



DEPARTMENT OF DEFENSE
DEFENSE LEGAL SERVICES AGENCY
DEFENSE OFFICE OF HEARINGS AND APPEALS
APPEAL BOARD
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Date: February 12, 2026

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 In the matter of:)
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 Applicant for Security Clearance)
 _____)

ISCR Case No. 24-00641

APPEAL BOARD DECISION

APPEARANCES

FOR GOVERNMENT

Andrea M. Corrales, Esq., Deputy Chief Department Counsel

FOR APPLICANT

Maurice Arcadier, Esq.

The Department of Defense (DoD) declined to grant Applicant a security clearance. On July 25, 2024, DoD issued a Statement of Reasons (SOR) advising Applicant of the basis of that decision – security concerns raised under Guideline G (Alcohol Consumption) of the National Security Adjudicative Guidelines (AG) in Appendix A of Security Executive Agent Directive 4 (effective June 8, 2017) and DoD Directive 5220.6 (Jan. 2, 1992, as amended) (Directive). On September 19, 2025, Defense Office of Hearings and Appeals Administrative Judge Braden M. Murphy denied Applicant national security eligibility. Applicant appealed pursuant to Directive ¶¶ E3.1.28 and E3.1.30.

Judge’s Findings of Fact

Applicant, in his mid-30s, has been employed by various defense contractors since 2015. He submitted an initial security clearance application (SCA) in March 2016 and was granted national security eligibility, which he continues to hold to-date. He completed a new SCA in November 2021.

Applicant began drinking alcohol as a teenager. In April 2012, he consumed alcohol before driving his motorcycle to a liquor store and was pulled over for speeding, administered a field

sobriety test, and arrested for driving under the influence (DUI). He was convicted of the reduced charge of reckless driving and sentenced to probation, which included attending Alcoholics Anonymous (AA) meetings and completing an alcohol education course.

Applicant had no other alcohol-related incidents until the fall of 2020, by which time he had developed depression and was experiencing stress from his divorce and the deaths of several friends and his grandfather. He had also begun taking caffeine pills and drinking significant amounts of coffee to help stay awake during his overnight shift at work.

In October 2020, Applicant failed to appear for work and his supervisor contacted him. Following a “nonsensical” conversation, police were contacted for a wellness check and found Applicant at home with his guns. Applicant did not recall the specifics of the conversation with his supervisor or the subsequent incident. He was involuntarily admitted to the hospital for suicidal ideation and depression and was diagnosed with adjustment disorder, depression, and insomnia. His blood alcohol content at admission was .125. Applicant recalled being recommended to abstain from alcohol by one of his hospital therapists.

Applicant remained at the hospital for about two days and was then voluntarily admitted into a 45-day inpatient alcohol treatment program, during which he was diagnosed with severe alcohol use disorder (AUD), alcohol withdrawal without perceptual disturbances, and caffeine-induced anxiety disorder. Upon his discharge from treatment in November 2020, Applicant was recommended to pursue support groups like AA and counseling, and he testified that the “overarching theme” of the program was alcohol abstinence. Decision at 4.

Applicant saw a therapist, Dr. V, from November 2020 to April 2021, with treatment focused on grief and loss and a “minor” focus on alcohol. *Id.* at 5. To Applicant’s knowledge, Dr. V did not have access to Applicant’s 2020 hospitalization or inpatient treatment records. Dr. V diagnosed Applicant with adjustment disorder with anxiety, and therapy ended in April 2021 when Applicant showed improvement. Applicant resumed drinking in the summer of 2021 and described his consumption as minimal at the time. He attended AA sporadically until 2023.¹

