DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
	)	ISCR Case No. 09-04696
	)	
	)	
Applicant for Security Clearance	)	

Appearances

For Government: David F. Hayes, Esquire, Department Counsel
For Applicant: *Pro se*

04/25/2013

Decision

MATCHINSKI, Elizabeth M., Administrative Judge:

Applicant's history of erratic compliance with the treatment protocol for his diagnosed bipolar disorder resulted in impairment of his judgment and in dysfunctional behavior requiring psychiatric hospitalization. A credentialed psychologist opined in October 2012 that Applicant will, in all likelihood, remain prone to periods of erratic behavior. While Applicant has been a valuable contributor to his defense contractor employer, psychological conditions security concerns persist. Clearance denied.

Statement of the Case

On November 9, 2012, the Department of Defense (DOD) issued a Statement of Reasons (SOR) to Applicant, detailing the security concerns under Guideline I (Psychological Conditions) and explaining why it could not find that it is clearly consistent with the national interest to continue Applicant's security clearance eligibility. The DOD took action under Executive Order 10865, *Safeguarding Classified Information within Industry* (February 20, 1960), as amended; DOD Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (January 2, 1992), as amended (Directive); and the adjudicative guidelines (AG) effective within the DOD on September 1, 2006.

On November 30, 2012, Applicant responded to the SOR allegations and requested a hearing before the Defense Office of Hearings and Appeals (DOHA). On February 8, 2012, the case was assigned to me to conduct a hearing and consider whether it is clearly consistent with the national interest to grant or continue a security clearance for Applicant. I scheduled a hearing for March 1, 2013.

I held the hearing as scheduled. Eleven Government exhibits (GEs 1-11) and one Applicant exhibit (AE A) were admitted into evidence without objection.[1] Applicant also testified, as reflected in a transcript (Tr.) received on March 8, 2013. At the Government's request, I agreed to take administrative notice of the section of the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., Text Revision (DSM-IV-TR), pertaining to bipolar disorders.

Summary of SOR Allegations

The SOR alleged under Guideline I that Applicant was psychiatrically hospitalized for erratic behavior and diagnosed with bipolar disorder in 2000 (SOR 1.a); that Applicant failed to comply with his psychiatric medication, leading to erratic, paranoid, or aggressive behavior, and to mental health hospitalizations in 2003 (SOR 1.b) and twice in late 2009 (SOR 1.c and 1.d); that Applicant's mental health condition required psychiatric hospitalization twice in 2012 (SOR 1.e and 1.f); and that a licensed, credentialed psychologist, who evaluated Applicant for the DOD in October 2012, concluded that Applicant was likely to remain prone to periods of dysfunctional and erratic behavior with the potential of compromising his ability to fulfill his security responsibilities (SOR 1.g).

Findings of Fact

In his Answer, Applicant admitted the psychiatric hospitalizations and bipolar diagnosis. He also admitted that he did not take his medication prescribed in 2003, with adverse impact on his mental health. He denied that he stopped taking his prescribed psychiatric medication in 2009, and he attributed his erratic behavior and two hospitalizations in 2012 to the "bad interaction" of a steroid medication taken for a medical problem.

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

Applicant is a 45-year-old senior systems engineer with a master's degree in physics. He has worked for his present employer, a defense contractor, since September 2004. He has prior U.S. military service, from December 1984 to August 1986 at the enlisted rank. A member of the inactive reserve from August 1986 to May 1990 while pursuing his college degree, Applicant enlisted as an officer in the same military branch in May 1990. (GEs 1, 5.) He held a secret-level security clearance while in the U.S. military.

[1] Applicant's exhibit consisted of a personal statement, counselor assessments, laboratory results, a character reference from his spouse, and work performance evaluations. They were offered by Applicant as one exhibit.

Applicant was married to his first wife from December 1988 to May 2005. They had three sons, who are now ages 22, 21, and 18, and a daughter now age 15. (GE 1.)

In May 2000, Applicant was psychiatrically hospitalized for a few days after an angry outburst to the executive officer on ship. He was diagnosed with bipolar I disorder. (GEs 8, 11; Tr. 39-43.) Applicant disagreed with the diagnosis and thought he was being harassed, so he chose not to take his prescribed psychiatric medications. (AE A; Tr. 34, 44-45.) On September 27, 2001, Applicant was granted a medical retirement from the military due to developing mental health issues. (GE 5.) In November 2001, he began working as a senior engineer with a defense contractor. (GE 1.) He was not under any active treatment for his bipolar illness between 2001 and 2003. (Tr. 45-46.)

