

“I Could Tell You, but Then I’d Have to Kill You”: Classified Information in the Psychiatric Evaluation

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Psychiatrists and other mental health professionals are presented with special challenges when their patients are involved in covert operations or other matters of national security. The patients’ involvement may, by legal necessity, limit disclosures during the evaluation. Such situations may be encountered with varying degrees of frequency by military psychiatrists or consultants to various federal or law enforcement agencies involved in classified or undercover activities. The need to assess relevant psychosocial stressors while avoiding prohibited disclosure, the legal requirements to report potentially adverse information, or the procedure to gain legal permission to discuss classified details may present novel challenges for therapists in such evaluations. In this article, we present a case report illustrating these challenges and review applicable regulations and public law governing the disclosure of classified information. We also discuss common pitfalls and strategies for handling such situations.

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“I could tell you, but then I’d have to kill you.”—Tom Cruise,
Top Gun

Tom Cruise’s line from the movie *Top Gun* has become a popular satire of the seriousness we afford matters of national security. However, if his character had been suffering from suicidal depression, his next line might well have been, “But if I don’t tell somebody, I’ll have to kill myself.” Psychiatrists and mental health professionals in a variety of settings may encounter patients involved in intelligence activities or undercover law enforcement operations. These patients may be legally prohibited from disclosing the details of their involvement, even though these activities themselves may be at the very heart of the psychosocial stressors prompting the evaluation. This article presents a case report that illustrates some of the challenges encountered in such evaluations and reviews the applicable public law and regulations that govern disclosure of classified information to guide the evaluation.

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Assertions by patients that they are engaged in such covert or classified activities are often delusional or may represent attempts to resist disclosure of embarrassing information; but these claims, on occasion, are factual. Military psychiatrists may encounter this situation with varying frequency. Mental health professionals who directly support intelligence units, special operations forces, or units actually engaged in combat may conduct such evaluations on a routine basis. Similarly, civilian psychiatrists who support other federal agencies handling classified information or those that treat law enforcement personnel involved in undercover operations may face similar challenges. Even the seemingly innocuous U.S. Department of Energy manages classified technical information involving nuclear material, and U.S. Department of Transportation personnel may be involved in classified drug interdiction operations. Given the potential for negative impact on their security clearances and careers, persons working for such agencies may seek mental health care from local private practitioners in an effort to avoid having reports of potentially adverse information reach their employers. Thus, practitioners in any setting may find themselves face to face with a patient who is legally prohibited from disclosing significant aspects of his or her life.

Case Report

S.V. was a 38-year-old divorced white male sergeant assigned to a military intelligence unit as a linguist. He was brought to the emergency room by one of his superiors after he had telephoned, in an intoxicated state, to say "goodbye" before his planned suicide. He reported an 18-month history of progressively depressed mood, with initial and terminal insomnia, anhedonia, feelings of hopelessness and worthlessness, low energy, and poor appetite and a suicide plan that included leaving a detailed note. Stressors during this period included multiple classified deployments overseas, during one of which his wife left him, and pending legal charges for unreported contact with foreign nationals while abroad. He had just learned that these charges would prevent his anticipated retirement until they were resolved. This knowledge appeared to lead to the acute exacerbation of symptoms and to the behavior that prompted the evaluation. He was admitted voluntarily to the inpatient psychiatry service of the regional military medical center, because of concerns for his safety and for treatment of major depressive disorder.

During the initial part of his hospitalization he remained angry and dysphoric and filed a request to leave against medical advice. He underwent an independent evaluation under the provisions of U.S. Department of Defense Directive (DoDD) 6490.1.¹ This directive provides for safeguards to protect military service members from inappropriate use of mental health referrals, including the right to an independent evaluation of the need for involuntary hospitalization (often referred to as Boxer evaluations, because they were provided for in legislation sponsored by Senator Barbara Boxer). He was found to represent a significant danger to himself and remained hospitalized involuntarily. He reluctantly began to engage passively in therapy but avoided talking about his condition, asserting that all his problems were due to classified events he was not at liberty to discuss. Efforts to talk about his thoughts or the emotions surrounding these stressors were often thwarted with circular arguments about the classified nature of events that he could not discuss. These arguments slowly diminished as he responded to somatic treatments, and he became more engaged in the therapeutic alliance.

