DEPARTMENT OF DEFENSE
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
	)	ISCR Case No. 23-02569
	)	
Applicant for Security Clearance	)	

Appearances

For Government: John Lynch, Esq., Department Counsel
For Applicant: Samir Nakhleh, Esq.

04/16/2025

Decision

GOLDSTEIN, Jennifer, I., Administrative Judge:

Applicant did not mitigate the security concerns under I (psychological conditions). Eligibility for access to classified information is denied.

Statement of the Case

On March 19, 2024, the Department of Defense (DoD) issued a Statement of Reasons (SOR) to Applicant detailing security concerns under Guideline I. Applicant responded to the SOR on April 21, 2024, and requested a hearing before an administrative judge. The case was assigned to me on February 5, 2025. The hearing convened as scheduled on March 4, 2025.

Evidence

Government Exhibits (GE) 1 through 5 were admitted in evidence without objection. Applicant testified and submitted Applicant's Exhibits (AE) A through L, which were admitted without objection.

Without objection, I have taken administrative notice of certain provisions of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Those excerpts are marked hearing exhibit (HE) I.

Findings of Fact

Applicant is a 37-year-old employee of a defense contractor. He has worked for his current employer since May 2024. He served on active duty in the U.S. Army from 2008 until he was honorably discharged in 2015. He has served in his state's Army National Guard since his discharge from active duty in 2015. His paygrade is E-5. He seeks to retain a security clearance, which he has held for 17 years. He has never received a security violation, has never been reprimanded at work, and has never received non-judicial punishment. He is married with three children. He is currently taking classes toward obtaining a professional certificate. (Transcript (Tr.) at 21-29, 32- 34, 59; GE 1; AE B, AE E)

In 2011 to 2012, Applicant deployed to Afghanistan. Prior to deployment, he attended a stress management class in May 2011. He also reported "fainting (syncope)." (GE 3 at 87-88) During deployment in Afghanistan, he lost multiple close friends who were killed in the line of duty. He also was in a truck accident and received a head injury. Applicant testified that his head injury caused a seizure condition, and that he has experienced grand mal seizures. He explained that he was diagnosed with mild traumatic brain injury (TBI), however his medical records on this claim are conflicting. (Answer; GE 1, GE 3 at 85, 351, 356-360) Between 2008 and 2015, he participated in multiple screening tests for anxiety and depression, which were always negative. (GE 3 at 688)

Since Applicant's discharge from active duty, he has had a history of mental health treatment and four suicide attempts. He received treatment through an Army clinic, Department of Veterans Affairs (VA) clinics, and private providers with varying frequency since October 2015 for depressive disorder – unspecified (SOR ¶1.a). He first sought treatment in 2015, right after he was discharged. At that time, he was struggling with the transition to civilian life. (Answer, Tr. 26, 35-40) His psychological history is as follows.

In September 2015, Applicant participated in a behavioral health prescreening that diagnosed him with adjustment disorder with anxiety at the time of his involuntary separation from the Army. (GE 3 at 81, 668-670) From January to March 2016, Applicant sought treatment on base with the mental health clinic. He received six months of extended medical benefits after his discharge, which allowed him access to the base medical clinic. (Answer; Tr. 65) His medical records show diagnoses of insomnia, depressive episodes, and migraine with aura. The credentials of the provider are not identified. (GE 3 at 80) After that six-month period, his treatment was terminated because his medical benefits expired. (GE 3 at 789) However, he sought treatment again in 2016 related to transitional stress. The treating psychiatrist at that time confirmed the earlier diagnosis. (GE 3 at 669)

In 2017, Applicant twice attempted suicide by overdosing on medications. (SOR ¶ 1.c) The first attempt was in January 2017, on the anniversary of one of his friend's deaths. He took 18 pills. They made him sleep for several hours, and then he woke up. He did not tell anyone outside of his family of his attempt at that time. (GE 3 at 788; Tr. 67-69) Applicant was prescribed Sertraline (Zoloft) by his primary care manager in June 2017. (GE 3 at 80 pdf 135) The second suicide attempt was in July or August 2017, after he had another seizure, and his migraines worsened. He again intentionally overdosed on a sleeping medication. He awoke the next day without incident. (Answer; GE 3 at 14; Tr. 70)

Applicant began mental health treatment in July 2017. He attended therapy with a licensed clinical social worker (EJ). EJ diagnosed Applicant with depressive disorder. Her treatment notes reflect about 30 different sessions over the course of five years, with the last session occurring in February 2021. Each session was for about an hour. (AE D) During treatment, he noted recurring suicidal ideation, noncompliance with his prescription of Zoloft, and repeated incidents of fluctuating moods. (SOR ¶ 1.i) (AE D; Tr. 50.)