In January 2003, Applicant had a manic episode. He had three of his children with him when he stopped off at a mall and locked his keys in the van. While waiting for his spouse to arrive with a spare set of keys, he became suspicious of his and his children's safety without reasonable basis. He sheltered himself and his children in an unlocked vehicle nearby. After his wife took their children from him,[2] Applicant began opening parked cars to activate their alarms and elicit the aid of mall security. The police brought Applicant to a local emergency room, where he was referred to the Veterans Administration (VA) hospital. On February 1, 2003, Applicant was put on a psychiatric hold and admitted for mental health treatment at the VA facility. Applicant disregarded the hold and left the facility. He took a bus to a hotel where he reserved a room and made dinner reservations for himself and his wife, from whom he was apparently estranged. She arrived with his brother and a friend, and together, they brought him back to the VA. Applicant, who had reportedly engaged in impulsive behavior for about a month, was diagnosed with bipolar disorder, manic episode, and prescribed Depakote and Risperdal (risperidone). Applicant's 72-hour hold was extended to a 14-day hold because he had no shelter and had "maxed out" his credit cards. His mania symptoms persisted in the hospital, and a temporary commitment was ordered. On February 19, 2003, Lithium and Klonopin medications were added to his psychotropic regimen. On March 11, 2003, Applicant was discharged in stable condition to temporary housing, and with instructions to follow up with bipolar support groups and his physician. Lithium, Depakote, Risperdal, and Klonopin medications were prescribed on discharge.[3] Applicant's thought processes were organized, and he expressed a willingness to honor a restraining order obtained by his first wife against him. (GE 6; Tr. 46-49.)

Applicant found shelter with a cousin, and his then spouse and their children moved to another state. At a VA outpatient clinic two weeks after his discharge, Applicant was reportedly compliant with his medications. He exhibited no delusions, no grandiose or paranoid themes, and was medically cleared to work. Over the next month, he was weaned

[2] Applicant testified that when his first wife arrived, she "sort of freaked out." Applicant denies any recall of having put his children in a car that did not belong to him. (Tr. 47.) He also has no recollection of trying to open cars to activate their alarms. (Tr. 48.)

[3] Applicant testified that his treating psychiatrist told him that the goal was to become medication free. (Tr. 52.) Available VA records (GE 6.) indicate that Applicant was maintained on Lithium. They do not show that he was in any way advised to stop taking his Lithium.

off the Risperdal. Applicant continued to follow up with supportive psychotherapy sessions every two to three weeks with his VA psychiatrist. He remained on Depakote and Lithium medications with adjustment in dosages. He had no manic or psychotic episodes, despite family stress over contact and visitation with his children. In the fall of 2003, his VA psychiatrist advocated for visitation rights for Applicant because he had been compliant with his treatment, including his mood stabilizer medications. Applicant's compliance was documented by checking for therapeutic blood levels on a regular basis. During a routine clinic visit in mid-November 2003, Applicant reported some dissatisfaction with his job and complained about having to take his psychiatric medications, but there were no acute manifestations of his bipolar condition. (GE 6.)

In January 2004, Applicant underwent a background investigation for a security clearance. A VA psychiatrist opined that Applicant had been stable on medications without any symptoms of his bipolar disorder for one year, despite ongoing struggles with his estranged wife over visitation and contact with their children. She assessed Applicant's prognosis as excellent provided continued treatment, including Depakote and Lithium medications. (GE 6.)

In February 2004, Applicant was laid off from his job when his contract ended. (GE 1.) VA staff clinicians continued to advocate for Applicant to have visitation rights with his children because of his compliance with his treatment regimen with no signs of mania. In mid-September 2004, Applicant moved across the United States to state X for his present job. Applicant was advised to follow up with the VA clinic in his new area. (GE 6.)

On January 25, 2005, Applicant had a medical intake at a VA facility in state X to establish care and obtain prescription medications (Lithium and divalproex). He denied any episodes of mania, anger outbursts, restlessness, impulsivity, increased spending, or sleeplessness. Applicant continued to receive medical care and medication management from the VA, but no psychological counseling. (GE 6.)

In September 2005, Applicant moved to state Y, where he bought a home. In February 2007, Applicant married his second wife. He became stepfather to her two children. (GE 1; Tr. 50.) Three years later, Applicant and his second wife divorced. (Tr. 50-51.)

On February 12, 2008, Applicant completed and certified an Electronic Questionnaire for Investigations Processing (e-QIP) to continue his security clearance eligibility. In response to section 21 concerning any mental health counseling or hospitalization in the last seven years, Applicant indicated that he was treated at a VA medical center from January to March 2003. (GE 1.)