During the second week of hospitalization, he requested that he be allowed to undergo questioning by counterintelligence agents investigating the charges against him. Because anticipation of this questioning was a significant stressor contributing to his depression, both the patient and the treatment team thought that some form of resolution would be potentially therapeutic. Arrangements were made to conduct the investigation while he was still within the safe environment of the inpatient ward. He further requested that the treating psychiatrist be present during questioning to evaluate the impact on his condition and stop the proceedings if he appeared to decompensate. The investigators agreed and initiated the necessary procedures to arrange for the psychiatrist's presence. The investigation was completed uneventfully within a few days, the patient continued to improve, and he was discharged after three weeks to continue outpatient treatment for depression and alcohol abuse.

Discussion

This case highlights several important considerations in the mental health evaluation of personnel with high-level security clearances. A first consideration is the level of classification itself. Levels of classification of national security information have been established by executive order,² and each federal agency responsible for such information has promulgated parallel regulations to implement these requirements. Information may thus be considered Unclassified, Confidential, Secret, or Top Secret. Top secret information may be further considered part of a special access program (SAP) or sensitive compartmented information (SCI), with more stringent security requirements. Access to classified information requires both the appropriate level of security clearance (i.e., at least as high as the level of classification of the material) and a need-to-know determination, made by the security manager for that program. All military officers are required to obtain security clearances, and military psychiatrists or psychologists are no exception. Some military units and other agencies with many personnel involved in top secret activities have a psychologist or psychiatrist assigned who has clearance for routine access to such information. However, this is the exception rather than the rule. Most health care officers routinely hold clearances at the secret information level and would not be authorized access to the types of top secret

information referred to in this article. Nonetheless, there are procedures for obtaining special one-time access to higher level information, as described in the case report.

General procedures for gaining this access are enumerated in Executive Order 12968.³ Procedures within the Department of Defense are specified in DoD 5200.2-R.⁴ SAP or SCI programs may have more specific requirements contained within the regulations that govern their operation, and these regulations are themselves often classified. A psychotherapist requiring this type of access is likely to be heavily involved with professional security managers already familiar with any specific requirements of the program in question. After security managers have obtained the requisite level of “urgent” or “exigent” authorization, the person being granted special access must execute a nondisclosure agreement (NDA). For all federal programs this is Standard Form 312, the use of which is governed by public law.⁵ Paragraphs 4, 7, and 12 of the form cite further laws that are applicable to handling the information that is accessed, as well as penalties for any violation of the agreement. Depending on the particular program involved, the clinician usually signs a “read-on” agreement for SAP or SCI programs that serves to document everyone who has ever had access to covered material. The clinician may then undergo an oral briefing beforehand about the types of information covered under the program and limits of further disclosure, as well as debriefing afterward concerning the exact material accessed.

Depending on the actual program involved and the presence or absence of complicating factors, this entire process is usually accomplished in a few days. If the information is considered especially politically sensitive or militarily significant, however, the threshold for a legitimate need-to-know decision may be raised considerably. If the patient is involved in legal proceedings, as is often true, then the government’s interest in that case may expedite or hamper the granting of access, depending on the desire to dispose of it quickly or to prosecute to the fullest extent possible. When several such factors are present, even special one-time access may take months to obtain.

The prohibitions against further disclosure of classified information may have ramifications in clinical practice. For example, clinical documentation may have to be limited to a very general description of the

matters discussed to avoid creating a document that contains classified information. If such documentation were deemed critical, then the clinical record itself would have to be classified, requiring physical security measures well beyond those normally required, even for medical records. If the patient is involved in civil or criminal litigation that requires psychiatric testimony, discussion of classified material must take place in closed court proceedings that are themselves classified.

