DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
	)	ISCR Case No. 21-00428
	)	
Applicant for Security Clearance	)	

Appearances

For Government: Andre Gregorian, Esq., Department Counsel
For Applicant: Jason Perry, Esq.

04/18/2023

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Decision

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RICCIARDELLO, Carol G., Administrative Judge:

Applicant failed to mitigate the security concerns under Guideline I, psychological conditions. Eligibility for access to classified information is denied.

Statement of the Case

On April 14, 2021, the Department of Defense (DOD) issued to Applicant a Statement of Reasons (SOR) detailing security concerns under Guideline I, psychological conditions. The action was taken under Executive Order (EO) 10865, *Safeguarding Classified Information within Industry* (February 20, 1960), as amended; DOD Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (January 2, 1992), as amended (Directive); and the adjudicative guidelines (AG) effective on June 8, 2017.

Applicant answered the SOR on May 17, 2021, and requested a hearing before an administrative judge. The case was assigned to me on August 15, 2022. The Defense Office of Hearings and Appeals (DOHA) issued a notice of hearing on September 9, 2022, scheduling the hearing for October 17, 2022. On September 22, 2022, Applicant through

Counsel requested an extended continuance based on Applicant's condition. The request was granted and on October 3, 2022, DOHA issued an amended notice of hearing scheduling the hearing for January 24, 2023. I convened the hearing as rescheduled.

The Government offered exhibits (GE) 1 through 5. Applicant testified and offered Applicant Exhibits (AE) A through AA. There were no objections to any exhibits, and all were admitted into evidence. The record was held open until February 27, 2023, to allow Applicant to provide additional documents and an opportunity for Department Counsel to review the documents. Applicant provided AE AB through AE AR. There were no objections to Applicant's additional exhibits, and they were admitted in evidence. There are numerous hearing exhibits (HE I through IX) that include administrative emails, summary explanations of exhibits, post-hearing arguments, requests for administrative notice, and an amendment to the SOR. I have taken administrative notice as requested in the documents submitted. The amendment to the SOR is addressed below. DOHA received the hearing transcript on February 3, 2023.

Procedural Matter

In accordance with DOD Directive 5220.6 the Government moved to amend the SOR to conform with the evidence by adding ¶ 1.c. The motion was granted. The amendment is as follows:

> From June 2017 through at least July 2022, you have suffered from altered mental status that casts doubt on your judgment, stability, reliability, and trustworthiness, including cognitive impairment, memory loss, confusion, paranoia, delirium, and psychosis. You have been hospitalized on multiple occasions to address these symptoms. (HE V)

Findings of Fact

Applicant admitted the allegation in SOR ¶ 1.a. She admitted and denied different aspects of SOR ¶ 1.b. Her admissions are incorporated into the findings of fact. After a thorough and careful review of the pleadings, testimony, and exhibits submitted, I make the following findings of fact.

Applicant is 52 years old. She served in the military on active duty from 1989 to 1993 and was in the reserves until 1996. She received an honorable discharge. She earned a bachelor's degree in 2001 and a master's degree in 2008. She has been married since 1995 and has an adult stepson. She worked for federal contractors since 2007 and held a security clearance throughout her employment. She started working for her present employer in January 2022. At the time of her hearing, Applicant was on medical leave until February 5, 2023. (GE 1; Tr. 19-26, 68-71)

Applicant has had a myriad of medical issues. In June 2017, she was hospitalized with encephalitis-like symptoms. Her symptoms were severe headache, nausea, and neck pain. She was provided different treatments that she said did not work and was

originally hospitalized for a week, released, and then hospitalized again. She returned to work in September 2017. Encephalitis is an inflammation of the brain. Flu-like symptoms are possible and in more severe cases people may experience problems with speech and hearing, hallucinations, personality changes, loss of consciousness, loss of sensation in some parts of the body, muscle weakness, partial paralysis in the arms and legs, impaired judgment, seizures, and memory loss.[1] (Tr. Tr. 28-29; AE-AO, AE-AP, AE-AQ, AE-AR; HE VIII)

