DATE: January 8, 2004

In Re:

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

Applicant for Security Clearance

ISCR Case No. 02-05768

DECISION OF ADMINISTRATIVE JUDGE

ROBERT ROBINSON GALES

APPEARANCES

FOR GOVERNMENT

Nygina T. Mills, Esquire, Department Counsel

FOR APPLICANT

Pro Se

SYNOPSIS

Thirty-year-old Applicant's 1997 hospitalization for a *manic episode*, eventually diagnosed as bipolar disorder, a condition that may indicate a defect in judgment, reliability, or stability, and his continuing treatment with a psychologist and psychiatrist for therapy and medication supervision to manage his bipolar symptoms, has satisfied all questions and doubts as to his security eligibility and suitability. The personality disorder is under control or in remission, and has a low probability of recurrence or exacerbation if he continues to follow medical advice relating to treatment of the condition. Clearance is granted.

STATEMENT OF THE CASE

On August 7, 2003, the Defense Office of Hearings and Appeals (DOHA), pursuant to Executive Order 10865, *Safeguarding Classified Information Within Industry,* dated February 20, 1960, as amended and modified, and Department of Defense Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (Directive), dated January 2, 1992, as amended and modified, issued a Statement of Reasons (SOR) to Applicant. The SOR 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 a clearance should be granted, continued, denied, or revoked.

In a sworn, written statement, dated August 26, 2003, Applicant responded to the allegations set forth in the SOR, and elected to have his case decided on the written record in lieu of a hearing. Department Counsel submitted the government's written case on September 23, 2003. A complete copy of the file of relevant material (FORM)[(1)] was provided to Applicant, and he was afforded an opportunity to file objections and submit material in refutation, extenuation, or mitigation. Any such submissions were due by November 9, 2003, and he submitted additional materials on October 31, 2003. The Department Counsel had no objection to the materials submitted. The case was assigned to me on January 6, 2004.

FINDINGS OF FACT

Applicant has denied the factual allegations pertaining to emotional, mental, and personality disorders under Guideline I.

After a complete and thorough review of the evidence in the record, and upon due consideration of same, I make the following findings of fact:

Applicant is a 30-year-old employee of a defense contractor, and is seeking to obtain a security clearance the level of which has not been divulged.

Applicant abused marijuana on a continuing basis from about 1989 until January 1999.(2) During the period September 1996 until February 1997 his marijuana use occurred about once each day.(3) In February 1997, Applicant was admitted to a hospital following a *manic outburst*, medically characterized as a *manic episode*,(4) initially thought to have been caused by poor quality marijuana.(5) In fact, the *manic episode* was eventually diagnosed as a bipolar disorder.(6) *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* classifies the various bipolar disorders as mood disorders.(7) Applicant was hospitalized for about one month,(8) treated with mood stabilizing medication, and discharged to outpatient care.(9) Since his 1997 hospitalization, and continuing until about May 2002, Applicant was treated on a monthly basis by a psychiatrist who prescribed and monitored his medications.(10) Another psychiatrist took over and has been providing therapy and medication supervision, also on a monthly basis, since May 2002.(11)

On June 30, 2003, Applicant participated in a mental health evaluation conducted by an active duty military clinical psychologist, not a psychiatrist as alleged in the SOR.(12) Applicant purportedly acknowledged his most recent *depressive episode* occurred in Spring 2001, and his most recent *manic* or *hypomanic episode* occurred in February 2002. As a result of the *manic episode*, Applicant was required to take time off from work for seven weeks.(13) He eventually returned to work with reduced work hours, with his work schedule gradually increasing over time.(14) As of July 1, 2003, Applicant was working a 36-hour work week.(15) Later that month his work schedule increased to a 40-hour week.(16)

Applicant purportedly currently takes four different prescribed medications,(17) and along with his monthly therapy sessions with his psychiatrist and psychologist, is better able to manage his condition because of:

. . . increased comfort with a new psychiatrist, awareness of risk factors, and understanding of the importance of regular sleep, taking medications, and seeking/following his doctor's advice. admitted to involved in two criminal incidents which occurred within six months of each other approximately 28 years ago.(18)

Based on the mental health evaluation, and the information furnished by Applicant, but without the benefit of any of Applicant's psychiatric records, as the psychiatrist was unavailable during the period of the evaluation,(19) the clinical psychologist rendered the following diagnosis: Axis I (Mental Disorders): 296.40 Bipolar I Disorder, Most Recent Episode Hypomanic. Axis II (Personality Disorders or Traits): V71.09 No Diagnosis on Axis II. According to the *DSM-IV-TR*, among the diagnostic criteria for that particular diagnosis are:

A. Currently, or most recently, in a *hypomanic episode*

B. There has previously been at least one *manic episode* or *mixed episode*

C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.(20)

The *DSM-IV-TR* describes the criteria for *hypomanic episode* in the following manner:

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(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)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).[(21)]

The clinical diagnosis pertaining to Axis II (Personality Disorders or Traits) was, as indicated above, V71.09 No Diagnosis on Axis II. The actual interpretation of that particular V Code for "persons without reported diagnosis encountered during examination and investigation of individuals and populations,"[(22)] is "observation for suspected mental condition - other suspected mental condition."[(23)] In other words, observation only, without diagnosis.

