DEFENSE LEGAL SERVICES AGENCY
DEFENSE OFFICE OF HEARINGS AND APPEALS

In the matter of:	)	
	)	
	)	ISCR Case No. 25-00040
	)	
Applicant for Security Clearance	)	

Appearances

For Government: Lauren A. Shure, Esq., Department Counsel
For Applicant: Sean Rogers, Esq.

06/22/2026

Decision

HARVEY, Mark, Administrative Judge:

Security concerns arising under Guidelines I (psychological conditions) and E (personal conduct) are mitigated. Eligibility for access to classified information is granted.

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Statement of the Case

On September 28, 2021, Applicant completed and signed an Electronic Questionnaire for Investigations Processing (e-QIP) or security clearance application (SCA). (Government Exhibit (GE) 1) On May 19, 2025, the Defense Counterintelligence and Security Agency (DCSA) issued a statement of reasons (SOR) to Applicant under Executive Order (Exec. Or.) 10865, *Safeguarding Classified Information within Industry*, February 20, 1960; Department of Defense (DOD) Directive 5220.6, *Defense Industrial Personnel Security Clearance Review Program* (Directive), January 2, 1992; and Security Executive Agent Directive 4, establishing in Appendix A the *National Security Adjudicative Guidelines for Determining Eligibility for Access to Classified Information or Eligibility to Hold a Sensitive Position* (AGs), effective June 8, 2017. (Hearing Exhibit (HE) 2)

The SOR detailed reasons why the DCSA did not find under the Directive that it is clearly consistent with the interests of national security to grant or continue a security clearance for Applicant and recommended referral to an administrative judge to determine whether a clearance should be granted, continued, denied, or revoked. Specifically, the SOR set forth security concerns arising under Guidelines I and E. (HE 2) On May 21, 2025, Applicant provided a response to the SOR and requested a hearing. (HE 3) On June 17, 2025, Department Counsel was ready to proceed.

On December 18, 2025, the case was assigned to me. On January 8, 2026, the Defense Office of Hearings and Appeals (DOHA) issued a notice scheduling the hearing for March 24, 2026. (HE 1) The hearing was held as scheduled.

Department Counsel offered five exhibits into evidence and requested administrative notice of 14 pages related to major depressive disorder (MDD) and borderline personality disorder (BPD) from the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (*DSM-5*); Applicant offered five exhibits into evidence; there were no objections; and I admitted the proffered exhibits into evidence. (Transcript (Tr.) 14-17; GE 1-GE 5; Applicant Exhibits (AE) A-AE E; HE 4) I also took administrative notice of the requested pages of *DSM-5*. (Tr. 16; HE 4) On April 2, 2026, DOHA received a transcript of the hearing. On June 15, 2026, Applicant provided an updated mental health report from Dr. W, which was admitted without objection. (AE F)

Some details were excluded to protect Applicant's right to privacy. Specific information is available in the cited exhibits and transcript.

Findings of Fact

In Applicant's SOR response, he admitted the SOR allegations in ¶¶ 1.b through 1.g, 2.a, 2.b, and 2.c. (HE 3) He denied the SOR allegations in ¶¶ 1.a and 2.d. He also provided clarifying and mitigating information. His admissions are accepted as findings of fact. At his hearing, he admitted all of the SOR allegations. (Tr. 64-65) Additional findings follow.

Applicant is a 32-year-old, manager of a team of seven people. (Tr. 33; AE A at 1) His resumé provides details of his employment history. (AE B) In 2018, he received a bachelor's degree in physics, and in 2023, he received a master's degree in business administration (MBA). (Tr. 17, 33) His parents are both psychologists, and Applicant assists with the business and financial management part of their practice. (Tr. 19-20) He has held a security clearance for about two years. (Tr. 20) He has never married, and he does not have any children. (Tr. 33) He has never been investigated for a security incident. (Tr. 21)

Psychological Conditions and Personal Conduct

Psychological conditions security concerns are alleged in ¶ 1, and personal conduct security concerns are alleged in ¶ 2. Allegations are addressed in chronological order.