In January 2024, Applicant was evaluated by a DoD-contracted licensed clinical psychologist, Dr. B, who reviewed materials from Applicant’s national security eligibility investigations and medical records from his 2020 hospitalization and inpatient treatment. During the evaluation, Applicant reported consuming alcohol twice a week, including two beers on Thursdays and eight to ten beers on weekends. He reported no history of alcohol misuse and questioned his past AUD diagnosis. Based on her review of available records, psychological test results, and the interview, Dr. B diagnosed Applicant with severe AUD. Highlighting that Applicant “acknowledges drinking as many beers in a sitting now that he described as ‘binge drinking’ during his alcohol use disorder treatment,” Dr. B expressed “grave concerns for relapse.” Government Exhibit 4 at 6. Noting that he lacked insight into his alcohol use and was not interested in further mental health treatment or alcohol abuse support groups, Dr. B found his prognosis guarded. *Id.*

¹ Applicant estimated that he attended “[s]omewhere around” ten to twenty AA meetings. Tr. at 90-91.

In preparation for his hearing, Applicant sought evaluation by a clinical psychologist, Dr. R, who interviewed Applicant and his supervisor, and reviewed hospital and medical records, results of psychometric testing, Dr. B's evaluation, and Dr. V's notes. Dr. R is also a government mental health contractor and has performed evaluations both in criminal and security clearance cases. Decision at 6. Dr. R agreed that Applicant met the criteria for severe AUD at the time of his 2020 inpatient admission. He opined that Applicant's 2020 alcohol abuse was acute, not chronic, and was manifested by intense stress and most likely resolved with removal of the stressor and through treatment and coping mechanisms. Dr. R challenged Dr. B's conclusion that Applicant suffered from "any level of severe alcohol abuse disorder just because he continued having some beers," and concluded that Applicant did not currently have AUD, assigning him a favorable prognosis. Tr. at 120-21.

The SOR alleged concerns regarding Applicant's 2012 DUI, 2020 hospitalization and inpatient treatment, and 2024 evaluation by Dr. B. Applicant testified that, after leaving treatment in 2020, he greatly reduced his alcohol consumption and had no subsequent episodes of binge drinking. After receiving the July 2024 SOR, he purportedly stopped drinking altogether and maintained his abstinence as of the June 2025 hearing, without the help of counseling or support groups. Applicant averred that he would reach out to several recently sober friends if he found himself craving alcohol again.

The Judge found that disqualifying conditions AG ¶¶ 22(a), 22(c), 22(d), 22(e), and 22(f)² applied variously to the SOR allegations. In terms of mitigation, the Judge found that several partially applied,³ crediting the passage of time since his 2012 DUI, his voluntary inpatient treatment in 2020, and his several months of counseling with Dr. V in 2021. Citing Applicant's two severe AUD diagnoses in 2020 and 2024 and that, as of early 2024, his alcohol consumption had escalated to near-2020 levels, the Judge declined to find any mitigating condition fully applicable. While he viewed Applicant's abstinence since July 2024 favorably, the Judge found "the lack of a formal support group or counseling to help him address the risk of relapse [] troubling" and weighed against finding a sufficient track record of modified consumption or abstinence to warrant full mitigation. Decision at 14.

² AG ¶¶ 22(a): alcohol-related incidents away from work, such as driving while under the influence, fighting, child or spouse abuse, disturbing the peace, or other incidents of concern, regardless of the frequency of the individual's alcohol use or whether the individual has been diagnosed with an alcohol use disorder; 22(c): habitual or binge consumption of alcohol to the point of impaired judgment, regardless of whether the individual is diagnosed with alcohol use disorder; 22(d): diagnosis by a duly qualified medical or mental health professional of alcohol use disorder; 22(e): the failure to follow treatment advice once diagnosed; 22(f): alcohol consumption, which is not in accordance with treatment recommendations, after a diagnosis of alcohol use disorder.

³ AG ¶¶ 23(a): so much time has passed, or the behavior was so infrequent, or it happened under such unusual circumstances that it is unlikely to recur or does not cast doubt on the individual's current reliability, trustworthiness, or judgment; 23(b): the individual acknowledges his or her pattern of maladaptive alcohol use, provides evidence of actions taken to overcome this problem, and has demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations; and 23(d): the individual has successfully completed a treatment program along with any required aftercare, and has demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations.