The clinical psychologist summarized: Applicant is diagnosed with bipolar disorder based on past symptoms and current ongoing treatment; the disorder has a continuing nature; it requires continuing and regular management; it "could potentially cause a significant defect in judgment and reliability;" and it "could potentially cause a significant defect in psychological, social, or occupational functioning."[(24)] He also added that Applicant "is using medications and regular therapy to effectively manage bipolar symptoms."[(25)] The clinical psychologist recommended Applicant's treating psychiatrist and psychologist be contacted for more information pertaining to current symptoms, diagnosis, functioning, treatment, and prognosis.[(26)]

Applicant's current psychiatrist, who has been providing therapy and medication supervision on a monthly basis since May 2002, disputes the information appearing in the clinical evaluation. The psychiatrist avers Applicant has had "no recurrence or mania or hospitalization since [1997].[(27)] In his regular contact with Applicant over the period of treatment, he has "not seen significant decompensation in [Applicant's] emotional stability."[(28)] Furthermore, he stated Applicant "has been rigorous in following his mood stabilizing regimen."[(29)]

Applicant graduated with a B.S.M.E. from a major university in May 1995, and has been employed by the same company, as a mechanical engineer II since October 1999. The quality of his performance has not been developed in the

record.

POLICIES

Enclosure 2 of the Directive sets forth adjudicative guidelines which must be considered in the evaluation of security suitability. In addition to brief introductory explanations for each guideline, the adjudicative guidelines are divided into those that may be considered in deciding whether to deny or revoke an individual's eligibility for access to classified information (Disqualifying Conditions) and those that may be considered in deciding whether to grant an individual's eligibility for access to classified information (Mitigating Conditions).

An Administrative Judge need not view the adjudicative guidelines as inflexible ironclad rules of law. Instead, acknowledging the complexities of human behavior, these guidelines, when applied in conjunction with the factors set forth in the Adjudicative Process provision in Section E2.2., Enclosure 2, of the Directive, are intended to assist the Administrative Judge in reaching fair and impartial common sense decisions.

Because the entire process is a conscientious scrutiny of a number of variables known as the "whole person concept," all available, reliable information about the person, past and present, favorable and unfavorable, should be considered in making a meaningful decision. The Adjudicative Process factors which an Administrative Judge should consider are: (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 voluntariness of participation; (6) the presence or absence of rehabilitation and other pertinent 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.

Based upon a consideration of the evidence as a whole, I find the following adjudicative guidelines most pertinent to an evaluation of the facts of this case:

Emotional, Mental, and Personality Disorders - Guideline I: 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. A credentialed mental health professional (e.g., clinical psychologist or psychiatrist), employed by, acceptable to or approved by the government, should be utilized in evaluating potentially disqualifying and mitigating information fully and properly, and particularly for consultation with the individual's mental health care provider.

Conditions that could raise a security concern and may be disqualifying, as well as those which could mitigate security concerns, pertaining to this adjudicative guideline are set forth and discussed in the Conclusions section below**.**

Since the protection of the national security is the paramount consideration, the final decision in each case must be arrived at by applying the standard the issuance of the clearance is "clearly consistent with the interests of national security,"[(30)] or "clearly consistent with the national interest." For the purposes herein, despite the different language in each, I have concluded both standards are one and the same. In reaching this Decision, I have drawn only those conclusions that are reasonable, logical and based on the evidence contained in the record. Likewise, I have avoided drawing inferences grounded on mere speculation or conjecture.

In the decision-making process, the burden of producing evidence initially falls on the Government to establish a case which demonstrates, in accordance with the Directive, it is not clearly consistent with the national interest to grant or continue an applicant's access to classified information. If the Government meets its burden, the heavy burden of persuasion then falls upon the applicant to present evidence in refutation, explanation, extenuation or mitigation sufficient to overcome the doubts raised by the Government's case, and to ultimately demonstrate it is clearly consistent with the national interest to grant or continue the applicant's clearance.