In April 2018, Applicant was hospitalized. Her medical records reflect that she had a long history of encephalopathy of unknown origin and was diagnosed with acute encephalopathy, pneumonia, and sepsis. Encephalopathy is a term for any disease of the brain that alters brain function or structure. It may be caused by other medical issues. The hallmark of it is an altered mental state. Common neurological symptoms are progressive loss of memory and cognitive abilities, subtle personality changes, inability to concentrate, lethargy, and progressive loss of consciousness.[2] At the time of her admission to the hospital her husband reported she had a cough, fever, and confusion and was not making sense. She testified that at that time, the doctors did not know if the encephalopathy or sepsis was the cause of her symptoms. She was discharged several days later, returned to work for ten days, and then relapsed. She was taken to a university hospital and was admitted for encephalopathy and psychosis. She was an inpatient for a week and discharged. She tried to work the month of May but was having recurring headaches and went to the community hospital two more times in May 2018. (Tr. 29-31; AE-AO, AE-AQ, AE-AR, HE VIII)

In June 2018, Applicant voluntarily went to the Department of Veterans Affairs (VA) hospital and was admitted. She made comments of a suicide nature to one of the resident physicians and the admission was converted to an involuntary admission. She explained she became frustrated and should not have made the comments she did. She was tired of the probing and said she was sick of being questioned and said if the window was open, she would jump out of it. They were on the second floor. She did not mean this as a suicidal statement, but more one of frustration. She spent four days in the hospital. (Tr. 31-34; GE 5; AE-AR)

In June 2018, when Applicant went to the VA hospital because she was having chest pains, foggy vision and altered mental status. She said she lost voluntary control at the time and felt like she was at the bottom of a pool and unable to respond to stimuli around her. She acknowledged having impaired reality testing (such as auditory and visual hallucinations and delusional beliefs). She had periods of severe confusion, cognitive problems or forgetfulness, distractibility, losing her train of thought, slow thinking and word finding difficulties. She indicated that beginning in May 2018 she was perceiving things that were not real. Applicant was on medical leave from her employment from June 2018 to June 2019. (Tr.94-95; GE 5 at 34-35, 93; AE-AR)

[1] HE VIII; https://www.ninhs.nih.gov/health-information/disorders/encephalitis
[2] HE VIII; https://www.ninhs.nih.gov/health-information/disorders/encephalopathy

After Applicant's discharge from the VA hospital, she began seeing Dr. D, a psychiatrist with the VA. She has been Dr. D's patient since June 2018. It is reported that Applicant began having confusion, disorientation, inability to communicate and seizures in late 2018. She was diagnosed with epilepsy in approximately June 2019 and takes anti-seizure medication for the epilepsy. (Tr. 34-39, 45-46; AE U)

Dr. D provided a letter from June 2019 stating she had been treating Applicant since June 2018 for depression disorder and anxiety disorder. Applicant had been compliant with treatment and recommendations and had achieved her baseline. She stated that Applicant would benefit from returning to work part-time. In April 2021, Dr. D provided another letter to provide a summary of Applicant's care. She indicated that Applicant initially had an altered mental status secondary to an infection of unknown source and not from a primary psychiatric disorder. She noted that Applicant should not have been admitted involuntarily to the psychiatric floor in June 2018 but should have been placed on the medical floor. After an extensive medical work up, Applicant was diagnosed with epilepsy, double pneumonia, sepsis, and encephalopathy. These all affected her cognitive ability. She has been somewhat depressed due to her cognitive decline, short term memory loss, seizures, and lifestyle modifications. Dr. D noted that her neurologist helped control her seizures. She returned to work in September 2019. She was discharged from Dr. D's care in approximately January 2020. Applicant reached out to Dr. D again after receiving the SOR and throughout 2021 and in the beginning of 2022. (Tr. 46-48, 132-136; AE S, T)