Discussion

We differ in our assessments of certain aspects of the January 2024 psychological evaluation. Nevertheless, we agree that the Judge's adverse determination is sustainable independent of that evaluation and is supported by the record evidence concerning Applicant's history of concerning alcohol-related conduct and failure to sufficiently demonstrate changed circumstances reflecting mitigation of those concerns.

Applicant had the ultimate burden, once the Government established a prima facie case against him, of demonstrating that it is clearly consistent with the national interest to grant or continue his national security eligibility. *See* ISCR Case No. 01-20700 at 2 (App. Bd. Dec. 19, 2002). In this case, we note the Judge's decision to analyze the two diagnoses of AUD separately under the disqualifying conditions, establishing that they raised concerns independently. The focus of the appeal rests with a critique of Dr. B's report and the appropriate weight the Judge should have given it in light of Dr. R's report and testimony. However, the Judge's conclusion that the concerns were unmitigated was not solely contingent upon Dr. B's diagnosis of Applicant, but rather on the substantial weight of the verified evidence, including the 2020 AUD diagnosis.

The Judge's analysis turned upon Applicant's history of alcohol consumption. Dr. B's analysis was a factor in that history, but other factors weighed heavily too. The Judge noted that Applicant's use of alcohol, which began when he was 17, had become problematic by his 20s and led to a 2012 arrest for DUI. Despite completing probation, AA participation, and alcohol evaluation after the DUI arrest, Applicant continued his excessive use of alcohol. His alcohol use then led to his 2020 hospitalization, diagnosis of severe AUD, and 45 days of inpatient treatment, following which Applicant was told he should abstain from alcohol use. He relapsed in 2021 and continued consuming alcohol in increasing amounts until about July 2024, when he chose to abstain from further alcohol use. The Judge examined Applicant's sobriety since July 2024 and determined that his past relapse "weighs against a finding that Applicant has a long enough track record to minimize or eliminate the risk of relapse." Decision at 14. He held that:

When balanced against his conduct, and his history of treatments and relapses, that is simply not enough. He did not establish that his excessive drinking and related conduct occurred under unusual circumstances, that his problematic drinking is unlikely to recur, or that it no longer casts doubt on his current reliability, trustworthiness, or judgment.

Id.

Ultimately, the Judge's decision came down to his doubts about Applicant's future alcohol use. The Judge's conclusion was predicated on the Applicant's documented history of relapse and the absence of a sustained track record of sobriety, which remain dispositive. Security clearance adjudications are predictive in nature, and it is foreseeable that individuals with prior good records may nevertheless engage in conduct or undergo circumstances that raise doubts about their future judgment or reliability. *See* ISCR Case No. 03-04927 at 4 (App. Bd. Mar. 4, 2005) ("[S]ecurity clearance decisions are not an exact science, but are predictive judgments about a person's security eligibility in light of that person's past conduct and present circumstances.") (citing *Dep't of the Navy v. Egan*, 484 U.S. 518, 528-529 (1988)).

Conclusion

Applicant has not established that the Judge’s adverse decision was arbitrary, capricious, or contrary to law. Our review of the record confirms that the Judge examined the relevant evidence and articulated a satisfactory explanation for the ultimate decision, which is sustainable on this record. “The general standard is that a clearance may be granted only when ‘clearly consistent with the interests of the national security.’” *Egan*, 484 U.S. at 528. “Any doubt concerning personnel being considered for national security eligibility will be resolved in favor of the national security.” AG ¶ 2(b).

Order

The decision in ISCR Case No. 24-00641 is **AFFIRMED**.

Signed: Allison Marie
Allison Marie
Administrative Judge
Member, Appeal Board

Signed: Jennifer I. Goldstein
Jennifer I. Goldstein
Administrative Judge
Member, Appeal Board

Separate Opinion of Board Member Moira Modzelewski

The Majority acknowledges that they “differ in [their] assessments of certain aspects of the January 2024 psychological evaluation,” but they agree that “the Judge’s adverse determination is sustainable independent of that evaluation.” I respectfully disagree. As detailed below, I conclude that Dr. B’s February 2024 diagnosis was fundamentally flawed, that the Judge’s reliance on her diagnosis was error, and that his decision was tethered so tightly to Dr. B’s report and diagnosis that it cannot be sustained independent of it. Rather than affirming the Judge’s decision, I would remand for correction of this harmful error.

