The Diagnostic Frame in National Security Evaluations

ABSTRACT: In clinical and most forensic evaluations, “diagnosis” connotes the expectation of a DSM-5 or ICD-10 formally labeled mental condition. When the task is to evaluate the security risk a person’s psychological makeup presents to an institution, such a molar diagnosis can blind the clinician and elevate the risk to a security agency. When “diagnosis” connotes achieving an understanding of a person’s behavior that has raised security concerns, then a different conceptualization of the diagnostic process is required. Unlike the clinical situation, the evaluation is not being performed to benefit the person but for the purpose of assessing risk to an agency. The differences this introduces involve every aspect of the evaluation and changes the type of diagnosis expected. Not appreciating these differences can cause the clinician to fail in the task of assessing psychological tendencies that affect national security.

KEYWORDS: forensic science, diagnosis, security, evaluations, DSM-5, diagnostic frame

The word “diagnosis” as used in the clinical setting has little shared meaning with its use in the realm of national security evaluations. People employed in security settings sometimes engage in behavior that brings about their judgment, reliability, stability, or trustworthiness into question. When that occurs, the agency employing that person usually requests that the employee be psychiatrically evaluated. It sometimes comes as a surprise to realize that there are hundreds of thousands of people who have jobs involving national security. They work for agencies such as the Department of Energy, Homeland Security, the various intelligence agencies, the national research and weapons development laboratories, large numbers of support contractors, and the Department of Defense.

Evaluations of an employee or prospective employee involved in national security work can be triggered by concerns of reported substance use at work or apparent abuse outside of work, an episode of manic behavior, talking in ways that are hard for others to follow, disregarding rules and procedures, intense eruptions of verbal anger, intimidation or physical violence, prolonged interpersonal withdrawal, decrements in performance following a promotion or after not being selected for a promotion, use of a psychotropic medication, beginning or having been in psychiatric treatment, disruptive or inappropriate sexual behavior, the viewing of pornography on work/government computers, recurrent financial indebtedness, and inexplicable data involving the designing, building, and transporting of major weapon systems. No matter how one views such tasks, it is important that those who perform them have sound judgment, are dependable reliable, emotionally stable and can be trusted to be truthful. The clinician performing a security evaluation is asked to assess whether employees have a mental condition that can impair their judgment, reliability, stability, or trustworthiness. In the United States, those four issues are the ones delineated by Presidential Executive Order and explicated by the Office of the Director of National Intelligence in the Federal Adjudicative Guidelines last revised in 2017 (1).

What Makes National Security Evaluations Different from Other Evaluations?

The Person Evaluated Appears to be Emotionally Healthy

Evaluating a person working in the security realm has significant differences from most forensic evaluations (see Table 1). In the security realm there are seldom questions of competency, determining the mental condition when a crime was perpetrated, or mental conditions associated with the mitigation of imposed sentences. It is exceedingly rare for the evaluator in a national security setting to be concerned with an employee’s malingering or symptom exaggeration. Instead, during a security evaluation, the person usually attempts to convey a picture of being unusually mentally healthy and denies or minimizes even small, common faults. There is a subset of people motivated to appear unusually healthy in forensic evaluations (e.g., child custody evaluations) but in the security process, that attitude/bias/distortion is always present, often to a very high degree.

The security arena demands that a person protect classified data involving the designing, building, and transporting of major weapon systems. No matter how one views such tasks, it is important that those who perform them have sound judgment, are dependable reliable, emotionally stable and can be trusted to be truthful. The clinician performing a security evaluation is asked to assess whether employees have a mental condition that can impair their judgment, reliability, stability, or trustworthiness. In the United States, those four issues are the ones delineated by Presidential Executive Order and explicated by the Office of the Director of National Intelligence in the Federal Adjudicative Guidelines last revised in 2017 (1).
TABLE 1—Differences between evaluations for national security evaluations and clinical or other forensic evaluations.