The actual disclosure of classified information in an evaluation is usually avoidable. Freud highlighted the importance of not allowing secrets in psychoanalysis, and even offered as an example his dismal experience with “a high official who was bound by his oath of office not to communicate certain things because they were state secrets.”⁶ Later models of psychotherapy, which are more focused and relatively brief compared with complete psychoanalysis, offer techniques that reduce the need to confront such secrets. With the use of principles of graded confrontation, similar to those adapted in the Critical Incident Stress Debriefing model⁷ or cognitive behavioral therapy,⁸ adequate therapeutic processing of relevant information is possible in most cases. In these models, the therapist sequentially addresses the events, thoughts, and emotions that contribute to the patient’s condition. By tactfully avoiding the classified aspects of the events, the therapist can direct attention to the related cognitions, beliefs, and affective states that accompany them and accomplish the usual degree of therapeutic success achieved with these methods. This may require special finesse on the part of the therapist to avoid alienating the patient and undermining the therapeutic alliance. The selection (and self-selection) processes for people entering covert operations favor the stoic, macho stereotype, and these patients may readily reject any overt attempt at exploring their feelings. Gradual progression through the spectrum of facts-thoughts-feelings and careful selection of the vocabulary used helps to mitigate this problem.

In practice, disclosure of classified information is better avoided in most cases if possible. First, the information has been classified for a reason: to protect a matter of national security. Each disclosure presents a risk of further unauthorized disclosure, which may be compounded if reflected in clinical records or psychiatric testimony, as mentioned earlier. Second, there is a significant risk of detracting

from the therapeutic nature of the interaction with the patient when such secrets are discussed. The adventurous quality of these secrets may subconsciously lead to vicarious thrill-seeking on the part of the therapist, and considerable time may be diverted from more important therapeutic issues while attempts are made to explore excessive details of these adventures. Conversely, many of these secrets, once revealed, turn out to be rather mundane. They may have been classified simply because they reveal data collection methods or geographical areas of operation that are not general public knowledge but are unsurprising, nonetheless. The unwary therapist may be prone to communicating subtly a sense of disappointment despite (or absent) efforts not to do so. A vulnerable patient may respond to the therapist's cues of approval or disappointment, however subtle or unconscious, and omit significant parts of the narrative, withdraw from the therapeutic process, or even fabricate further classified details (which, of course, are exempt from corroboration) in an attempt to please the therapist. Parallels may also be drawn to the problem of the special patient who requires a special therapist, and the attendant risks to the therapeutic process, as has been described in discussions of the treatment of very important persons (VIPs).⁹

If disclosure of classified information becomes a necessary part of therapy, the treating therapist must be especially vigilant for such transference and countertransference reactions and process them appropriately. In the case presented, efforts to circumvent the need for disclosure were met with considerable resistance by the patient, but were eventually obviated by his request to include the therapist in the investigative process. Although he may have had ulterior motives for this request (such as stopping further questioning, to avoid certain topics, under the pretext of worsening his condition), the potential therapeutic benefit of resolving a significant stressor was thought to outweigh the risk.

Given the special confidentiality ascribed to psychotherapy, the patient may be tempted to ignore the legal prohibitions against disclosure, creating an ethical dilemma for the therapist. Although recent changes to the Military Rules of Evidence (MRE) have expanded the psychotherapist-patient privilege for members of the military,¹⁰ there are still limitations on the confidentiality of military mental health evaluations. In fact, the new MRE 513 implemented

by Executive Order 13140 specifically excludes the privilege if the security of classified information is involved. The law is vague about whether there is any affirmative duty to report unauthorized disclosure when the issue has not been raised by investigators, but such a duty may be construed to exist for the Department of Defense physicians under DoDD 5210.50.¹¹ This directive states that every "civilian and military member of the Department of Defense, and every DoD contractor or employee of a contractor working with classified material, has the responsibility to report promptly through appropriate channels any suspected or actual unauthorized public disclosure of classified information" (Ref. 11, p 4) Whether unauthorized disclosure to a therapist constitutes public disclosure is a matter of interpretation.