On appeal, Applicant cites the Judge’s reliance on Dr. B’s report and diagnosis as the “critical error” in his decision.⁴ Applicant challenges Dr. B’s report on multiple grounds: that she made factual errors; that she failed to consider Dr. V’s treatment records; that she was “flippant

⁴ Appeal Brief at 15.

and careless” in her reports, with “dire results” for the applicants whom she is evaluating; and that she failed to articulate the basis for her diagnosis under the diagnostic criteria in DSM-V, which the Government introduced into evidence.⁵ At least two of Applicant’s arguments have merit, and I address them below.

Applicant first argues that Dr. B’s diagnosis is fatally flawed because she did not use the diagnostic criteria for AUD, Severe that are listed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5). As Applicant argues:

At a minimum for a person to be diagnosed with [AUD, Severe], the mental health practitioner must find a minimum of 6 out of the 11 factors to be present. Dr. [B] does not tell us what the factors are, other than falsely stating that [Applicant] is currently binge drinking.⁶

Applicant is correct. In her conclusion, Dr. B stated that Applicant “continues to meet **criteria** for alcohol use disorder, severe,”⁷ but she entirely failed: 1) to state that the relevant “criteria” are found in the DSM-5; 2) to list those 11 criteria; or 3) to identify which six criteria apply to Applicant and establish the diagnosis of AUD, Severe. Instead, in support of her diagnosis, Dr. B merely cited to Applicant’s 2020 diagnosis, his continued alcohol consumption, and, oddly, the fact that his consumption at the time of her evaluation was excessive under **CDC** guidelines, which are nowhere referenced in the DSM-5.

Notably, the Government—unlike its contracted psychologist—clearly believed that the DSM-5 definition of AUD and its criteria were relevant, as it requested administrative notice of the same.⁸ The Government also requested administrative notice of a National Institute of Health publication entitled *Understanding Alcohol Use Disorder*, which states:

Healthcare professionals use criteria from the DSM-5 to assess whether a person has AUD and to determine the severity if the disorder is present. Severity is based on the number of criteria a person meets based on their symptoms—mild (2-3 criteria), moderate (4-5 criteria), or severe (6 or more criteria).⁹

Remarkably, the Government first requested administrative notice of publications that establish the professional protocols and criteria for a diagnosis of Alcohol Use Disorder and then submitted a psychological evaluation that entirely failed to comply with those standards.

As Applicant highlights, Dr. B then buttressed her inadequate diagnosis with an erroneous and misleading statement. In describing Applicant’s current alcohol habits, Dr. B reported Applicant told her that he typically has two beers on Thursdays and 8–10 over the weekend. In her concluding paragraph, in which she diagnosed Applicant with “Alcohol use disorder, severe,” Dr.

⁵ *Id.* at 15–18.

⁶ Appeal Brief at 17–18.

⁷ GE 4 at 6 (emphasis added).

⁸ Administrative Notice (AN) 1 at 1–8.

⁹ AN 1 at 10.

B asserted something quite different, stating that Applicant “acknowledges drinking as many beers in a sitting now that he described as ‘binge drinking’ during his alcohol use disorder treatment.”¹⁰

Applicant calls that statement in Dr. B’s report “totally false.”¹¹ At a minimum, it is incorrect and misleading. In treatment and in testimony, Applicant acknowledged that, in the time leading up to his 2020 hospitalization, he would sometimes binge drink a 12-pack at a time. To state the obvious, drinking a 12-pack of beer in one evening is quite different than drinking 8–10 beers over the course of a weekend. Dr. B’s statement that Applicant was drinking as much in February 2024 as he had at the time of his 2020 hospitalization is not supported either by her own evaluation or the record before her. This misstatement was careless at best and inarguably adverse to Applicant as Dr. B used it to bolster her diagnosis of AUD Severe and her “guarded” prognosis. Applicant’s argument that Dr. B’s diagnosis is not credible has merit.