Starting in January 2009, Applicant began reducing his intake of Lithium without first consulting with his primary care physician or VA clinicians. (GE 6; Tr. 52.) Applicant decided to wean himself off his medication, reportedly because a psychiatrist had told him in 2003 that the goal was for him to eventually be free of psychiatric medication. (Tr. 53.) On May 5, 2009, Applicant was contacted by an authorized investigator for the Office of

Personnel Management (OPM) about any current medical treatment. He admitted previously undisclosed treatment, consisting of Lithium medication managed by a local VA clinic since 2004 for bipolar disorder. Applicant indicated he was in compliance with his treatment. (GE 2.)

Applicant had a particularly stressful year in 2009. His sister died suddenly early in the year, and he changed positions with his employer, which meant a lengthy three-hour roundtrip commute. (Tr. 53.) Applicant's ingestion of reduced levels of Lithium (twice instead of three times a day) led to a deterioration of his mental health (paranoia and delusional behavior in the evenings) by October 2009. On October 20, 2009, at the request of his primary care physician, Applicant was evaluated by VA outpatient psychiatry for urgent medication management. Applicant presented with an even affect and easygoing disposition, despite his noncompliance with his Lithium regimen. Applicant indicated he was under stress because of his lengthy commute to work, long hours at work, and legal problems with his ex-wife, who was seeking an increase in alimony and child support. Applicant was continued on his Lithium dosage and risperidone was added. (GE 6.)

Applicant returned to the VA the following day for an outpatient mental health assessment. He denied racing thoughts, impulsive behavior, paranoia or delusions, or mood swings. He presented as organized, stable and at baseline, with no irritability noted. His judgment and insight were assessed as good. Lab testing was ordered to obtain a Lithium level. He was not interested in individual counseling, but indicated that he would utilize it if needed in the future. Applicant was continued on Lithium and, as needed, risperidone. (GE 6.)

On November 4, 2009, Applicant's then wife called the local police complaining of his bizarre behavior over the previous six weeks. He was not sleeping or eating, had been spending money excessively, and was paranoid and aggressive at times. Applicant was assessed in a local emergency room as being irritable with tangential thoughts. He was referred to a nearby psychiatric hospital in state Y, where he was voluntarily admitted for management of his bizarre behavior in the context of known bipolar I disorder. Applicant admitted he was not taking the full dosage of prescribed Lithium, but he denied any change in his mood or in his sleeping and eating habits. Applicant was assessed as having an episode of hypomania related to noncompliance with his Lithium therapy and lack of regular psychiatric follow up. Over the next few days, Applicant was intermittently angry, paranoid, and demanding, although he attended groups and was generally compliant with his medications. His Lithium dosage was gradually increased until November 13, 2009, when he was discharged. At discharge, he exhibited no evidence of a thought disorder, and his judgment was assessed as fair to good. Applicant recognized the need to take Lithium, although he would not acknowledge that he had been psychiatrically ill. Applicant was referred for psychiatric follow up to the VA clinic with a principal diagnosis of bipolar disease, most recent episode manic with mild psychotic features. (GE 7; Tr. 61.)

In mid-November 2009, Applicant went out drinking at a strip club. The next day, he threatened his wife during an argument. She reported to VA clinicians that Applicant had "maxed out" one of their credit cards (GE 6.), which Applicant denies doing. (Tr. 56.) Later

in the month, she informed the VA that she decided to separate from Applicant permanently. She did not know of his whereabouts, and he was likely without his psychiatric medications since they were in the home. (GE 6.)

On November 30, 2009, the police were called to a hotel in state X on staff reports of bizarre behavior by Applicant (disoriented and claiming he was an FBI agent "testing" their security). (Tr. 54-55.) Applicant was admitted to a hospital's emergency department for exhibited confusion and agitation. He became combative with staff, and hospital security was utilized for staff safety. Laboratory testing showed his Lithium level was sub-therapeutic (below 0.1). Applicant was started on Zyprexa. At a mental health evaluation on December 1, 2009, Applicant claimed he was taking his Lithium as prescribed, but he exhibited loose associations and laughed to himself. Applicant appeared grandiosely paranoid, and his judgment and insight were poor. Applicant was eventually discharged from the hospital on December 9, 2009, and advised to stay on his medications as prescribed. (GE 8; Tr. 62.) Applicant missed work for several days because of his hospitalization, and he was given a warning from human resources. (GE 6.)