From August 19 through August 21, 2017, Applicant was involuntarily hospitalized after a suicide attempt. (SOR ¶ 1.b) Prior to his attempt, he was taking a prescribed medication called amitriptyline, which was supposed to help with his sleep issues and migraines, but only exacerbated his sleep issues. He had been unable to sleep for three days when while viewing Facebook, he saw a picture of a friend that had been killed in action. His recollection of events after that is imperfect, but he acknowledged that he ended up retrieving his firearm with the intent to shoot himself. His wife and sister intervened. Police transported him to a local hospital, where he received treatment for three days. He was diagnosed with PTSD and discharged with prescriptions of Zoloft and Restoril. (GE 3 at 7, 13; AE D; Tr. 38-40, 71-73)

In November 2017, Applicant stopped taking prescription Zoloft, without the consent of his prescribing doctor. (SOR ¶ 1.d) He testified that he did discuss it with his doctor because he thought it was making his migraines worse and he was also experiencing sexual dysfunction. (Tr. 41-42) In November or December 2019, he again discontinued taking Zoloft as prescribed. (SOR ¶ 1.f) Each time he informed his doctor he was not medicine compliant; his doctor encouraged him to continue taking it as prescribed. He also reported that he sometimes would stop taking his medication when on drill weekends because he was operating heavy machinery. (Tr. 43) He felt that the Zoloft conflicted with another medication he took for his traumatic brain injury called Zonegran, which he claimed is also used as an anti-depressant. (Tr. 44)

In January or February 2019, Applicant again stopped taking his prescribed psychotropic medications. (SOR ¶ 1.e) He "fell off the back of a truck while on military duty" and experienced more intensified migraines and light sensitivity. He also got a letter from the VA with an initial disability rating of 0%. About that same time, his grandfather, cousin, and another Soldier he knew passed away. Treatment records from May 2019 note that Applicant screened negative for "lifetime history of mania." (GE 3 at

700) A note from his treating psychiatrist on September 27, 2019, reflected “Pt. relates he self-discontinued all psychotropic medications about x3/4 months ago. Pt. elaborates he stopped taking the medications because he felt like he was doing better and didn't need them.” (GE 3 at 144, 672) The psychiatrist again prescribed him Zoloft and noted in the diagnostic impressions that “Pt. appears to be an unreliable historian.” He was again diagnosed with depressive disorder, unspecified. (GE 3 at 675)

Applicant chose to go off his medication for “a few days” which resulted in an attempted suicide in November or December 2019. On that occasion, he ran a hose to his vehicle’s exhaust system so that it dispersed carbon monoxide into the cabin of the vehicle. (SOR ¶ 1.g) His wife discovered him in the driveway and his suicide attempt was not successful. (Tr. 46-47, 89-91)

In March or April 2020, Applicant stopped taking prescription Zoloft for about a month, without the consent of his prescribing doctor. He testified that this was a result of the supply-chain disruption at the VA that occurred during COVID19. (SOR ¶ 1.h) (Tr. 92; GE 3 at 793)

On February 5, 2021, Applicant was prescribed 100 MG Zoloft. (Ex 2 at 114) It was about this time that he stopped treatment with his licensed clinical social worker, JE, and returned to the VA for treatment. (Tr. 100-101, GE 3; AE D)