SOR ¶¶ 1.e and 1.f allege Applicant was involuntarily hospitalized in about June 2010 for suicidal ideation or suicide attempt or both by overdosing on medication, respectively. SOR ¶ 1.d alleges Applicant received residential mental health treatment for MDD and Anxiety from about October 2010 to about January 2011. SOR ¶ 2.a alleges in about September or October of 2010, Applicant harassed and threatened an ex-girlfriend after he found out she was unfaithful. He was arrested and eventually agreed to three months of treatment in a residential facility and one year of probation. A court ordered him to attend this treatment based on his charge of felony criminal threat following the incident involving his girlfriend. SOR ¶ 2.d cross alleges that information set forth in SOR ¶¶ 1.a through 1.f. As indicated previously, he admitted the allegations in SOR ¶¶ 1.d, 1.e, 1.f, and 2.a.

Applicant started taking Accutane when he was 15 years old to address his acne, and he used it for about two months. (Tr. 23, 34) The medication container warns about a possible side effect of depression if the user has a high disposition for depression. (Tr. 23, 34) After he stopped taking Accutane, in June 2010, he overdosed on an antidepressant, Wellbutrin. (Tr. 37) He consumed the bottle of Wellbutrin and sent texts to his friends saying "goodbye." (Tr. 38) His friends came to his residence. (Tr. 38) One of the parents of his friends found his text message and informed Applicant's mother about the text. (Tr. 38) She found the empty pill bottle and called the hospital. (Tr. 38) He was admitted for inpatient mental health treatment for about one week. (Tr. 38)

About three months after the first suicide attempt in 2010, Applicant entered his parent's room at night to get pills so that he could attempt suicide. (Tr. 40) He again overdosed on his medications. (Tr. 39) His mother took him to the hospital. (Tr. 40) He was admitted for inpatient mental-health treatment for about one week. (Tr. 41)

In about September 2010, Applicant's girlfriend ended their relationship. (Tr. 23) A few days after he was discharged from the hospital in September of 2010, a friend told him that "she had been cheating on [him], and [he] reacted in anger, sending her [threatening] text messages." (Tr. 23-24, 41-42) Applicant said, "I didn't have any intent to follow through or do anything else. I just wanted to make her [to] feel [like] I felt. And I was arrested, I think, a few days later after those text messages were sent." (Tr. 24)

The court ordered him to complete three months in a residential treatment facility, and he was on probation for one year. (Tr. 24, 42-43) His criminal record was subsequently sealed and expunged. (Tr. 24)

After Applicant stopped taking Accutane, he continued to be depressed. (Tr. 23) A psychiatrist advised him that Accutane can stay in a person's system for about two years. (Tr. 23)

SOR ¶ 2.b alleges, and Applicant admitted, in about 2011, he was told not to communicate with a girl he met in school. He received a peace order restraining him from contacting her. (HE 2)

As to the allegation in SOR ¶ 2.b, Applicant said that he told a girl in his high school class whom he was trying to impress that he had "a felony for what's technically a violent crime." (Tr. 47) He said:

> She did not tell him directly to stop contacting her but subsequently told one of the teachers at school that I was bothering her. When the teacher told me to stop contacting her, I was confused and asked her directly if she wanted me to stop talking to her, to which she said no. At the time, I figured the teacher made a mistake as I did not fully understand why someone would do that instead of being direct. I continued contact with her, at which point she told her father. (HE 2)

The girl's father, who was a police officer, saw the texts or something or she told her father. Then her father obtained the peace order. (Tr. 47)