In December 2020, Applicant participated in a mental health evaluation with Dr. B, a psychologist approved by the government. Dr. B administered psychological tests to Applicant. The results were considered normal and there was no significant psychopathology. Applicant's responses were below average for motivation for treatment. Dr. B diagnosed Applicant with unspecified anxiety disorder, unspecified depressive disorder, and functional neurologic disorder (previously referred to as conversion disorder in prior versions of the DSM). She noted that Applicant was compliant with medications prescribed by her physicians for anxiety and depression. Dr. B reported that Applicant had not continued treatment with a psychiatrist or therapist, which contradicts Applicant's testimony. Dr. B had concerns that Applicant could have a recurrence of conversion symptoms due to her lack of ongoing treatment for anxiety and depression. She recommended Applicant continue her psychiatric/psychological treatment, despite her psychological test results that indicated Applicant is not interested in doing so, and her history that documents her failure to adhere to treatment recommendations. Consequently, Dr. B stated that her prognosis is guarded. Applicant's history of psychotic episodes leads Dr. B to be concerned about Applicant's reliability, judgment, stability, and trustworthiness. Applicant testified that her meeting with Dr. B was through the Zoom platform and lasted one hour. (Tr. 43-44; GE 4)

Medical records show that in July 2021, Applicant met with Dr. T, a rheumatologist, for follow-up treatment. Applicant reported to Dr. T that she continued to have memory problems and impaired cognitive ability, such that she could not even play Bingo. She

had difficulty with recall and word-finding. She realized she was incorrectly performing some tasks, like putting cereal in the dog bowl. (Tr. 119-120, 130; AE-AR)

On March 28, 2022, Applicant was admitted to the hospital. She had been experiencing neurological symptoms like Bell's palsy and dizziness in early March. It was determined to be a virus. At the end of March, Applicant experienced severe headaches that worsened over several days and she exhibited confusion. Her husband took her to the hospital where she was involuntarily admitted. She testified she was involuntarily admitted into the psychiatric ward due to suffering from encephalopathy. Her symptoms included confusion, psychosis and "she was not making sense." Her treating physician Dr. T communicated with the admitting hospital, and she was started on high dose of steroids. She was discharged and remained on a five-day regiment of intravenous steroids. (Tr. 50-53, 141-142; AE-AR) When asked if Dr. T had diagnosed her, Applicant's testimony was as follows:

> [Dr. T] suspected that it was autoimmune encephalopathy. And she also consulted with a neurologist in the community because I had responded with the high dose of steroids, that's always been her diagnosis has been autoimmune encephalopathy, steroid responsive. (Tr. 53)

At the bottom of the July 2021 medical report, Dr. T wrote a note dated March 31, 2022, which stated:

> I have sent this note for her MD to review as I have been informed of her admission for mental health status changes. Please consider a Neurology eval[uation] for encephalopathy of all etiologies. Her Sjogren's dx predisposes her to autoimmune CNS involvement. (AE V)

Applicant remained in the hospital from March 28, 2022, until the third week of April 2022. She reached out again to Dr. D, and she is now seeing her every four to six weeks. Applicant testified that Dr. D strongly ruled out any type of conversion/functional neurological disorder as mentioned by Dr. B. Dr. D provided letters from August 2021 and October 2021, which specifically rule out a conversion disorder. In her October 2021 letter, Dr. D noted that she has been treating Applicant since June 2018 and she has followed all treatment recommendations. Based on her treatment of Applicant, she did not have concerns regarding her reliability, judgment, stability, and trustworthiness and did not have reservations recommending her for a security clearance. (Tr. 48-50, 136-141; AE W, AE X, AE-AQ, AE-AR)

Applicant testified that a neurologist was consulted during her March 2022 hospital admission about her diagnosis of autoimmune encephalopathy steroid-responsive. Applicant was discharged from the hospital on April 19, 2022. Applicant was treated with antipsychotics and Lorazepam. She testified that when she was discharged from the hospital, she was struggling with short-term memory loss, but was uncertain if it was due to the drugs she was prescribed, including the antipsychotic drug. She said she had

similar symptoms in June 2021 after she stopped taking the drugs. The antipsychotic drug was discontinued in July 2022. (Tr. 54-58, 119-125; AE-AQ)