Since 2015, Applicant has visited the VA monthly for medical treatment. In 2023, he obtained treatment for sleep apnea. He also has limited his consumption of Monster energy drinks. (GE 3 at 591, 608) Applicant has also received mental health treatment at the VA. However, it would often be six months from the time he requested an appointment to the date of the session, and frequently it would be with a new doctor. (Tr. 51) The week prior to the hearing he visited his primary care doctor who ordered a consult on mental health. (Tr. 54-55) He is not currently prescribed any psychotropic medications. He claimed he has not had any thoughts of self-harm in the past five years. He copes with stress by journaling, fishing, and enjoying nature. He is close to his family and extended family. (Tr. 57)

On May 31, 2023, Applicant was evaluated for suicide risk. Medical records reflect that he “has current thoughts of engaging in suicide-related behavior” and explained, “They come and go, its not an every day thing, its mainly when I think too much, or remember certain things that trigger memor[y], things that happened in the past.” He was diagnosed with PTSD. (GE 3 at 343-348, 399, 487; Tr. 96-100)

On August 18, 2023, Applicant was evaluated at the request of the DOD by a psychologist. (SOR ¶ 1.j) Applicant met with the psychologist (Dr. B) once online. In her report, the Dr. B opined:

> I also have concern about his stability without ongoing treatment. It is clear that he possesses a condition that could impede his judgment,

> trustworthiness, and reliability in the future. His prognosis is guarded unless he returns to regular treatment for bipolar II disorder. (GE 2)

Out of the 885 pages of evidence submitted by the Government, there are three mentions of a diagnosis of bipolar affective disorder. In his medical records on August 2, 2017, bipolar disorder was identified as a "rule out diagnosis" due to Applicant's "lack of sleep and mood instability." On August 2, 2017, the entry appears to be tied to a diagnostic clinical interview that was to be consolidated into a "Comprehensive report with background information, tests results, and summary/impressions will be available following completion of testing." (GE 3 at 789, 862) Further, treatment records in evidence reflect no diagnosis of hypomania. (145, 653, 673, 701-702)

The diagnosis of bipolar II disorder, in remission is only found in the Dr. B's report, which noted the two prior references. She stated:

> Also of note, the applicant was previously treated only for depression; however, it seems the applicant is actually suffering from a bipolar disorder, which includes both depressive and hypomanic episodes. Bipolar II disorder is a chronic condition that is known to wax and wane over time. Without ongoing psychiatric/psychological treatment, there is a high risk of relapse for either depressive or hypomanic episodes. I feel strongly that he should be treated for bipolar disorder. It is also worth noting that some medications prescribed for seizures are also effective for managing bipolar disorder symptoms. (GE 2 at 6)

She found "hypomanic symptoms" citing "a decreased need for sleep, increased goal directed activities, racing thoughts, and increased energy levels." (GE 2 at 3) In September 2023, Applicant's diagnosis was anxiety and cognitive communication defect. (GE 3 at 487) He testified that he last met with a psychotherapist in April 2024. (AE J; Tr. 108) He is not currently taking any mental health medications. He is sleeping better since starting treatments for sleep apnea. (AE L; Tr. 109) In 2024, he participated in cognitive communication therapy with a speech pathologist that focused on "functional compensatory strategy used to improve cognition, specifically, organization, prospective memory, attention, concentration, learning, memory and cognitive flexibility." (AE L)

Whole Person

Applicant has been awarded the State Active Duty Service Ribbon twice, the Humanitarian Services Medal, and the Army Reserve Component Achievement Medal. His performance evaluation reflects that "his technical/tactical proficiency is unmatched." He was part of a team that received recognition as the "Component Team winner" for resolving a video teleconference problem at work. He also received a spot bonus in October 2024 for his role in resolving that problem. He runs a suicide awareness program for the National Guard and helps with his children's sports. (AE C, AE F, AE G at 30, AE H; Tr. 31, 33, 56)

Applicant also presented a letter of recommendation from his IT Director that reflects he is a valued team member and has excellent work quality, timeliness, and dedication to meeting the command objectives. He also presented a letter of recommendation from his now retired Army National Guard platoon leader. He is recognized for his ability to make ethical, clear, and concise decisions. He is said to have unmatched technical skills. (AE I)

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

The DSM-5 is the standard classification of mental disorders used by mental health professionals in the United States. Department Counsel produced the DSM entry for bipolar and related disorders for administrative notice. The following is the definition of hypomanic episode from the DSM-5 that was part of the submitted excerpt:

> A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
>
> B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
>
> 1. Inflated self-esteem or grandiosity.
> 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
> 3. More talkative than usual or pressure to keep talking.
> 4. Flight of ideas or subjective experience that thoughts are racing.
> 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli, as reported or observed.
> 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
> 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
>
> C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
>
> D. The disturbance in mood and the change in functioning are observable by others.
>
> E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate

hospitalization. If there are psychotic features, the episode is, by definition, manic.
F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for cyanosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Policies

This case is adjudicated 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), which became effective on June 8, 2017.