| National Security Evals | Clinical Evals for Therapy | Other Forensic Evals |
|-------------------------|---------------------------|----------------------|
| Dynamics and reference to unconscious processes are not the basis of the evaluation and should rarely be reported. | Dynamics and description of unconscious processes are usually very important. | Depending on the issue, dynamics and unconscious motivations are often necessary to explain acts. |
| Evaluation of strengths is less useful than a focus on cognitive weaknesses. | Reporting strengths and indications of decompensation or regressions is important. | Reporting of strengths is particularly important where reality testing, judgment, and impulse control are issues. |
| The evaluation is not expressly for the person's benefit. | The evaluation should always be performed for the person's benefit. | The evaluation may or may not be for the defendant's benefit depending on which side of an issue is performing the evaluation. |
| The person always presents as unusually, even unrealistically, emotionally healthy. Malingering or symptom exaggeration is very rare. | Malingering or symptom exaggeration can occur to ensure therapeutic attention. Presenting as unusually emotionally healthy is uncommon. | Positive or problem-laden purposeful distortions of one's self are often present depending on the issue. |
| Collateral interviews with anyone other than the employee's treatment personnel are prohibited. | Collateral interviews may occur if needed. | Collateral interviews are usually required for an evaluation to be seen as competent. |
| Diagnosis is focused on enduring personality facets or cognitive functions rather than discovering whether a DSM-5 diagnosis is warranted. | Diagnoses are often descriptive, performed to elucidate interpersonal dynamics and not constrained by the need to fit a DSM-5 category. | There is a strong preference by the courts for a person to be understood in terms of a DSM-5 diagnosis. |
| The person's willingness to be truthful in difficult situations is an extremely important determination. | The person's difficulty being truthful is treated as only one of several “resistances” to be worked with over time. | The lack of candor is usually expected. |
| The likelihood of relapses can make the person unpredictable and therefore unsuitable to hold a clearance. | Relapses or regressions are expected and seen as a normal part of development/recovery. | The potential for regressions can significantly affect judicial decisions. |
| The employee's ability to form a working alliance about resolving contradictions that could be negative is evaluated. | The therapeutic alliance involves the conveying of empathy without encouraging the patient to resolve contradictions. The patient usually wants to be at least partially known. Self-report tests usually are helpful. | No alliance, possibly not even a working alliance based on a truthful recounting of an event, is expected. |
| The employee usually approaches the evaluation with a wish to conceal questionable behavior. Self-report tests are usually distorted by efforts to minimize problems. | Evaluations of highly functioning people are usually performed to screen for less obvious underlying but serious pathology. | The client often does not want to be known. This affects the self-report test information in unpredictable ways. |
| Character pathology in high-functioning people with subtle pathology will seldom result in a DSM-5 diagnosis. Their higher level functioning very often disguises the pathology. | This may be viewed as an asset but can be dealt with as a resistance if it becomes so later in the treatment. | The absence of obvious pathology usually results in the psychiatric aspect of a case being dismissed. Subtle or “non-clinical” facets or traits are not persuasive. |
| Pride in the employee's highly positive scruples and self-presentation can present a vulnerability | | Proclamations of saintly values are usually not influential in court. |

The Goal of the Security Evaluation is Different

The focus of an evaluation in the realm of national security is on the person’s psychological makeup and not on whether the person is a security risk or is otherwise capable of performing a job. That said, the evaluating clinician must have a grasp of the psychological issues that can raise an agency’s concern, why they do, and what the agency views as mitigating factors about such concerns. Deciding how the person’s psychology could impact security, however, is usually the job of others within clearance granting agencies (The Nuclear Regulatory Commission is one exception in which the clinician is requested to provide an opinion about whether the person should be granted a security clearance). Fitness for Duty evaluations are usually performed by the Occupational Medicine Department of agencies or companies and have a different focus.