Applicant testified that Dr. D believed her episodes were due to medical and not psychiatric causes. Applicant testified that in April 2022 she was diagnosed with autoimmune encephalopathy that is steroid responsive. Applicant stated that she had not yet been diagnosed with autoimmune encephalopathy with steroid-responsive when she met with Dr. B. (Tr. 38-44)

Dr. D provided another letter from May 2022. She confirmed that Applicant was admitted to the VA hospital in March 2022 with altered mental status and was transferred to another hospital. She was treated with antipsychotics and Lorazepam for possible catatonia. She was diagnosed with encephalopathy associated with autoimmune thyroiditis that responded to steroids. Dr. D expected Applicant to make a full recovery in the next 9 to 12 months. She noted that the last episode Applicant had was three years ago and it lasted 14 months. She said Applicant would be monitored and her medications adjusted accordingly. (AE Y)

Applicant admitted that until July 2022 she was taking prescribed antipsychotic drugs that were prescribed to her, presumably during her last admission to the hospital. She explained that when she was admitted to the hospital in March 2022, she exhibited an altered mental status that presented as confusion, catatonic behavior, and emotionally detached. She said neither Dr. T nor Dr. D had been consulted while she was admitted. (Tr. 73, 77)

Applicant testified that the course of treatment for encephalopathy was determined to be immunosuppressant theory. In September 2022, she had not yet begun immunosuppressant therapy to know if it is an effective treatment for her condition. There are four drugs potentially to treat her condition, and she began taking one in October 2022. She continues to be on it and will need it or a similar drug for the rest of her life to control her condition. (Tr. 143-146)

Dr. D provided an updated letter on January 11, 2023. She stated that Applicant was successfully tapered off her antipsychotics and mood stabilizers. Her Lorazepam daily dose has been decreased. She has followed up with her doctor for encephalopathy associated with autoimmune thyroiditis that has successfully responded to steroids. She noted Applicant's mental status examination is intact as well as her character, judgment, reliability, and integrity. The recommended treatment plan is for her to continue to take immunosuppressive medication, which will help prevent recurrence of the encephalopathy. She should have a good prognosis if she continues to follow up as she has done in the past. Dr. D had no reservations about recommending Applicant for a security clearance. (Tr. 144; AE Z)

Dr. T provided a letter from January 2023. She said she has been taking care of Applicant since November 2018. She stated that Applicant suffers from recurrent encephalopathy, which is presumed to be autoimmune secondary to Sjogren's

syndrome.[3] She noted that her condition is steroid responsive. She is on a daily preventive treatment with immunosuppressants that "should limit or fully prevent any recurrence of her encephalopathic manifestations." Her condition in Dr. T's opinion does not affect her character, integrity, or judgment "when it is under control, as it currently is and should not prevent her from continuing with her job." (Tr. 53-54, 146; AE-AA)

Applicant testified that her recovery is going well. Dr. T has eliminated some medications and is prescribing other medications for long-term care to prevent recurrence of the issues related to autoimmune encephalopathy. Dr. T and Applicant are working out a strategy for a long-term treatment plan. She and her husband are aware of what to look out for if she begins experiencing symptoms that raise concerns that the encephalopathy is recurring. She noted that stress is a factor that triggers her symptoms and the autoimmune disorders. She acknowledges that she experienced anxiety and depressive disorders in the past. She disagreed with Dr. B's diagnosis of conversion disorder. She understands that Dr. T is attempting to find the right dosage of medication for her continued treatment. She understands that this is an ongoing process. She explained that her symptoms are documented in her medical records, but there is no way she can say definitively that future problems will not recur. She does not think they will and trusts that they will not, but she cannot say with certainty; however, she knows what to do if symptoms recur. (Tr. 57-67; 147-151)