A person who seeks access to classified information enters into a fiduciary relationship with the Government predicated upon trust and confidence. It is a relationship that transcends normal duty hours and endures throughout off-duty hours as well. It is because of this special relationship the Government must be able to repose a high degree of trust and confidence in those individuals to whom it grants access to classified information. Decisions under this Directive include, by necessity, consideration of the possible risk an applicant may deliberately or inadvertently fail to protect or safeguard classified information. Such decisions entail a certain degree of legally permissible extrapolation as to potential, rather than actual, risk of compromise of classified information.

One additional comment is worthy of note. Applicant's allegiance, loyalty, and patriotism are not at issue in these proceedings. Section 7 of Executive Order 10865 specifically provides industrial security clearance decisions shall be "in terms of the national interest and shall in no sense be a determination as to the loyalty of the applicant concerned." Security clearance decisions cover many characteristics of an applicant other than allegiance, loyalty, and patriotism. Nothing in this Decision should be construed to suggest I have based this decision, in whole or in part, on any express or implied decision as to Applicant's allegiance, loyalty, or patriotism.

CONCLUSIONS

Upon consideration of all the facts in evidence, and after application of all appropriate legal precepts, factors, and conditions, including those described briefly above, I conclude the following with respect to the allegations set forth in the SOR:

With respect to Guideline I, the government has established its case. By his own admission, Applicant was admitted to the hospital in February 1997 for a *manic episode* which was eventually diagnosed as a bipolar disorder. Since that 1997 hospitalization, and continuing through the present, Applicant has been treated on a monthly basis by psychiatrists who provided therapy and prescribed and monitored his medications. It is undisputed that Applicant has been "rigorous" in following his mood stabilizing regimen, including regular therapy and medication.

The remaining evidence is in dispute. For example, the clinical psychologist commented that Applicant was diagnosed with bipolar disorder based on "past symptoms and current ongoing treatment." Yet those symptoms are in dispute for they are based substantially, if not solely, on a layperson's opinion--Applicant's recollections--and not on any medical or psychiatric records or through independent professional assessment and diagnosis. In this instance, the opinion of the clinical psychologist--the nonexamining physician--must be an informed one if it conflicts with the opinion of the treating physician. As noted above, Applicant's psychiatrist was unavailable during the period of the evaluation and none of Applicant's psychiatric treatment records were reviewed, and the Axis II "diagnosis" was V71.09 No Diagnosis, which is nothing other than "observation for suspected mental condition - other suspected mental condition," or an observation only, without diagnosis.

The clinical psychologist also commented that the condition or disorder has a continuing nature. It is unclear if Applicant's most recent *depressive episode* occurred in Spring 2001, or if his most recent *manic* or *hypomanic episode* occurred in February 2002, as reported. Applicant's psychiatrist certainly disputes that contention and has clearly stated that Applicant has had no recurrence of mania or hospitalization since [1997]. Applicant purportedly acknowledged to the clinical psychologist what his psychiatrist has denied. What has been referred to as a *manic* or *hypomanic episode* by the clinical psychologist--a distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least four days, that is clearly different from the usual nondepressed mood--may have been misunderstood by Applicant as being something that it really was not, in psychological terms.

The assessment by the clinical psychologist that the disorder has a continuing nature is somewhat less than accurate for it completely discounts both the possibility and probability that the disorder might be in full or partial remission. In addition, subparagraph 1.b. of the SOR alleges statements purportedly made by Applicant's initial psychiatrist--allegations denied by Applicant--facts not supported by any evidence in the record from that psychiatrist. In the absence of documents supporting those comments coming from the psychiatrist, I will not consider them in the abstract.

The clinical psychologist also commented that the disorder requires continuing and regular management, and Applicant's psychiatrist has acknowledged that Applicant is following his mood stabilizing regimen, including regular therapy and medication. Furthermore, the Department Counsel has offered no evidence to rebut that evidence.

The major area of concern, and one for which there is inconsistent and incomplete evidence, is the observation by the clinical psychologist that the disorder "could potentially cause a significant defect in judgment and reliability;" and "could potentially cause a significant defect in psychological, social, or occupational functioning." The clinical psychologist recommended that Applicant's treating psychiatrist and psychologist be contacted for information pertaining to Applicant's current symptoms, diagnosis, functioning, treatment, and prognosis. Yet despite the absence of all that information, the clinical psychologist was able to offer the above opinions, seemingly based purely on textbook commentary.

As stated above, one of the conditions set forth in the criteria for a *hypomanic episode* is that the episode is "not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features." On the other hand, one of the conditions set forth in the diagnostic criteria for bipolar I disorder, most recent episode hypomanic, is that the mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. It is unclear what constitutes "clinically significant distress or impairment." In any event, Applicant's disorder in this regard seemingly falls within Disqualifying Condition (DC) E2.A9.1.2.1. (*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 E2.A9.1.2.2. (*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*), and DC E2.A9.1.2.4. (*information that suggests that the individual's current behavior indicates a defect in his or her judgment or reliability*) clearly do not apply in this instance.