The Available Information and the Clinical Options Differ

The information available to the evaluator performing security evaluations also differs from that usually available in the clinical setting. To perform a security evaluation, the psychologist or psychiatrist is usually provided several hundred pages of detailed information about the person. This information was collected from a number of independent sources such as credit agencies, investigations by the FBI or Office of Personnel Management, national data base law-enforcement records, interviews with families, spouses and neighbors, and reviews of employment performance reports. The evaluator will then interview the person, perhaps administer psychological tests and order laboratory tests. If the person has had, or currently is having, treating clinicians, then they too will have been contacted. Differing from the clinical situation, collateral sources such as spouses, family members, and friends are unfortunately not directly interviewed by the clinician due to tight security concerns. The material is then sifted and integrated and a diagnosis is made that could affect the person’s career. The noun “diagnosis” does not imply an attempt to fit the person’s questionable behavior into a formal DSM-5 category. It refers to understanding a concerning behavior in terms of the person’s psychology and what characterological or enduring cognitive tendencies (ego functions) motivate or permit such behavior. This often involves the descriptive reference to DSM-5 personality “facets.” The data on which a security evaluation is based are patterns of behavior, usually not one single act, and rarely if ever on unconscious dynamics. Principle unconscious dynamics are usually appreciated in these evaluations but such inferences are inappropriate to include as the basis of a report in the security realm.

The Implications of a Diagnosis Differ

The meaningfulness of a diagnosis in the security situation differs sharply from that developed in the clinical setting. The
goals of the security evaluation make this obvious. In the clinical situation, an evaluation is usually focused on developing a deep understanding of a patient’s psychological structure, including strengths and weaknesses, and identifying attitudes and aspects that a therapist might use to facilitate a treatment. The likely impediments to treatment for this particular person with his/her particular psychology are also usually discussed. The signs of relapse or decompensation could be noted so that the therapist could alter the therapy’s parameters (e.g., reduce the encouragement for insight, become more concretely focused, change the dosage of medications) in order to stabilize the therapeutic frame. The diagnostic focus is not only of the person’s current condition but also on the progressively challenging process of change. The patient’s willingness to be truthful may be noted but is seldom the central focus.

In contrast, an agency’s interest is whether at this time there is a mental condition that is apt to result in poor decisions, vulnerability to manipulation, lack of candor, or emotional instability. This moves the concern from “strengths and weaknesses” to “weaknesses” and whether the questionable behavior was a one-time occurrence or is an expression of more ingrained personality tendencies. The emphasis, then, is on what is “wrong” and whether it can be readily “fixed” with little probability of relapse. Someone who has had their first psychotic break in a bipolar I disorder is an unknown entity from the security perspective. It is readily understood that he will need a mood stabilizing medication, perhaps with a major tranquilizer, an antipsychotic, hypnotics, and possibly hospitalization. If the immediate treatment is successful in attenuating his/her symptoms, several security questions then arise: will the person remain on his medication; does he enjoy the special and creative feeling of his mania so much that relapses are likely or does he deeply grasp that if he does not seek help when the first prodromal signs of mania appear he puts his career, finances, and possibly his family at risk; will the course of the disorder for this particular person be possible to control or will there be further psychotic episodes? Because of such “unknowns,” a person with a diagnosis of a bipolar disorder (I or II) will often be considered to be too risky for an agency. On the other hand, depressions, even recurrent depressions or cyclothymic conditions, can be identified and managed with medication and verbal therapy providing that the depression is not severe and does not involve serious concerns of suicide or symptoms of psychosis. The security agency needs to have an indication of the bandwidth of the person’s dysfunction but does not expect a totally nonsymptomatic individual.

The Implication of High “Virtue” May Differ

Some behaviors that might be considered to be neutral or even assets in the clinical evaluation can be areas of concern in the security evaluation. People who repeat their loyalties to an organization or a faith or their adherence to some virtue should raise the evaluator’s concern. Sometimes these are people who struggle to not enact the very issues that their overly emphasized proclamations try to negate. Sometimes this is an unconscious defense (i.e., reaction formation) but more commonly such proclamations are conscious efforts to deceive. The televangelist Jimmy Swaggart is one well-publicized example. Weekly he preached to a large TV congregation about the evils of visiting prostitutes. His righteous denunciation of another televangelist, Jim Bakker, for “immoral behavior” (visiting prostitutes) led to Swaggart himself being exposed as a frequent visitor to pornography sites on a government computer. When he was interviewed, he stated that he often briefly knelt on his building’s steps before entering his office, praying to be able to resist the temptation but would then go in and look at porn. His shame was intense. His proposed solution was to pray more with his
A DSM-5 Diagnosis Can Be Too Molar to Identify the Problem