At the time of her hearing, Applicant had not yet been cleared to return to work by Dr. D. Applicant testified that she did not have current symptoms of short-term memory loss or altered mental state. She anticipated seeing Dr. T or another specialist for the rest of her life. She also said she will continue to see Dr. D until she discharges her and will follow her recommended treatment plan. Applicant is not on antipsychotic drugs at present. She further testified that she has a medical diagnosis that has psychiatric symptoms that she is being treated for. Although she was diagnosed with anxiety and depression, she does not believe it affects her ability to perform her job. Since the doctors have determined the underlying cause of her symptoms, she has noticed an improvement in her condition because she has a better understanding of her issues. (Tr. 57-67, 147-153)

Applicant provided numerous character letters. Many of them were written before her most recent hospitalization in March 2022. She testified that she reached out to those providing letters to make them aware of her hospitalization and inquired if any of them wanted to revoke their letters. None of them wanted to revoke their letters. She is described as dynamic, confident, generous, thoughtful, composed, professional, fair, strong, steady, resilient, determined, honorably, disciplined, honest, loyal, smart, talented, positive, compassionate, patriotic, reliable, respected, trustworthy, and responsible. She possesses technical, leadership and business-related skills. Her past work performance is described as exceptional. She possesses a high level of trust and integrity and a strong work ethic. (AE A through AE R, AE-AB)

[3] Sjogren syndrome is an autoimmune disorder in which immune cells attack and destroy the glands that produce tears and saliva. https://rarediseases.info.nih.gov/diseases/1025/sjogren-syndrome

Medical Record Review

A review of Applicant's medical records from 2018 through 2022 reflect that in April 2018 it was noted that she had a long history of encephalopathy with unclear origin and a diagnosis of acute encephalopathy secondary to sepsis. She was experiencing confusion at the time.

On March 30, 2022, Applicant was involuntarily hospitalized at the VA hospital. Her medical records noted that she had a history of present illness for depression, anxiety, Sjogren's disorder, seizure disorder, hypothyroidism, PCOS (polycystic ovarian syndrome) and neurogenic bladder. She was admitted to inpatient psychiatry for acute psychosis. She was placed in restraints due to disruptive behavior that posed a risk of injury to herself and others. She was climbing on the windowsill, removing her hospital scrubs, pacing, banging on a chair and bedside table and unable to follow simple directions. Later, she admitted to the medical staff that she had been bad, and she was responsible for the use of restraints but was unable to give a coherent answer as to what she meant but acknowledged there was a safety issue. She reported seeing things that were not present in reality. The medical records reflect that there was concern from Dr. T that her symptoms were the result of medical problems, and she was transferred to a medical floor. Multiple doctors considered Dr. T's diagnosis of autoimmune encephalopathy and recommended further medical testing. A VA psychiatrist noted that Applicant was transferred to the medical floor for a workup for the medical etiology of symptoms which was unrevealing. Other neurologists discussed the use of steroids on patients suspected of having immune mediated encephalopathy. Worsening psychosis was discussed with the neurology team, and it was felt that a lumbar puncture should precede a steroid trial. This procedure was declined by Applicant's family. The VA doctors considered Dr. T's diagnosis of autoimmune encephalopathy but none of the diagnostic tests confirmed abnormalities. She was treated with high dose steroids but the precise cause for her medical problems are unclear. (AE-AR)

According to the medical records when Applicant was discharged from the VA hospital on April 9, 2022. Dr. P's diagnosis on discharge was acute psychosis. Tests had been performed with no acute findings. Dr. P noted that if there was a plausible diagnosis for metabolic/autoimmune/Hashimoto's encephalopathy then he supported treatment with high dose steroids, but he did not find either clinically or biochemically that Applicant had encephalopathy. He recommended ancillary testing to formally diagnose Anti-N-methyl D-aspartate (NMDC) encephalitis or to rule out an infectious source. He noted the family refused the procedure of lumbar puncture to make this determination, so neurology empirically treated her with high dose steroids for a working diagnosis of autoimmune encephalitis. (AE- AO, AE-AR)