When evaluating an applicant's suitability for a security clearance, the administrative judge must consider the adjudicative guidelines. In addition to brief introductory explanations for each guideline, the adjudicative guidelines list potentially disqualifying conditions and mitigating conditions, which are to be 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, administrative judges apply the guidelines 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."

Under Directive ¶ E3.1.14, the Government must present evidence to establish controverted facts alleged in the SOR. Under Directive ¶ E3.1.15, the applicant is responsible for presenting "witnesses and other evidence to rebut, explain, extenuate, or mitigate facts admitted by the applicant or proven by Department Counsel." The applicant has the ultimate burden of persuasion to obtain a favorable security decision.

A person who seeks access to classified information enters into a fiduciary relationship with the Government predicated upon trust and confidence. This relationship transcends normal duty hours and endures throughout off-duty hours. The Government reposes a high degree of trust and confidence in individuals to whom it grants access to classified information. Decisions include, by necessity, consideration of the possible risk the applicant may deliberately or inadvertently fail to safeguard classified information. Such decisions entail a certain degree of legally permissible extrapolation of potential, rather than actual, risk of compromise of classified information.

Section 7 of EO 10865 provides that adverse 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 inference concerning the standards in this guideline may be raised solely on the basis of mental health counseling.

AG ¶ 28 provides conditions that could raise psychological conditions security concerns. 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;
>
> (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 a prescribed treatment plan 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.

AG ¶¶ 28(a) and 28(c)

Applicant attempted suicide four times, in January 2017, July 2017, August 2017, and in December 2019. (SOR ¶¶ 1.b, 1.c, and 1.g) He had suicidal ideations in between 2017 and 2021, as reflected in his licensed clinical social worker's records. (SOR ¶ 1.i) He was hospitalized in August 2017 after suicidal ideations. (SOR ¶ 1.a) AG ¶¶ 28(a) and 28(c) are applicable.

AG ¶ 28(b)

AG ¶ 28(b) requires 1) an opinion by a duly qualified mental health professional that the individual has a condition; and 2) that the condition may impair judgment, stability, reliability, or trustworthiness.

The first step in analyzing the applicability of AG ¶ 28 (and subsequently the mitigating conditions in AG ¶ 29), is to identify what condition is said to raise concerns under this guideline. There are three different diagnoses alleged in the SOR including depressive disorder, bipolar II disorder – in remission, and unspecified anxiety disorder. Applicant's medical records reflect various diagnoses including the three alleged conditions. In 2015 he was diagnosed with adjustment disorder with anxiety. In 2016 he was diagnosed with insomnia and depressive episodes. In 2017 he was diagnosed with depressive disorder and PTSD. In 2019 his diagnosis was depressive disorder, unspecified. In August 2023, Dr. B diagnosed him with bipolar II disorder – in remission, and unspecified anxiety disorder. In September 2023, Applicant's diagnosis was anxiety and cognitive communication defect. He has had multiple providers, and each provider seems to have diagnosed him differently based on their knowledge and how he presented to them. My analysis of the disqualifying conditions is limited to those conditions alleged in the SOR: depressive disorder, bipolar II disorder, and unspecified anxiety disorder.