When Applicant was 18 years old, he and his parents were overseas on a tour. (Tr. 44) He was drinking heavily and thinking about suicide. (Tr. 44) He cut himself with some glass. (Tr. 44) The hospital labeled the incident as a suicide attempt. (Tr. 44; GE 4 at 12, 23) Applicant said, "it wasn't really like an attempt. It was more just like self-harm. I had friends that would cut themselves and I wanted to kind of see what that was like, I guess." (Tr. 44)

From about 2013 to 2016, Applicant was in a three-year relationship with a woman. (Tr. 66, 88-89) They lived together for part of that time. (Tr. 66) He ended the relationship on amicable terms when he went to college. (Tr. 66)

Applicant took Lexapro starting when he was 18 years old for several years, and in about 2015, he stopped taking Lexapro and other mental-health medications until about 2019. (Tr. 26)

In December 2018, Applicant graduated from college. He was under stress for several circumstances. He was unable to find employment. (Tr. 26) He was living at home with his parents. (Tr. 26)

SOR ¶ 1.c alleges, and Applicant admitted, that he received treatment from Dr. T.B. for MDD, recurrent, severe, from about October of 2019 to about July of 2020. He received referrals to a doctor who could prescribe medication, but the provider noted that he was not interested in medication to assist with his mood. Against treatment recommendations he ceased treatment. He said it was due to a lack of results. The evaluator stated that if left untreated, his condition could result in enduring instability and impulsiveness.

In December of 2019, Applicant told his therapist that he discussed a plan to commit suicide with a friend in November of 2019. (Tr. 50) He said, "I was having suicidal thoughts and was actively kind of wanting to do it." (Tr. 50) At that time he was unemployed, and he was not collocated with friends. (Tr. 51)

In 2020, the COVID-19 pandemic reduced employment opportunities, and Applicant's social contacts were reduced. (Tr. 27) He was unable to interact in person with friends. He had unreciprocated feelings for a woman. (Tr. 26) In June of 2020, he took concrete steps toward committing suicide, including offering his bank account to a friend. (Tr. 51) Applicant did not believe he was improving and described himself at his hearing as depressed and in crisis. (Tr. 52) However, in 2020 he did not recognize that he was in a crisis. (Tr. 52) He did not commit suicide because his therapist called Applicant's parents and asked them not to leave town. (Tr. 52) He increased his therapy sessions, and his therapist developed a safety plan with him. (Tr. 52-53) In the summer of 2020, he purchased a shotgun. (Tr. 53) In July of 2020, his therapist told him to go to a doctor who could prescribe medication; however, Applicant did not want medication. (Tr. 53) Applicant terminated his treatment with the therapist. (Tr. 53) His therapist opined that if he did not receive treatment, he would likely continue to have instability and impulsiveness. (Tr. 53)

SOR ¶¶ 1.b and 2.c allege, and the record establishes, that in about August 2020, Applicant became extremely depressed when a love interest did not reciprocate his romantic feelings for her, and he sent her a text message that included a picture of himself with a loaded gun in his mouth. She called his mother and the police, he was detained by the police and taken to a hospital. He received an emergency evaluation at a hospital due

to suicidal ideation. Applicant was treated for MDD, recurrent, severe, with anxious distress. He was transferred into the partial hospitalization program (PHP) at the hospital, where he received inpatient hospitalization for four days. Upon discharge, the hospital staff recommended that he continue outpatient treatment. (HE 2)

About a month after he discontinued therapy in August 2020, Applicant's love interest was at a birthday party, and he was feeling "very isolated." (Tr. 29) He reasoned, "these people are socializing and doing all this stuff while I wasn't, and that made [him] feel more depressed and suicidal. And so he basically sent her the picture after that to basically tell her how [he] was feeling at the time." (Tr. 29) The picture was of himself with the muzzle of a shotgun in his mouth. She called his parents and the police. (Tr. 27, 29, 56-57) The shotgun was loaded. (Tr. 54) The police took him to the hospital for a "wellness check." (Tr. 27) He was admitted for four days of inpatient mental-health treatment. (Tr. 28) After he was discharged, he was referred to an intensive outpatient program (IOP). (Tr. 28) He was diagnosed with MDD, recurrent, severe, with anxious distress. (Tr. 56) Applicant gave the shotgun to his father. (Tr. 116)