Applicant's second wife obtained a restraining order against him, and a six-month physical separation was ordered. On December 16, 2009, Applicant had an initial outpatient psychotherapy session with a psychiatric clinical nurse specialist (PCNS) at the VA. Applicant admitted that multiple stressors (child support, issues at work) caused him to stop taking his psychiatric medications. He presented as somewhat hypomanic, talkative, overly bright, somewhat expansive, but not delusional or paranoid. He recognized that he had a bipolar illness for which he needed to take prescribed Lithium. He was encouraged to take prescribed risperidone for the next few weeks to stabilize his mood. Applicant was to be monitored closely for any decompensation in his mental health, and he was referred for outpatient counseling with a VA licensed clinical social worker (LICSW). (GE 6.)

Applicant's frustrations increased over the next few days. He drove to an airport twice to pick up his son only to discover that the flights were cancelled. He received parking tickets both times. When his son was finally in route, Applicant decided to rent a car to drive to the airport because his vehicle was having mechanical problems. He charged the rental to his employer-sponsored credit card because money was tight. After his son called to indicate he was being driven by a friend, Applicant drove the rental car to see his family in state Y. He "forgot" he was driving a rental car, while his own vehicle was towed to a dealership. Applicant had not taken any Lithium because it was in his car. He was "really worked up" by the time he went to the dealership on December 22, 2009, to retrieve his vehicle. Whether due to anger or hypomania, he became upset when the car dealer put his call on hold. At the dealership, he crashed his vehicle into two cars in the lot. (Tr. 63-66.) Arrested for criminal mischief, Applicant was jailed pending bail. He continued to be without his medications (Tr. 68-69.), and agitated, he tried to escape. (GEs 6, 11.) Applicant now denies he tried to escape from jail. (Tr. 67.)

At a January 13, 2010, outpatient psychotherapy session with the VA PCNS, Applicant claimed he was doing well, although he then revealed the recent incident at the dealership and expressed concern that he could possibly lose his job over it. In a "very

stressful" meeting at work, Applicant had been confronted about his behavior, including his unauthorized charges on the corporate credit card when he was out of funds. To the VA PCNS, Applicant appeared to minimize the extent of the damage to the vehicles at the dealership. He had difficulty recalling dates and sequence of events. He was talkative, pressured, tangential, redirectable only after prompting, and exhibited some delusions or paranoia about airplanes crashing. Nonetheless, the VA concluded that inpatient treatment was not necessary because Applicant was more stable after being on Lithium for the past week. Applicant agreed to take medications (Lithium and risperidone) as prescribed, to get labs drawn as needed, to receive outpatient psychotherapy every two weeks, and, if needed, to seek treatment at a nearby VA hospital. Applicant's lithium level was low. He was advised to abstain from alcohol as much as possible. Applicant had been stable in the past for almost five years on his mental health medications. It was felt that Applicant could regain that level of stability provided he complied with his treatment (psychiatric medications and appointments) for diagnosed bipolar disorder and remained sober. (GE 6.)

By his next psychotherapy session two weeks later, Applicant was approaching his baseline of functioning. He showed good insight into his illness, although he had chosen not to take his risperidone on some Sunday nights because it made him groggy. Applicant exhibited good judgment in repaying his employer and creditors for the funds spent during his manic episode. His treatment plan was to return to the VA in one month, or sooner if needed. (GE 6.)

Due to time and attendance issues, and work performance problems, Applicant was referred by his employer to a licensed mental health counselor affiliated with its Employee Assistance Plan (EAP). Applicant had eight sessions of individual counseling from January 14, 2010 to March 29, 2010. He reported a history of prescription medications and treatment for an undisclosed condition through the VA. Because he was on medication, the EAP and VA recommended that he abstain from alcohol as part of his treatment plan. (GE 10.)

In February 2010, DOHA asked Applicant about any consultations with mental health providers because his primary care physician at the VA had indicated that he was not actively involved in his care. Applicant disclosed his outpatient counseling with the VA PCNS. About his recent arrest for criminal mischief, Applicant indicated the situation was "simply an accident that would require the filing of insurance claims to pay for damages." When he contacted the dealership to retrieve his vehicle, he got the "run-around" for about a half hour. He became "overwhelmed by the situation" because of his bipolar condition and lack of medication, and "accidentally hit vehicle" owned by the dealership. Applicant related that court hearings were pending, but he was allowed to return to work on January 11, 2010. (GE 3.)

As of late February 2010, Applicant's treating PCNS at the VA noted that Applicant's compliance with his psychiatric medication had improved, although Applicant was not taking his risperidone daily because of its effects (made him too groggy). Applicant denied any racing thoughts or anxiety. Work was not as stressful for him. Applicant was to return

in one month for VA psychotherapy and, at the recommendation of his EAP counselor, to begin social work therapy at the VA. At his initial intake with the LICSW on March 10, 2010, alcohol was identified as a potential problem in that Applicant indicated that he was drinking one alcoholic beverage a night and two or three on the weekends, although he reportedly had been abstinent for the previous week. (GE 6.)