Another diagnostic problem is that clinical evaluations often employ psychological tests that were derived from descriptions of patients with obvious pathology or from the criteria for these pathologies listed in the American Psychiatric Association’s Diagnostic and Statistical Manual. These clinical descriptions were derived from observing people with obvious symptoms, who often functioned so poorly that they required hospitalization. The population working in agencies requiring the handling of classified information, or performing highly technical and secret research, or who manufacture and guard the nation’s weapons, usually are people who function at a very high level and are not identifiable by such pathology-laden criteria. As has been pointed out, people who are high on the continuum of psychological functioning (i.e., ego-functioning) have fewer and more subtle overt symptoms of a disorder. They are more self-observing, their sense of self and their characterizations of others are stable and complex, they are more able to suppress impulsive or inappropriate inclinations and have better organized and more effective defenses. Their moral values and ethics tend to be internally consistent. These more mature abilities allow the person to act in a more socially appropriate manner (5–7). Variations along the continuum from pathologically low-functioning to high-level functioning can be observed in daily life. While the severity decreases at higher levels of organization, the “self-other” behavioral paradigms remain apparent and can be the crux of a security issue. For example, the continuum of narcissism illustrates the potentially more serious hidden vulnerability of the high-functioning narcissist. The lower functioning narcissist is easily recognizable due to their preening, intolerance of different points of view, frequent reference to their own greatness, sharp castigation of those who disagree with them, and lauding idealizations of those who do. They can switch from ideализation to devaluation quickly depending on momentary perceptions and experience no concern about their often remarkable contradictions. On the other hand, when the narcissism is less intense, more contained and channeled, the person can be an effective, charming and accomplished leader, though his self-importance and subtle devaluation are still apparent. The private self-importance and contempt for restraining regulations have been known to motivate, among another things, the unauthorized accessing of information to which the person is not entitled. The high-functioning person with narcissistic organization will tend to make decisions based on self-interest rather than in an agency’s interest or can sabotage the work of a colleague who threatens to surpass him. The same continuum can be observed to range from the paranoid wariness seen in people who function at a dangerously psychotic level of primitive organization to those who harness their interest in hidden details and become effective detectives, researchers or theoretical physicists. And the employee with a high-level paranoid organization can impede work by hoarding or withholding information needed by co-workers and experience their attempt to gain access as proof of their envy of him or wish to steal and take credit for his work.

Symptoms in high-functioning people are less dramatic than in those warranting a DSM-5 formal diagnosis because of their obvious pathology. In the business arena there is little to be gained in diagnosing these subtle tendencies but in the security area, perceiving and diagnosing such tendencies can be important. Because psychological tests, such as the MMPI and PAI, were developed to identify obvious pathology, they can be blind to the subtle pathology in higher functioning people. For example, a person who has been found to lie about his use of a company computer to view pornography may not be experienced as lying more generally. He might be emotionally warm and caring with his family and perceived as a valued work colleague. He might not openly devalue others who disagree with him or on the surface appear to have more than a reasonably positive sense of himself. In other words, he may not fit the criteria for (or even be best understood as) a person with a narcissistic personality disorder. Feeling superior to company rules (which in this case could have caused the introduction of malware into a computer containing classified information) and his deception are, however, two manifestations of a narcissistic personality style in a highly functioning person. Even though not a personality disorder, he still may have the tendency to misrepresent the truth when the stakes are high and his reputation is threatened. This of course would not correctly characterize him as a “liar,” but it is a serious tendency in an agency dependent on the employee’s honesty, making it a concern about his trustworthiness. If he were to additionally claim to be a fervent man of faith, his vulnerability to coercion might be considered increased due to his fear of exposure. None of this would likely become apparent on psychological tests. In practice the singularity or subtleness of a problem behavioral facet, especially as occurs in high-functioning employees, can result in the evaluator being blind to the degree of actual risk. To look for customary indications of major pathology such as is enumerated in the DSM can readily lead to the security evaluator not appreciating the more subtle facets which in fact usually pose the most serious security risks, especially in high-functioning individuals. Diagnosing a person in the clinical situation based on one feature would be clinically irresponsible and likely useless. Determining whether a single act of poor judgment or an episode of instability is an integral part of a person’s psychological structure, and therefore is likely to continue, can be essential in the security evaluation, however.