The heart of Applicant’s appeal, however, is not only that Dr. B’s diagnosis was “flippant and careless” but that the Judge relied too heavily upon it in arriving at his adverse decision. Again, this argument has merit. As Applicant highlights, the Judge repeatedly referred to and relied upon Dr. B’s 2024 diagnosis for the proposition that Applicant had been diagnosed **twice** with the same disorder, as detailed below:

“Applicant has **two diagnoses** of severe alcohol use disorder (AUD) more than three years apart.”

“[O]ne must start with the fact that Applicant has **two diagnoses** of several alcohol use disorder, over three years apart—one in October 2020, and one in February 2024.”

“Applicant also does not believe he has a problem with alcohol, despite **two diagnoses** of severe alcohol use disorder, several years apart.”

“When balanced against Applicant’s **two prior diagnoses** of severe AUD, [his expert’s opinion that Applicant does not have an alcohol use disorder] is difficult to reconcile.”

“Applicant has about a year of sobriety and abstinence from alcohol. . . . But his **two diagnoses** of severe alcohol abuse disorder (October 2020 and February 2024) are over three years apart.”

Decision at 1, 14 (emphasis added).

At hearing, Applicant’s counsel requested that the Judge take notice of a 2022 Appeal Board case in which we noted numerous issues with an evaluation by this same psychologist, including her **negative** analysis of **positive** PAI results and her failure to acknowledge or consider five years of mental health treatment records that were favorable to the applicant in that case. We concluded that the first issue was “perplexing” and that the second “call[ed] into question the

¹⁰ GE 4 at 4, 6.

¹¹ Appeal Brief at 17.

validity and value of her report.” ISCR Case No. 20-01838 at 8 (Dec. 29, 2022). In his closing argument, Applicant’s counsel highlighted the Appeal Board’s concerns with the validity of Dr. B’s evaluation and report in the prior case.

Against this backdrop, it is baffling that the Judge failed to recognize the inherent flaws in Dr. B’s report and diagnosis. They are not nuanced or subtle but instead leap off the page. The Judge’s failure to acknowledge that Dr. B did not use the DSM-5 criteria is particularly perplexing, as he discounted the weight to be given the testimony of Applicant’s clinical psychologist (Dr. R) largely because of a purported deviation from the DSM-5:

Dr. R’s more recent prognosis was favorable. [Dr. B’s and Dr. R’s] may well be accurate. But Dr. R also found not that Applicant’s alcohol use disorder is in remission, but rather that he does not have an alcohol used disorder at all. **(Compare AE 1 at 13–14; Tr. 120-123 with AN 1 (DSM-5) at 2 (defining “sustained remission”))**. When balanced against Applicant’s two prior diagnoses of severe AUD, this is difficult to reconcile.¹²

Said differently, the Judge discounted the testimony of Applicant’s expert because the DSM-5 does not explicitly consider the possibility that someone who was once diagnosed with AUD may no longer meet the criteria for any AUD diagnosis, including one of sustained remission. Applicant’s psychologist explained this distinction at length at the hearing. Nevertheless, the Judge faulted him for this deviation from the criteria established in the DSM-5, while inexplicably ignoring the fact that Dr. B’s diagnosis—upon which he relied—failed to comport with the most basic requirements of the DSM-5.

As a separate issue, the Judge adopted Dr. B’s misstatement about Applicant’s alcohol consumption as of early 2024, although he appeared also to recognize that it did not align with the evidence:

Applicant does not dispute, however, that by the time of Dr. B’s DoD evaluation his drinking level and frequency had again increased and was about the same as it had been in October 2020—two beers on Thursdays with his teammates, and then eight, ten, or 12 beers on weekends when he was off work. This drinking seems to have been over the course of a weekend rather than at one sitting.¹³

Although he apparently recognized that the evidence did not support Dr. B’s conclusion, the Judge later repeats the misstatement: “While he resumed drinking in 2021, his drinking was initially moderated, or at least less than it had been. However, by February 2024, when he met with Dr. B, Applicant’s drinking had increased to about what it was in October 2020.”¹⁴ The Judge’s adoption of Dr. B’s misstatement is of concern, and that concern is not lessened by the fact that he appears to recognize its inaccuracy. As stated earlier, the distinction between drinking 12 beers at one

¹² Decision at 14 (emphasis added).