Applicant continued to receive outpatient psychotherapy and medication management at the VA on a monthly basis. He reported taking his Lithium daily and his risperidone "most days." He was motivated for treatment and showed good insight into his mental illness. As of his April 2010 session, he was somewhat depressed because of his separation from his second wife and the garnishment of his pay by his first wife for spousal and child support. As of June 2010, Applicant had less stress in that his second wife agreed to sell the home that they had shared before their separation, so that he could move closer to his job. Of concern to this VA outpatient psychotherapist, Applicant had a sub-therapeutic Lithium level. Applicant admitted to the VA that he had missed doses of Lithium. As of August 2010, Applicant's Lithium level was down from 0.4 to 0.2.[4] (GE 6.)

By September 30, 2010, Applicant was living closer to work and pursuing a short-sale of his house. He was at his Lithium baseline and showed good judgment. He was taking a medication for a medical condition, and permitted to adjust his dosage of Lithium to help with fatigue provided he was taking his prescribed dose each day. During a primary care visit that fall, concerns were noted about that other medication. He was told not to take the drug for medical flare-ups because of a possible interaction with his mental health medication. (GE 6.)

At a December 2, 2010 outpatient psychotherapy session with the VA PCNS, Applicant reported work was going well. He admitted to some stress over difficulty selling his house, but no mood swings, anxiety, or manic symptoms. Despite a sub-therapeutic Lithium level (0.34), Applicant was maintained on the same dosage of Lithium. At his next VA psychotherapy session in late January 2011, Applicant reported one day where he felt stressed, which he relieved with a full dose of risperidone. Applicant reported he had an offer on the house, and he and his spouse were getting divorced. Lithium-level monitoring showed him to be at the low end of therapeutic. (GE 6.)

On February 26, 2011, Applicant informed DOHA that he was still taking Lithium. (GE 4.) On March 7, 2011, his VA therapist (the PCNS) opined Applicant had a condition that could impair his judgment, reliability, or ability to properly safeguard classified, national security information. His prognosis was good as long as he continued to take his medication. On March 9, 2011, the VA PCNS and the VA LICSW co-signed a letter confirming Applicant's attendance at the VA outpatient clinic for treatment of bipolar disorder with a long history of being stable and doing well on his medication. They opined that if Applicant was to come off his medication, "his behavior can and will become unpredictable." (GE 6.)

[4] According to the VA, Applicant functioned well when his Lithium level was 0.5 or higher. (GE 6.)

In May 2011, Applicant met his current spouse. (AE A.) In June 2012, while in the midst of moving their household, Applicant displayed paranoia and expressed unreasonable concerns to his spouse about their safety. Applicant asserts that he was compliant with his bipolar medications, and that the episode was brought on by a bad interaction of his Lithium medication and a steroid medication taken for a medical condition. At his spouse's suggestion, he admitted himself for inpatient psychiatric treatment for eight to ten days. His Lithium level was low. Following this hospitalization, Applicant was out of work for three weeks. Shortly after his return to work, Applicant became depressed over the loss of his mentor at work. In late July or early August 2012, he was admitted to a VA hospital for ten days for treatment of his first mixed bipolar episode (mania and depression). Three days after his discharge, he returned to work.[5] (GE 11; AE A.) His steroid medication was discontinued (AE A; Tr. 74.), although because of his bipolar disturbances, his Lithium dose was increased from 900 mg. per day to1200 mg. per day. (Tr. 76-77.) As of March 1, 2013, Applicant was still on this dose of Lithium. (Tr. 81.)

From August 17, 2012 to mid-February 2013, Applicant had counseling with an EAP-affiliated LICSW. Applicant was compliant with the LICSW's treatment recommendations. (AE A.) The EAP clinician advised Applicant to continue with their sessions as well as his VA counseling, and to take his pharmacological medications as prescribed. (Tr. 75.)

On October 2, 2012, Applicant underwent a psychological evaluation by a licensed clinical psychologist for the DOD. Applicant remained "somewhat tense" throughout the evaluation. His speech was "somewhat rapid and mildly pressured." He remained "friendly, appropriate, cooperative, and focused throughout the evaluation." He reported low stress. He was living with his fiancée (now spouse) and her two children, and he was reportedly exercising regularly. The psychologist assessed Applicant's bipolar condition as chronic and likely to continue throughout his working life:

> [Applicant's] bipolar condition will, in all likelihood, continue throughout his working life, although it is not unusual for the severity of manic and hypomanic episodes to subside somewhat with the reduction in energy accompanying the aging process. His times of dysfunctionality and erratic behavior appear to come on quite rapidly, although had he more insight and awareness of his own mental-emotional state it is possible that he would be able to identify the precursors to episodes, rather than, as has usually been the case, his instability first being detected by others. On the positive side, he does not have the history of substance abuse so common in those with his condition; on the negative, there is no firm reason to believe that his pattern of irregular taking of prescribed bipolar medication has changed. He will in all likelihood remain prone to periods of dysfunctionality and erratic behavior

[5]The file contains no outpatient psychotherapy notes of sessions at the VA after January 31, 2011. So, although the PCNS confirmed that Applicant was in psychotherapy as of February 22, 2013, it is unclear whether clinicians attribute his episodes to the interaction of his Lithium with his steroid medication, to stress, to another cause not apparent in the record, or to a combination of factors.

possibly compromis[ing] the responsibility with which he is entrusted. (GE 11.)

Available laboratory test results show Applicant's Lithium level was slightly below therapeutic as of early October 2012, although it was a therapeutic .88 in January 2013. Applicant still attends the VA outpatient clinic for treatment of his bipolar disorder. His treatment plan is to continue taking psychopharmacological medication (mainly Lithium) and receiving supportive counseling. As of February 22, 2013, his VA therapist opined that when Applicant is stable, on medication, and invested in his treatment, he is capable of functioning at a normal level. Yet, the nature of bipolar disorder makes it difficult to predict Applicant's future compliance with his treatment plan. (AE A.)

Applicant understands that his bipolar illness is life-long and requires daily medication to control it. He intends to comply with treatment recommendations, which involve taking the dosages of pharmacological medications prescribed for him, having routine blood workups to check medication levels, and routine psychotherapy. Every couple of weeks, he has counseling at the VA, and every three or four weeks, he sees the EAP clinician. (AE A; Tr. 35, 72-73, 76.) Applicant's spouse is supportive of him. She makes sure that he takes his nightly dose. (AE A; Tr. 78.)

Applicant's annual work performance evaluations from 2008 through 2012 show that he has a record of valuable technical, organizational, and leadership contributions. He exceeded the requirements of his position in 2008 and met them in subsequent years. For 2011, he was described as a "valued and versatile individual" at the company. In 2012, his key strengths were work ethic, task management, leadership ability, and presentation skills. Applicant worked many extra hours to complete tasks on time and with high quality. He performed best on a small team, where his maturity and professionalism improved productivity. Supervisory personnel believed he would benefit from a mentor who could advise him on career advancement. (AE A.) Applicant denies any violations of security regulations or procedures at work or in the military (Tr. 37.), and no evidence was presented to the contrary.

Policies

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

scrutiny of a number of variables known as the "whole-person concept." The administrative judge must consider all available, reliable information about the person, past and present, favorable and unfavorable, in making a decision.

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

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

Analysis

Guideline I—Psychological Conditions

The security concern for psychological conditions is set out in AG ¶ 27:

> Certain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness. A formal diagnosis of a disorder is not required for there to be a concern under this guideline. A duly qualified medical 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. No negative inference concerning the standards in this Guideline may be raised solely on the basis of seeking mental health counseling.

Applicant required inpatient psychiatric treatment in May 2000, after an incident involving the ship's executive officer. He was diagnosed with bipolar disorder and prescribed a mood stabilizer. A diagnosis of bipolar disorder is not per se disqualifying, and no negative inferences are raised solely on the basis of counseling or medication

management for the condition. However, Guideline I concerns are raised when the mental health condition is not adequately managed and results in behavior that casts doubt on judgment, reliability, or trustworthiness. Applicant refused to acknowledge his mental illness in 2000, and he did not take his medication. After a manic episode in a mall parking lot in January 2003, Applicant was psychiatrically hospitalized for six weeks. He was mentally stable for a sustained period thereafter while in treatment with the VA, consisting primarily of monitoring prescribed Lithium. Around January 2009, Applicant decided, on his own, to reduce his daily intake of Lithium. He began taking only two doses rather than three, at a time when his home and work life were especially stressful. By October 2009, he was exhibiting delusional and paranoid behavior at home. At the request of his primary care physician, Applicant was evaluated by VA outpatient psychiatry for urgent medication management on October 20, 2009. He was placed on risperidone as well as Lithium. He chose to take minimal doses of risperidone because he did not like its effect on him, and he declined individual psychotherapy.

In early November 2009, Applicant was admitted to a psychiatric hospital for hypomania related to noncompliance with his Lithium therapy and lack of regular psychiatric counseling. At discharge on November 13, 2009, his judgment was assessed as fair to good, but he continued his bizarre behavior (e.g., threatened his second wife, spent excessively on credit). On November 30, 2009, after he impersonated an FBI agent claiming he was testing hotel security, he was admitted to a hospital exhibiting mania, confusion, and agitation. Laboratory testing showed Applicant's Lithium level to be sub-therapeutic. At discharge from the hospital on December 9, 2009, Applicant was encouraged to take his medications.