The Availability of Appropriate Treatment Can Impact the Evaluation

The responsible agency usually asks whether the employee’s diagnosed problem is likely to resolve with treatment and if so what kind of treatment is recommended. Conditions that call for treatments that are usually challenging and long-term, such as with personality disorders, often present additional difficulties due to the lack of clinicians trained and experienced in treating personality disorders. Several of the country’s national laboratories and weapons facilities are in small communities away from
universities and sophisticated medical centers with their departments of psychology or psychiatry. The community-based clinician will often be charmed by the person with characterologically embedded problems or be prone to mistakenly accept the person’s “realization” that he should never again engage in the particular questionable behavior. These are clinician vulnerabilities that have a high probability of resulting in only the appearance of change, but their treatments actually form impediments to real change. Because of the complexity of treating the person with a narcissistic, antisocial or paranoid disorder, such a diagnosis presents a continuing risk for an agency. The evaluator may appreciate sound treatment techniques but if they are unavailable or the person does not have the personal resources, the motivation, or the likely time for the treatment to be effective, then that pessimistic opinion must be conveyed to the agency. This is neither the employee’s “fault” nor the agency’s responsibility to provide the treatment. People with mental conditions that cannot be effectively treated with medications (e.g., anxiety and depressive disorders) or short-term interventions (e.g., intensive outpatient addiction programs, short-term couple’s therapy, social sensitivity mentoring for the high-functioning autistic person) are probably not good candidates for working in agencies that handle classified information or processes. In the clinical realm, the clinician’s duty is to the patient. In the security realm, it is to protect the national interest. The security clearance is not a “right” but a privilege granted to those considered able and willing to consistently use sound judgment, be truthful, and who are emotionally stable.

Conclusions

Institutions like the federal government use words that seem to have a consensual, commonly understood meaning but in fact do not; diagnosis is one such word. The problems that arise from such assumptions are several. An agency concerned about security and whether an individual elevates the institutional risk may ask for a psychiatric evaluation. To the clinician, that could be understood as questioning whether the person has a formal DSM-5 diagnosis indicating a condition that will impair the person’s judgment, reliability, stability, or trustworthiness. If this were the clinician’s or agency’s diagnostic frame or expectation, then so doing could place the agency at elevated security risk. Assessing whether the person has such a diagnosis may actually be irrelevant to answering the security question. High-risk tendencies do not need to be labeled as a psychiatric disease in order to be identified as a potential risk to national security. A formal diagnosis seldom identifies an elevated security risk. Being diagnosed with depression, anxiety, cyclothymia, or having PTSD, for instance, may not threaten security. Overly scrupulous and rigid honesty in an Obsessive-Compulsive Personality Disorder, however, could be a serious problem. In the security evaluation, the diagnosis should focus on a more micro and detailed level, the level of “facets” (in DSM-5 terminology).

When the security task is understood as determining whether the person has a formally diagnosed DSM-5 mental condition, then identifying the risk to the institution is restricted to that subset of cases that warrant a formal diagnosis. When a formal diagnosis is expected, then only a small subset of risk elevating employees will be identified. The security evaluation tasks are to understand what is “wrong” with a person, to assess how entrenched the problem appears to be, and to form an opinion about the likelihood of the problem being contained with appropriate treatment, rather than shoehorning the person into a DSM-5 label. In the clinical situation, the evaluator can usually accept the possibility of decompensations or relapses as reasonable risks when attempting to affect long-term change. In fact, they are generally expected and viewed as part of the treatment process. When evaluating a person who could decompensate and become frenzied around nuclear material, or whose paranoia loses reality moorings, or who has shown a superior disregard for regulations in a classified setting, then singular personality facets often become very important.

Failure to appreciate these differences can (and often has) resulted in clinicians performing evaluations in the security arena that do not adequately address aspects of the person which are of primary interest to an agency. Such reports create misguided expectations in Administrative Judges about the nature of the “diagnoses” that they “require” in order to adjudicate a case, much less to decide to remove a person’s security access. Confusion about the focus of the diagnostic process can also result in the employee’s attorney and expert witness misaligning their defense arguments.

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