¹³ Decision at 12.

¹⁴ *Id.* at 13.

sitting and drinking 8-10 beers over the course of a weekend is both obvious and significant in the context of this case.

The differing opinions of the two mental health professionals—Dr. B and Dr. R—left the Judge with conflicting evidence, which he was required to weigh and resolve. *See* ISCR Case No. 05-06723, 2007 WL 4379274 at *3 (App. Bd. Nov. 14, 2007). He was not compelled to accept the DoD consultant’s diagnosis, nor was he compelled to reject it simply because conflicting evidence existed in the record. Rather, he had to consider the record evidence as a whole in deciding what weight to give the conflicting opinions. *See* ISCR Case No. 99-0288, 2000 WL 1805217 at *2 (App. Bd. Sep. 18, 2000).

In discussing the competing mental health evaluations, the Judge acknowledged that their differing prognoses may both be accurate, considering that Dr. R’s was conducted more recently than Dr. B’s. What he failed to acknowledge, however, were the obvious flaws in Dr. B’s report, which were forcefully highlighted throughout the hearing—from opening statements, during Dr. R’s expert testimony, and in closing argument. Instead, the Judge found that Dr. B’s “diagnosis was proper given the evidence before her, notwithstanding counsel’s arguments undercutting the weight to be given the evaluation and its conclusions.”¹⁵ Having accepted Dr. B’s diagnosis as “proper,” over objection, the Judge then premised his entire mitigation analysis upon the fact that there were **two** diagnoses of severe alcohol use disorder (AUD) more than three years apart, citing to that fact at least six times.¹⁶ In failing to acknowledge the fundamental flaws in Dr. B’s diagnosis and in relying so heavily upon it, the Judge erred. He failed to consider an important aspect of the case and failed to articulate a satisfactory explanation for his conclusion—over objection—that her diagnosis was “proper.” That leaves only the issue of whether the error is harmful, warranting remand, or harmless as the Majority opinion suggests.

Turning to that issue—the Majority declines to resolve: 1) whether Dr. B’s diagnosis was valid; and 2) whether the Judge erred in relying upon it. Instead, they implicitly conclude that any error was harmless, as “the Judge’s adverse determination is sustainable independent of that evaluation.” They rely at least in part on the fact that the Judge applied the disqualifying condition of AG ¶ 22(d) to the 2020 diagnosis as well as to Dr. B’s 2024 diagnosis. More broadly, the Majority asserts that the Judge’s analysis turned largely upon Applicant’s history of alcohol consumption since 2020 and that, although Dr. B’s diagnosis was “a factor in that history,” he weighed other factors as well.

I disagree that this decision survives independent of Dr. B’s diagnosis. The fact that there were two diagnoses, with Dr. B’s diagnosis as recent as 2024, permeated the Judge’s entire mitigation analysis, in which he repeatedly, in not relentlessly, cited to that fact. Had the Judge instead discounted Dr. B’s diagnosis as inadequate and not in accord with the professional standards of which he took administrative notice, he would have been left with the October 2020 diagnosis of AUD Severe and the more recent favorable evaluation and prognosis of Dr. R, an experienced Government mental health contractor. In that context, the Judge might well have weighed Dr. R’s evaluation and testimony quite differently.

¹⁵ Decision at 12.

¹⁶ Decision at 1, 14.

Remand is appropriate where, as here, the legal errors can be corrected upon remand and there is a significant chance of reaching a different result upon correction. I would remand.

Signed: Moira Modzelewski
Moira Modzelewski
Administrative Judge
Chair, Appeal Board