In this case, DOD hired Dr. B to assess Applicant. Dr. B diagnosed Applicant with bipolar II, which she believed was a condition that could impede his judgment, trustworthiness, and reliability in the future, even though it is in remission. Of note is that Dr. B failed to specify whether it was in partial or full remission. Technically, her opinion meets this disqualifying criterion. As established in ISCR Case No. 20-01838 at 6, n.3 (App. Bd. Dec. 29, 2022), bipolar disorder is a condition that, by its very nature, raises a security concern. However, Dr. B's bipolar II diagnosis is inconsistent with his other treatment providers' diagnoses. The providers in the past did not document diagnosis of

bipolar disorder or a hypomanic episode even though he was tested for it in August 2017. While Dr. B is a psychologist with a doctorate in psychology and has higher level educational training than that of the treating licensed clinical social worker JE, JE has met with Applicant 30 times over five years. Dr. B reviewed his treatment records and had one short video teleconference with Applicant. JE's diagnosis of depression is also supported by treating psychiatrists, who are medical doctors. It also appears that JE's diagnosis was confirmed by the neuropsychological testing. Dr. B also failed to articulate what about the medical records caused her to find "hypomanic symptoms" other than citing "a decreased need for sleep, increased goal directed activities, racing thoughts, and increased energy levels." She does not appear to look at the totality of his treatment records. For instance, she cites a decreased need for sleep in her analysis, when his sleep problems were eventually diagnosed as sleep apnea. His energetic bursts appear to be related to heavy use of Monster, an energy drink with high amounts of caffeine. As a result of reviewing the record in its entirety, I do not find that the evidence presented supports application of this disqualifying condition with respect to bipolar II disorder, in remission.

Anxiety and depressive disorder, however, are not typically conditions that raise a security concern. ISCR Case No. 22-00396 at 7, n.2 (App. Bd. October 17, 2024). Conditions like depressive disorder and anxiety, may require elaboration by the mental health professional as to how the condition may impair the individual's judgment, stability, reliability, or trustworthiness. In this case, however, his anxiety and depression manifested in suicide attempts and suicidal ideation. While he has not had a suicide attempt since 2019, he did have suicidal ideations as recently as 2023. In this instance, his anxiety and depression which have led to self-harm or thoughts of self-harm indicate that he has a condition that has impaired his judgment, stability, reliability, or trustworthiness in the past and those conditions remain a concern. AG ¶ 28(b) is applicable.

AG ¶ 28(d)

Applicant also has failed to follow his prescribed treatment plan by inconsistently taking Zoloft, the medication he has been prescribed multiple times. AG ¶ 28(d) is applicable.

AG ¶ 29 provides conditions that could mitigate psychological conditions security concerns. The following are potentially applicable:

> (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.

None of the mitigating conditions, individually or collectively, are sufficient to mitigate Applicant's diagnoses of depression and anxiety with concomitant suicide attempts and suicidal ideations. His psychological conditions appear tied to his head injuries (potential TBI), epilepsy, and cognitive problems. While he is receiving cognitive therapy from a speech therapist, he did not present enough information to establish that his psychological problems or judgment issues are under control. Applicant has the burden of establishing evidence of mitigation and did not produce enough documentation to establish there is a low probability of recurrence. His depression and anxiety may potentially be controllable with treatment, but he has failed to show he has followed an established treatment plan. He did not offer a favorable prognosis into the record. Instead, his history of treatment from 2015 to present shows inconsistent compliance with prescribed medications. Without more evidence of a favorable prognosis or other supporting mitigation, I cannot find there is no longer a problem. Considering his long history of suicidal ideation and attempts, not enough time has passed to support full mitigation at this time.

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 relevant 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 have incorporated my comments under Guideline I in my whole-person analysis. I also considered Applicant's favorable character evidence. Applicant performs well at work and is highly regarded for his expertise. He performs community service and supports his fellow Soldiers. He has dedicated his life to serving the United States and has experienced a number of life-changing events because of his willingness to serve. Unfortunately, those events have impacted his mental health and at this time, there is not enough evidence to support mitigation.

Overall, the record evidence leaves me with questions and doubts about Applicant's eligibility and suitability for a security clearance. I conclude Applicant did not mitigate the security concerns under Guideline I.

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.i:	Against Applicant
Subparagraph 1.j:	For Applicant

Conclusion

It is not clearly consistent with the national interest to continue Applicant's eligibility for a security clearance. Eligibility for access to classified information is denied.

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Jennifer I. Goldstein
Administrative Judge