On April 12, 2022, Applicant was again hospitalized. Her prior history noted that she had seizure disorder, anxiety, depression, and prior reported encephalitis and recent multiple hospitalizations for decline in cognitive status and altered mental status. At the time of admission, she was having ongoing altered mental status issues. The medical record again noted that there was suspicion of possible Hashimoto's encephalopathy and

neurology had recommended she be placed on high dose steroids. It was also noted that acute encephalopathy had an unclear etiology. She was subsequently discharged on April 19, 2022. (AE-AQ)

Policies

When evaluating an applicant's national security eligibility, the administrative judge must consider the AG. In addition to brief introductory explanations for each guideline, the adjudicative guidelines list potentially disqualifying conditions and mitigating conditions, which are used 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 overarching 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 national security eligibility will be resolved in favor of the national security." In reaching this decision, I have drawn only those conclusions that are reasonable, logical, and based on the evidence contained in the record. Likewise, I have avoided drawing inferences grounded on mere speculation or conjecture.

Under Directive ¶ E3.1.14, the Government must present evidence to establish controverted facts alleged in the SOR. Directive ¶ E3.1.15 states an "applicant is responsible for presenting witnesses and other evidence to rebut, explain, extenuate, or mitigate facts admitted by applicant or proven by Department Counsel, and has the ultimate burden of persuasion as to obtaining 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 an 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 EO 10865 provides that decisions shall be "in terms of the national interest and shall in no sense be a determination as to the loyalty of the applicant

concerned." *See also* EO 12968, Section 3.1(b) (listing multiple prerequisites for access to classified or sensitive information).

Analysis

Guideline I: Psychological Conditions

The security 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 mental health professional (e.g., clinical psychologist, or psychiatrist) employed by, or acceptable to and approved by the U.S. Government, should be consulted when evaluating potentially disqualifying and mitigating information under this guideline and an opinion, including prognosis, should be sought. No negative interference concerning the standards in this guideline may be raised solely on the basis of mental health counseling.

The guideline notes several conditions that could raise security concerns. I have considered all of the disqualifying conditions under AG ¶ 28, and the following are potentially applicable:

> (a) behavior that casts doubt on an individual's judgment, stability, reliability, or trustworthiness, not covered under any other guideline and that may indicate an emotional, mental, or personality condition, including, but not limited to, irresponsible, violent, self-harm, suicidal, paranoid, manipulative, impulsive, chronic lying, deceitful, exploitative, or bizarre behaviors; and
>
> (b) an opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness;
>
> (c) voluntary or involuntary inpatient hospitalization; and
>
> (d) failure to follow prescribed treatment plans related to a diagnosed psychological/psychiatric condition that may impair judgment, stability, reliability, or trustworthiness, including but not limited to, failure to take prescribed medication, or failure to attend required counseling sessions.

There is sufficient evidence that from approximately 2018 through 2022 Applicant exhibited emotional and mental conditions and behaviors as described in AG ¶ 28(a). The evidence also includes an opinion by a qualified mental health professional that Applicant has a condition that may impair her judgment, stability, reliability, and trustworthiness. She has been hospitalized both voluntarily and involuntarily on several occasions since 2017. AG ¶¶ 28(b) and 28(c) apply.

There is evidence that doctors recommended for the purposes of proper diagnosis that she have a lumbar puncture to determine if her issues are medical vice psychiatric. The procedure was declined by her family. I am not convinced that her failure to have a lumbar puncture is a treatment plan related to a diagnosed psychological/psychiatric condition. It was an invasive diagnostic procedure to determine whether she should be treated with steroids. She was treated with steroids without the puncture. In addition, she did not decide against the procedure; her family did. AG ¶ 28(d) does not apply.