It should be noted, however, that no military physician has ever been prosecuted for maintaining a soldier's confidentiality.¹² Nevertheless, an Air Force psychiatrist has received an administrative sanction for failing to stop a patient's relative from destroying her psychiatric records, which he had previously refused to turn over to a military court on grounds of confidentiality typically adhered to in civilian courts.¹³ There would be no such duty to report for a private civilian therapist evaluating a patient outside the scope of the patient's employment. However, there is potential, albeit remote, for a private physician to be compelled to forgo therapeutic privilege if investigating authorities raise the issue, should it come to light through other means. These problems and the potential detraction from the therapeutic process are best circumvented by taking measures to prevent unauthorized disclosure in the first place.

Clearly, there is no psychotherapist-patient privilege when the evaluation has been initiated at the request of authorities for the specific purpose of determining fitness for duty or suitability for a security clearance. In the case presented, the evaluation was conducted under emergency conditions, when dangerousness was an issue, and future security clearance issues were not an immediate concern, given the patient's imminent retirement from the military. When the request for evaluation is specifically directed toward suitability for a security clearance, however, the general principles of conducting any forensic psychiatric examination apply. This includes the need to identify the specific psychiatric-legal matter to be considered and the criteria that will be used to resolve that matter.¹⁴ Even if the evaluation is being con-

ducted purely for the purposes of diagnosis and treatment, familiarity with these criteria is helpful, because the question of suitability is likely to be raised eventually. Investigators often resolve this matter through consultation with treating therapists (with appropriate release of information authorized by the patient), with the more difficult cases being referred for independent evaluation.

Executive Order 12968 established the requirement for standards to determine the eligibility for a security clearance.³ Specific guidelines for determining eligibility have been enumerated in Director of Central Intelligence Directive 1/14,¹⁵ and are incorporated in the regulations promulgated by each federal agency affected, including each of the military services. It should be noted that these are adjudicative guidelines, which implies two things: (1) they are only guidelines, and do not represent inflexible rules; and (2) they are intended primarily for use by security personnel who have final adjudication over determining whether an individual is to be granted access to classified information. The guidelines are divided into 13 areas of human conduct that adjudicators consider in determining whether someone represents a security risk. Each of the guidelines lists the potential security concern involved, conditions that may be disqualifying, and conditions that could mitigate the security concerns. For those areas of human conduct evaluated by mental health professionals, these concerns center on the psychiatric-legal issue of the individual's judgment, reliability, and stability. Specific guidelines applicable to mental health evaluations include Guideline D: Sexual Behavior; Guideline G: Alcohol Consumption; Guideline H: Drug Involvement; and Guideline I: Emotional, Mental, and Personality Disorders.¹⁵ Each lists the criteria that should be considered in the evaluation process, such as the presence of a DSM-IV diagnosis, need for or response to treatment, length of time in remission, and prognosis.

Conclusion

Claims of involvement in clandestine activities may be delusional or may be fabricated or exaggerated in an attempt to manipulate a psychiatric evaluation or as a manifestation of resistance. However, there are many situations in which these claims may represent a patient's understanding of legal prohibitions that are indeed applicable in his or her case.

Disclosure of classified information, whether authorized or not, is usually better avoided because of the potential for undermining the therapeutic process. Standard techniques for confronting resistance or focusing on the associated thoughts and emotions should be used to this end. When classified material is a central psychosocial issue for the patient, and its discussion is necessary to the psychotherapeutic process, there are outlined legal procedures that govern the therapist's access to the material. These procedures should be adhered to strictly, in an effort to protect both patient and therapist from further legal difficulties. When the patient's suitability for access to classified information becomes a consideration, there are specific guidelines for the nature of the evaluation that should be used to determine the problems that must be resolved for its completion.

The case presented herein highlights many of the principles discussed. Specific considerations that pertain to military or civilian personnel within the Department of Defense were emphasized. However, the general principles discussed, including common pitfalls and strategies for handling them, may be applied to a wider variety of situations in which patients are legally prohibited from disclosing important information in therapy.

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