of the Guidelines. Here, while Applicant is able to meet the successful treatment and favorable prognosis prongs of MC 4, he clearly does not meet either the AA or 12 month abstinence conditions to enable him to take advantage of MC 4.

Considering the record as a whole, Applicant is unable to make a convincing showing that he has the maturity and current resource support at his disposal to avert any recurrent problems with judgment lapses related to alcohol abuse. For so long as Applicant's prior disposition to self medicate his emotional symptoms with alcohol is circumscribed by only his still very limited renascent experiences with prescribed medications, any predictive judgments against relapse risks are tenuous at best. While Applicant has made considerable progress in becoming abuse-free, it is still too soon to make safe assessments he out of harm's way. Favorable prospects for the future are inextricably linked to his recurrent past and require further seasoning with his current choice of medications. So, unfavorable conclusions warrant with respect to the judgment impairment allegations covered by Guideline G. Applicant's 2000 DuI is sufficiently causally related to his co-occurring alcohol and emotional disorders, though, to mitigate any criminal implications from his DuI conviction. Sub-paragraph 3.a of Guideline J is concluded favorable to Applicant.

Applicant's diagnosed emotional disorders

Along with diagnosed abuse and dependence (most recently in diagnosed remission), Applicant has been diagnosed by a series of mental health professionals (most recently by Dr. Z) with assorted depression, anxiety and panic disorders. He has been prescribed anti-depressants (mostly Prozac) to control his anxieties and enable him to avoid self-medicating with alcohol. The results have been mixed. With the aid of Prozac, he has enjoyed brief periods of abstinence and freedom from binge drinking and other abuses of alcohol. But his periods of abstinence have always been followed by voluntary cessations of taking his anti-depressants, which, in turn, have ushered in drinking relapses. Applicant's troubles with alcohol and emotional disorders have proved major impediments to not only his professional development

(which by all accounts has been praiseworthy when he is not abusing alcohol and taking his medications), but his reliable exercise of the high judgment and trustworthiness expected of those afforded access to classified information.

Whether the diagnosed emotional disorders and their associated anxiety and panic symptoms reflected by Applicant in moments of stress reflect risk producing psychological impairment or treatable features relating to manageable personality disorders pose core questions, for which risk determinations about Applicant's dependability and trust must ultimately be drawn. The questions are poignant but most important both for Applicant and the Government. At the risk of seeming cold and terribly unfair for applicants interested in protecting their jobs and clearances, such issues must be answered with as much objectivity as can humanly be summoned. Too important is Government's mandate for protecting its secrets from judgment lapses (both deliberate and inadvertent) to accommodate any slack in the appraisal function.

To be sure, informal appraisals of mental abilities and idiosyncracies are made every day by countless numbers of people (both lay and professional). But formal judgments about a person's mental and emotional state have engendered far more structured probability tests by courts and administrative boards (DOHA's included) to minimize risks of error. *See Speiser v. Randall,* 357 U.S. 513, 425-26 (1958). Medical science accepts generally that at a given time or another, most persons exhibit behavior that might be symptomatic of destabilizing emotional or mental disorders, but which fall within normal ranges of acceptable conduct, or conduct that is correctable. *See Addington v. Texas,* 441 U.S. 418, 426-27 (1978). Certainties about the human mind forever escape easy grasp. Even psychiatric diagnoses are predicated on expert impressions drawn from observations and testing at a particular time and largely reflect subjective analysis filtered through the experiences of the diagnostician. Separating the person who exhibits destabilizing anxiety and panic traits from the one suffering from medically and/or psycho-social stressors (isolated in nature) who presents with an otherwise stable personal and professional profile is the difficult adjudicative task at hand in this proceeding and requires close attention to the facts as derived from careful examination of the record, controlling Adjudicative Guidelines and common sense principles that gauge opinions/diagnoses, circumstances extant at the time and appraised probabilities of recurrence.

In Applicant's case, his anxiety and panic disorders, with attendant risks of judgment lapses (even if not sufficiently developed along the Axis III and IV classifications to warrant a valid and reliable diagnosis), realistically carry some potential for exposing him to security risk to inadvertently compromise classified materials in his custody or control, especially considered in conjunction with his co-occurring alcohol abuse and dependence diagnoses (even if currently in remission). To this extent, DC 1 (an opinion by a credentialed mental health professional that the individual has a condition or treatment that may indicate a defect in judgment, reliability or judgment), DC 2 (failure to follow appropriate medical advice) and DC 4 (information that current behavior indicates a defect in judgment or reliability) of the Adjudicative Guidelines for emotional disorders are applicable here.

The best case for reconciling Applicant's history of emotional disorders symptomatic of defects in judgment with the Government's security concerns can be made from Applicant's own professional evaluator, Dr. Z, who found favorable changes in Applicant's emotional status since he has been taking prescribed Wellbrutin medication to address his anxieties and other stresses. Little is known, however, about Applicant's current medication regimen, and whether his Wellbutrin medication is being periodically monitored and titrated for continued efficacy. Both the circumstances, recency, and continued monitoring of his prescribed medications must, by necessity, be updated, titrated if necessary, and evaluated by the treating primary physician who prescribed the medication for Applicant, and who is logically best positioned to make evaluative and predictive judgments about Applicant's prognosis. With a record of aborting prescribed medications and returning to self medicating with alcohol, Applicant cannot be safely assumed at this still early stage of his treatment to be on a safe and committed track of recovery.