Applicant presented as somewhat hypomanic at an initial intake for outpatient psychotherapy at the VA on December 16, 2009, and he was urged to take risperidone as well as Lithium. Within the next week, Applicant crashed his vehicle into two cars at a dealership after he got upset when the dealer placed his call on hold. He attempted to escape from jail where he had been confined on a criminal mischief charge for damaging the cars at the dealership. After he returned to work, Applicant expressed unreasonable concerns about planes crashing during a session at the VA on January 13, 2010.

Applicant showed improved compliance with his Lithium medication while in outpatient psychotherapy with the VA, although he missed some dosages. As of August 2010, his Lithium level was low. He also did not take his full dosage of risperidone because it made him feel groggy. Although prescribed "as needed," VA clinicians continued to recommend that he take the full dosage for beneficial effect. Applicant drank alcohol despite being advised to avoid alcohol as much as possible.

After being relatively stable for 2.5 years, Applicant was twice hospitalized for mental health issues in the summer of 2012. In June 2012 Applicant displayed paranoia, expressing concerns to his spouse for their safety. After his first inpatient stay of eight to ten days, he had a hypomanic and depressive episode in late July or early August 2012. No medical records were made available for either admission, and there is no confirmation from his therapist at the VA that the bipolar episode was attributable in whole or in part to a

bad interaction of steroid medication with his Lithium. At the same time, there is no evidence that he took less Lithium than prescribed.

Under Guideline I, Applicant's erratic and, at times, bizarre behavior during hypomanic episodes implicates disqualifying condition AG ¶ 28(a), "behavior that casts doubt on an individual's judgment, reliability, or trustworthiness that is not covered under any other guideline, including but not limited to emotionally unstable, irresponsible, dysfunctional, violent, paranoid, or bizarre behavior." AG ¶ 28(b), "an opinion by a duly qualified mental health professional that the individual has a condition not covered under any other guideline that may impair judgment, reliability, or trustworthiness," applies. A licensed clinical psychologist, who evaluated Applicant at the DOD's request in October 2012, opined that Applicant has a chronic bipolar condition, and that he is likely to remain prone to periods of dysfunctional and erratic behavior that could possibly compromise the responsibility to which he is entrusted.

AG ¶ 28(c), "the individual has failed to follow treatment advice related to a diagnosed emotional, mental, or personality condition, e.g., failure to take prescribed medication," is also established. Applicant has a history of not fully complying with the treatment for his bipolar illness, even assuming he is currently following his treatment plan. He did not accept the diagnosis of bipolar disorder or the need for treatment in 2000. It led to the manic episode in January 2003. Once he began taking Lithium, his mental health stabilized, although he declined recommendations for psychiatric counseling. He also drank alcohol against clinical advice. Around January 2009, he stopped taking his full dose of daily Lithium. His decision to reduce his intake of Lithium was medically contraindicated in 2009, whatever he had been told in 2003 about the course of his illness long term. Applicant also chose not to take risperidone on many Sundays because it made him feel groggy. By October 2009, his mental health had deteriorated to require an emergency consultation at the VA for medication management. Applicant's hypomania in October 2009 and in early November 2009 was attributed by mental health clinicians to his noncompliance with his Lithium and the lack of regular psychiatric follow up. After Applicant was discharged from his psychiatric hospitalization on November 13, 2009, he did not immediately follow up on the referral to outpatient treatment at the VA. His failure to pursue recommended treatment had negative consequences for his mental stability, as evidenced by his drinking at a strip club in mid-November 2009, spending excessively on credit, and in late November 2009 impersonating an FBI agent.

Applicant's history of erratic compliance with his treatment for his diagnosed mental illness precludes reasonable application of mitigating condition AG ¶ 29(a), "the identified condition is readily controllable with treatment, and the individual has demonstrated ongoing and consistent compliance with the treatment plan." Also, it is difficult to fully apply AG ¶ 29(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." Applicant's 2012 psychiatric hospitalizations were voluntary, but he also has a history of involuntary mental health admissions. He was confused, agitated, and exhibiting loose associations when brought to the hospital by the police after he was observed

impersonating an FBI officer claiming to test a hotel's security in late November 2009. AG ¶ 29(b) also requires a favorable prognosis. Applicant's VA therapist considers him capable of functioning at a normal level, if he is stable, on medication, and invested in his treatment, but the PCNA also opined that the nature of bipolar disorder is such that it is difficult to predict how Applicant will do in the future. Moreover, a qualified clinical psychologist assessed Applicant's condition as chronic, with "no firm reason to believe that his pattern of irregular taking of prescribed bipolar medication has changed." Applicant maintains that he has been compliant of late with his psychiatric medication. Even so, it failed to prevent the manic episode in June 2012 or the bipolar (depression and manic) behavior in late July or early August 2012. Available evidence is insufficient to attribute the recent exacerbations of his illness, in whole or in part, to pharmacological interaction of steroid medication rather than to the nature of his bipolar illness, which, by history, has been of rapid onset and in response to stress.