Assuming the accuracy of the diagnosis made by the clinical psychologist, as well as the fact that there has been no recurrence of mania since 1997, or even if there were some manifestations in Spring 2001 and February 2002, as found

by the clinical psychologist, the question remains whether there is an indication of a current problem, thus activating Mitigating Condition (MC) E2.A9.1.3.1. (*there is no indication of a current problem*). In this regard, it is interesting to note that the DC generally refers to the terms condition, treatment, or behavior, rather than the term problem as found in the MC. Nevertheless, based on all of the above, I conclude that there is sufficient evidence to find Applicant's condition, disorder, or problem remains current, thus negating consideration of MC E2.A9.1.3.1.

However, the evidence does support the activation of MC E2.A9.1.3.2. (*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*). The credentialed mental health professionals, both the clinical psychologist and Applicant's psychiatrist, agree he is using medications and regular therapy to effectively manage bipolar symptoms. With the psychiatrist's opinion that Applicant has not exhibited any significant decompensation in his emotional stability since he commenced treating him in May 2002, Applicant's disorder seems to be under control or in remission. And, so long as he continues to properly manage his medications for the disorder, there appears to be a low probability of recurrence or exacerbation.

Consequently, Applicant has, through evidence of extenuation and explanation, successfully mitigated or overcome the Government's case. Accordingly, allegations 1.a. and 1.b. of the SOR are concluded in favor of Applicant.

For the reasons stated, I conclude Applicant is eligible for access to classified information.

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: FOR THE APPLICANT

Subparagraph 1.a.: For the Applicant

Subparagraph 1.b.: For the Applicant

DECISION

In light of all the circumstances presented by the record in this case, it is clearly consistent with the national interest to grant or continue a security clearance for Applicant.

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Robert Robinson Gales

Chief Administrative Judge

1. The government submitted six items in support of its contentions.

2. Item 5 (Statement, dated October 26, 2000), at 1-2.

3. *Id.*, at 1.

4. Attachment to Response to FORM (Letter from psychiatrist, dated October 20, 2003).

5. Item 5*, supra* note 2, at 1-2.

6. *Id.*, at 2.

7. *DSM-IV-TR*, at 345-6.

8. Item 6 (Mental Health Evaluation and Recommendation, dated July 1, 2003), at 1.

9. Attachment to Response to FORM, *supra* note 4.

10. Item 6, *supra* note 8, at 1; Item 5, *supra* note 2, at 2.

11. Attachment to Response to FORM, *supra* note 4.

12. Item 6, *supra* note 8.

13. *Id.*

14. *Id.*

15. *Id*.

16. Attachment to Response to FORM, *supra* note 4.

17. Item 6, *supra* note 8. Clonazepam is used in the treatment of seizures (*Physicians' Desk Reference (PDR)*, 51 ed. (1997), at 2294); Lithium is used in the treatment of manic episodes of manic-depressive illness *(PDR*, at 2659); Trilafon ® is used in the management of manifestations of psychotic disorders *(PDR*, at 2532); and Seroquel ® is a new class of antipsychotic medications used in the management of the manifestations of psychotic disorders (PDR On Line, Seroquel, http://www.pdrhealth.com/drug_info/rxdrugprofiles/drugs/ser1402.shtml)

18. Item 6, *supra* note 8, at 1

19. *Id.*

20. *DSM-IV-TR*, at 388.

21. *Id.*, at 368.

22. *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*, Vol. 1 (1995), at 691.

23. *Id*., at 692.

24. Item 6, *supra* note 8, at 2.

25. *Id.*

26. *Id.*

27. Attachment to Response to FORM, *supra* note 4.

28. *Id.*

29. *Id.*

30. Exec. Or. 12968, *"Access to Classified Information;"* as implemented by Department of Defense Regulation 5200.2-R, *"Personnel Security Program,"* dated January 1987, as amended by Change 3, dated November 8, 1995, and further modified by memorandum, dated November 10, 1998. However, the Directive, as amended by Change 4, dated April 20, 1999, uses both "clearly consistent with the national interest" (Sec. 2.3.; Sec.2.5.3.; Sec. 3.2.; and Sec. 4.2.; Enclosure 3, Sec. E3.1.1.; Sec. E3.1.2.; Sec. E3.1.25.; Sec. E3.1.26.; and Sec. E3.1.27.), and "clearly consistent with the interests of national security" (Enclosure 2, Sec. E2.2.3.); and "clearly consistent with national security" (Enclosure 2, Sec. E2.2.2.)