The guideline also includes conditions that could mitigate security concerns arising from psychological conditions. The following mitigating conditions under AG ¶ 29 were considered:

> (a) the identified condition is readily controllable with treatment, and the individual has demonstrated ongoing and consistent compliance with the treatment plan;
>
> (b) the individual has voluntarily entered a counseling or treatment program for a condition that is amenable to treatment, and the individual is currently receiving counseling or treatment with a favorable prognosis by a duly qualified mental health professional;
>
> (c) recent opinion by a duly qualified mental health professional employed by, or acceptable to and approved by, the U.S. Government that an individual's previous condition is under control or in remission, and has a low probability of recurrence or exacerbation;
>
> (d) the past psychological/psychiatric condition was temporary, the situation has been resolved, and the individual no longer shows indications of emotional instability; and
>
> (e) there is no indication of a current problem.

Applicant has experienced mental health and medical problems since 2017. There is a conflict of opinions between the doctors who have treated her regarding the etiology of those problems. She has exhibited bizarre behaviors at times, which in turn cause serious concerns about her judgment, reliability, and trustworthiness. At the time of her hearing, she had not yet been cleared to return to work due to her physicians' concerns about the efficacy of new medications that she recently began taking.

Given the differing professional opinions as to the cause of Applicant's mental health and medical condition, and the fact that she has been on a new treatment regimen for a relatively short period of time, I am unable to conclude that her condition is readily controllable and there has been ongoing and consistent compliance. AG ¶ 29(a) does not apply.

Applicant obviously is searching for the cause of her problems and has been in treatment with Dr. D since 2018 who has given her a favorable mental health prognosis. Although there is hope that her issues are amenable to treatment, it is too soon to conclude that definitively. AG ¶ 29(b) has some application. However, based on Dr. B's mental health prognosis, AG ¶ 29(c) does not apply.

From 2017 to April 2022, Applicant was hospitalized several times for psychotic symptoms, cognitive and memory issues, and other serious behavioral problems. Based on her six-year psychiatric and medical history, I am unable to conclude at this time that Applicant's conditions were temporary, are resolved, and she no longer shows indications of emotional instability. AG ¶ 29(d) does not apply. Applicant appears to be stable; however, I am unable to fully conclude at this time that there is no indication of a current problem given her long history of struggling with medical and psychiatric issues. AG ¶ 20(e) applies minimally. Despite some mitigating evidence, it is insufficient to overcome the concerns raised.

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 the applicant's conduct and all the circumstances. The administrative judge should consider the nine adjudicative process factors listed at AG ¶ 2(d):

> (1) the nature, extent, and seriousness of the conduct; (2) the circumstances surrounding the conduct, to include knowledgeable participation; (3) the frequency and recency of the conduct; (4) the individual's age and maturity at the time of the conduct; (5) the extent to which participation is voluntary; (6) the presence or absence of rehabilitation and other permanent behavioral changes; (7) the motivation for the conduct; (8) the potential for pressure, coercion, exploitation, or duress; and (9) the likelihood of continuation or recurrence.

Under AG ¶ 2(c), the ultimate determination of whether to grant eligibility for a security clearance must be an overall commonsense judgment based upon careful consideration of the guidelines and the whole-person concept.

I considered the potentially disqualifying and mitigating conditions in light of all the facts and circumstances surrounding this case. I have incorporated my comments under Guideline I in my whole-person analysis.

It is apparent that Applicant has been frustrated in her search for the causes of her medical and mental health problems. Perhaps the professionals have found a path forward for her and after an extended period of stability she will be in a more positive position. However, my duty is to provide a fair, impartial, and commonsense decision with the protection of the national security as the paramount consideration. Any doubt must be resolved in favor of the national security. The record evidence leaves me with

questions and doubts as to Applicant's eligibility and suitability for a security clearance. For these reasons, I conclude Applicant failed to mitigate the security concerns arising under Guideline I, psychological conditions.

Formal Findings

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

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

Conclusion

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

_____
Carol G. Ricciardello
Administrative Judge