In fairness, Applicant is entitled to some mitigation benefits of one of the mitigating conditions of the Adjudicative Guidelines for emotional disorders: MC 2 (recent opinion by a credentialed mental health professional that prior condition is under control or in remission, and has low probability of recurrence). But neither the mitigating conditions nor any of the whole person considerations listed in E.2.2 of the Directive permit Applicant to be absolved of all of the security risks associated with his diagnosed emotional disorders.

Taking into account all of Applicant's collected personal histories, evaluations compiled by the different mental health

professionals, past treatment failures as gauged by relapses, and Applicant's own accounts of his taking recent leave from his employment to deal with the stresses of his clearance investigation this past January 2002, Applicant does not convince his emotional disorders (so interrelated with his alcohol disorders) are sufficiently manageable to facilitate safe predictions he will not experience recurrences in the foreseeable future. As with his alcohol problem, more time is needed to demonstrate the stabilizing affects of his new medicating regimen. Applicant does not at this time meet his evidentiary burden of mitigating the adverse security implication raised by his diagnoses and relapses in conjunction with his co-occurring alcohol abuse and dependence disorders. Conclusions warrant, accordingly, that the allegations covered by Guideline I are determined unfavorable to Applicant.

Applicant's DSS omissions

By the findings made *supra,* Applicant's accounts provided Agent A in his first two DSS interviews and ensuing statements excluded material information about his history of alcohol use and treatment. That Applicant might have felt intimidated and pressured by Agent A's probing questions to the point of disclosing more complete treatment and consumption profiles than he wished to provide is not enough to overcome either the presumption of regularity that accompanies a DSS agent's conducting of an applicant interview, or Agent's A's assurances that his interviews with Applicant were conducted in a professional way at all times. *See* ISCR Case No. 01-26893 (October 16, 2002), at 9 (rebuttable presumption that agency officials act in good faith).

After considerable prodding from Agent A, Applicant succumbed to Agent A's concerted efforts to enlist the full truth about the former's treatment and alcohol consumption history in the face of determined Applicant efforts to avert disclosures of treatment and continuing consumption he had withheld from his SAFE/R Center providers and his probation officer. While stress and anxiety over disclosing most extensive treatment and consumption patterns may have contributed to Applicant's initial failures to be up-front with Agent A, Applicant cannot avert application of DC 3 (deliberately providing false information to an investigator) of the disqualifying conditions of the Adjudicative Guidelines for Personal Conduct.

Overall, Applicant's claims of investigatory irregularity, fear, anxiety, and panic are not enough to surmount continuing Government concerns about his reliability and trustworthiness when asked to provide full background information considered necessary to establish his clearance eligibility. Unfavorable conclusions warrant with respect to the falsification allegations covered by Guideline E. Applicant's omissions were affected enough by his emotional disorders, however, to dispel any criminal intentions by his omissions and misstatements. Favorable conclusions warrant with respect to sub-paragraph 3.b of Guideline J.

Applicant's traffic infraction

Besides Applicant's alcohol/emotional disorders and untrue statements made in a series of DSS interviews, Government claims Applicant's admitted traffic infraction in 1999 raises still additional security concerns about his reliability and trustworthiness. The infraction was not accompanied by alcohol in any way that can be gleaned from the evidence, and the infraction is not considered material to a security clearance determination without more presented in the essential facts of record. Favorable conclusions warrant with respect to sub-paragraph 2.a of Guideline E.

In reaching my recommended decision, I have considered the evidence as a whole, including each of the factors and conditions enumerated in E.2.2 of the Adjudicative Process of Enclosure 2 of the Directive.

FORMAL FINDINGS

In reviewing the allegations of the SOR in the context of the FINDINGS OF FACT, CONCLUSIONS and the FACTORS and CONDITIONS listed above, this Administrative Judge

makes the following separate FORMAL FINDINGS with respect to Appellant's eligibility for a security clearance.

GUIDELINE G (ALCOHOL): AGAINST APPLICANT

Sub-para. 1.a: AGAINST APPLICANT

Sub-para. 1.b: AGAINST APPLICANT

Sub-para. 1.c: AGAINST APPLICANT

Sub-para. 1.d: AGAINST APPLICANT

Sub-para. 1.e: AGAINST APPLICANT

Sub-para. 1.f: AGAINST APPLICANT

Sub-para. 1.g: AGAINST APPLICANT

Sub-para. 1.h: AGAINST APPLICANT

Sub-para. 1.I: AGAINST APPLICANT

Sub-para. 1.j AGAINST APPLICANT

GUIDELINE E: (PERSONAL CONDUCT): AGAINST APPLICANT

Sub-para. 2.a: FOR APPLICANT

Sub-para. 2.b: AGAINST APPLICANT

Sub-para. 2.c: AGAINST APPLICANT

Sub-para. 2.d: AGAINST APPLICANT

Sub-para. 2.e: AGAINST APPLICANT

Sub-para. 2.f: AGAINST APPLICANT

GUIDELINE J (CRIMINAL CONDUCT): FOR APPLICANT

Sub-para. 3.a: FOR APPLICANT

Sub-para. 3.b: FOR APPLICANT

GUIDELINE I (EMOTIONAL DISORDERS): AGAINST APPLICANT

Sub-para. 4.a: AGAINST APPLICANT

DECISION

In light of all the circumstances presented by the record in this case, it is not clearly consistent with the national interest to grant or continue Applicant's security clearance.

Roger C. Wesley

Administrative Judge