AG ¶ 29(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," is not established. A duly-qualified clinical psychologist, who evaluated Applicant for the DOD, opined that Applicant lacks sufficient insight and awareness of his own mental-emotional state to be able to identify the precursors to his bipolar episodes. He concluded that Applicant will in all likelihood remain prone to periods of dysfunctional and erratic behavior.

Neither AG ¶ 29(d), "the past emotional instability was a temporary condition (e.g., one caused by death, illness, or marital breakup), the situation has been resolved, and the individual no longer shows indications of emotional instability," nor AG ¶ 29(e), "there is no indication of a current problem," is implicated in light of the chronic nature of Applicant's mental illness, even if he is currently functioning well. The psychological concerns are not fully mitigated under Guideline I.

Whole-Person Concept

Under the whole-person concept, the administrative judge must evaluate an applicant's eligibility for a security clearance by considering the totality of his conduct and all relevant circumstances in light of the nine adjudicative process factors listed at AG ¶ 2(a).[6] Applicant's valuable contributions to his employer since 2008 weigh in his favor under the whole-person assessment. During extended periods of mental stability, Applicant showed himself to be a good leader, well-organized, and capable of handling his job and

[6]The factors under AG ¶ 2(a) are as follows:

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

security responsibilities. At the same time, he has a chronic condition that requires ongoing pharmacological intervention with clinical monitoring. He exercised extremely poor judgment when he chose not to take doses of prescribed psychiatric medication without first consulting mental health professionals or his primary care physician. The negative consequences of his noncompliance with his treatment included bizarre and even potentially dangerous behavior. None of the episodes occurred at work, although they affected his job in lost time. While in the throes of a manic episode in December 2009, he used his employer-sponsored credit card to rent a vehicle for personal use without authorization.

Whether due to his hypomanic state at the time, to self-denial of his mental illness, or to reluctance to admit to behavior raising serious security concerns, Applicant denies any recall of trying to activate car alarms in the mall parking lot in 2003. He claims his first wife "freaked out" when she arrived with the keys for his vehicle. He denies that he spent excessively on credit during his second marriage or that he tried to escape from jail after his arrest for criminal mischief. Applicant attributes his latest bipolar episodes in the summer of 2012 solely to the "bad interaction" of a steroid medication to his Lithium. The record evidence does not indicate that Applicant was taking less medication than was prescribed, and voluntary treatment is viewed favorably. Yet, mental instability severe enough to require a psychiatric admission certainly raises concerns about whether his mental illness is being properly controlled or managed. Applicant's commitment to adhere to his treatment plan going forward is not enough to overcome the Guideline I security concerns, especially when a duly-qualified mental health professional is not confident about Applicant's ability to recognize the precursors to a bipolar episode or to take his medications on a regular basis. The DOHA Appeal Board has long held that the federal government need not wait until an applicant actually mishandles or fails to safeguard classified information before it can deny or revoke access to such information. The absence of security violations does not bar or preclude an adverse security clearance decision. *See e.g.,* ISCR Case No. 08-09918 (App. Bd. Oct. 28, 2009.) Based on all the circumstances, I cannot conclude that it is clearly consistent with the national interest to continue Applicant's security clearance at this time.

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
Subparagraph 1.a:	Against Applicant
Subparagraph 1.b:	Against Applicant
Subparagraph 1.c:	Against Applicant
Subparagraph 1.d:	Against Applicant
Subparagraph 1.e:	For Applicant
Subparagraph 1.f:	For Applicant[7]

[7] In the absence of evidence showing that Applicant resisted treatment, or that behavior by Applicant caused

Subparagraph 1.g: Against Applicant

Conclusion

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

Elizabeth M. Matchinski
Administrative Judge

or contributed to the exacerbations of his bipolar disorder in the summer of 2012, SOR 1.e and 1.f are resolved in his favor. Nonetheless, this does not preclude me from considering these episodes in determining whether his bipolar condition is sufficiently stable to conclude that hypomanic, paranoid, delusional, or bizarre behavior is not likely to recur.