Applicant was in the IOP for about three weeks. (Tr. 28, 57) After the IOP, he did not receive further therapy; however, he was prescribed 10 mg of Lexapro. (Tr. 30, 58) He did not remember whether there was a treatment recommendation when he completed IOP. (Tr. 58) He took Lexapro until around January of 2025. (Tr. 30) In response to a question about the basis for his decision to stop taking Lexapro, Applicant said:

> I consulted with my parents, who are both psychologists. I told them I would like to try stopping taking Lexapro. They both agreed, and they agreed to monitor me and see if they could tell if my mood was acting up or if I was doing any unusual behaviors that I couldn't see myself. And they did. And that was how I approached that. (Tr. 30)

SOR ¶ 1.g alleges that Applicant did not comply with treatment recommendations, to include from providers set forth in SOR ¶¶ 1.b. and 1.c., above. He is not currently obtaining any treatment for his underlying psychological condition.

Dr. Z's Psychological Evaluation

SOR ¶ 1.a alleges Applicant was evaluated by a licensed clinical psychologist, Dr. Z, on June 28, 2024. Collateral records, his self-report, and the clinical interview show he meets the criteria for BPD.[1] The psychologist noted that while he was apparently stable

[1] Diagnostic Criteria in *DSM-5* at 663 for borderline personality disorder are as follows:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

at the time of this evaluation, his personality and underlying psychological issues continue to result in unpredictable interpersonal relationships; since the age of 16 he has experienced a pattern of unstable and intense personal relationships, impulsivity, recurrent suicidal ideations and gestures, chronic feelings of emptiness, inappropriate and intense anger and mood instability. The psychologist opined that given the significance of behavior decompensation in the intimate context, possible interpersonal difficulty will remain without adequate treatment. As a result, the psychologist concluded that Applicant's reliability, judgment, stability, and trustworthiness are compromised by his current psychological state.

Dr. Z performed his evaluation at the request of the DCSA. Dr. Z provided the description of symptom, diagnosis, and prognosis that is indicated in SOR ¶ 1.a. (GE 5 at 5)

Dr. Z was suspicious of Applicant's description of his medical history and current mental-health status. He explained his concerns as follows:

> Applicant's self-report was a mix of inconsistency and minimization. He was evasive about various past incidents in which legal or other authority figures intervened, and only offered details after I introduced them, despite having ample opportunities to broach them himself. . . . He was unclear about his medication history, specifically regarding his current Lexapro medication, how long it has been prescribed to him and by whom, and not recalling his past prescribing physician to provide records of ongoing treatment. While his initial suicide attempt could have been partly due to side effects of the Accutane he had been prescribed, his attempt and general affective and interpersonal instability are better attributed to a personality disorder. There is clear evidence of such maladaptive behaviors years after he stopped Accutane. Further, he minimized his treatment with Dr. [T.B.], describing it as having lasted two weeks, but which records show lasted at least three months over two years (2019 & 2020). He also generally stated he has

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

received Lexapro for the past four years, could not recall his current physician s name, who he has seen only once, and could not recall his past physician's name, who he believes has since relocated. His medication history was ambiguous at best, calling into question the truthfulness of treatment consistency. To his credit, he agreed to provide me with a treatment summary from his current physician. . . . His psychological testing results accurately demonstrated his general approach to our interview, which was primarily an attempt to minimize and appear better adjusted than he truly was. (GE 6 at 5-6)

Dr. Z concluded as follows:

In sum, the subject's self-report was not reliable. It is possible he is at a juncture in which he is taking accountability for his psychological state. This is noted in not having had a (known) episode of psychological decompensation in the past four years. However, his past episodes appear to be situationally specific to intimate relationships, as noted in his suicide attempt and additional ideation at age 16 and his most recent gestures in 2020. Given the significance of his behavioral compensation in the intimate context, it is possible such interpersonal difficulty will remain, without adequate treatment, and they may extend to other relationships. While it is helpful that he is prescribed Lexapro, that alone will not effectively target deeper personality based maladjustment. I recommend that the subject continue his current medication regimen and establish a more intensive psychotherapeutic treatment, such as individual dialectical behavior therapy. It is my professional opinion, within reasonable certainty, that the subject's **reliability, judgment**, **stability, and trustworthiness are compromised** by his **current** psychological state. (GE at 6 (emphasis in original))

Dr. W's Psychological Evaluation

On February 13, 2026, Dr. W, a clinical psychologist, provided his opinion and recommendations regarding Applicant at the request of Applicant's counsel. (AE A) Dr. W met with Applicant "virtually for two hours on February 13, 2026. His assessment involved a clinical interview with [him] and a thorough review of relevant available documents associated with his security clearance, interviews, decision, and appeal." (AE A at 1) He also completed the following psychological tests: Minnesota Multiphasic Personality Inventory (MMPI-3); Patient Health Questionnaire (for Depression; PHQ-9); Generalized Anxiety Disorder Questionnaire (GAD-7); and Adverse Childhood Experiences (ACE) Questionnaire. (AE A at 2) In his evaluation, Dr. W noted Applicant's description of suicidal ideations and attempts, impulsive and criminal behaviors, and hospitalizations for mental health treatments. *Id*. at 4. These descriptions were consistent with Applicant's statement at his hearing. Dr. W made five recommendations as follows:

1. [Applicant's] history and patterns of emotions/behavior merit the diagnoses of Major Depressive Disorder (in remission) and Borderline Personality Disorder, as outlined in his 2024 psychological evaluation.

2. [Applicant's] symptoms of MDD and BPD appear well-managed following appropriate treatment and concerted efforts on his part to manage his emotions and behavior appropriately. He appears at low risk of the emotional and behavioral instability that is traditionally associated with these diagnoses, given his stability over the past six years.

3. [Applicant's] appears to clearly understand what would be expected of him should his appeal be granted. He appears fully willing and able to abide by all rules necessary to achieve this professional goal and, should he succeed in this goal, to maintain his position via appropriate behavior in the future.

4. Like many individuals experiencing employment-related stressors, it is recommended that [Applicant] pursue counseling/psychotherapy in the future to help him continue to develop appropriate and healthy coping strategies, and to support him in developing insight into past behaviors and in managing current and future stressors.

5. In order to fully explore the range of treatment options available to him, it is also recommended that [Applicant] seek a psychiatric consultation to explore options for medication interventions, with the goal of maximizing and maintaining his emotional stability moving forward. (AE A at 5)

Dr. W said:

Diagnostically, Applicant meets the criteria for Major Depressive Disorder (in remission). In addition, he meets the criteria for Borderline Personality Disorder (BPD), given his history of emotional instability, self-injury, and suicide attempts. These diagnoses are consistent with a psychological evaluation [he] received in 2024. It should be noted, however, that [Applicant] has been emotionally stable for the past six years, which bodes well for his prognosis, especially if he establishes relationships with treatment providers in the future. It is recommended that [he] re-establish relationships with treatment providers in order to maximize the likelihood that he will remain emotionally stable moving forward. (AE A at 5)

Applicant denied that he had any behavioral issues in the one year since he stopped taking Lexapro. (Tr. 62) He told Dr. W that the only times he had depression and suicidal ideations were in 2016 and during the COVID-19 pandemic. (Tr. 62-63) He did not disclose the incident where he cut himself with glass to Dr. W; however, Applicant said he told Dr. W about the suicide plan in 2019. (Tr. 63) Dr. W recommended that

Applicant resume treatment. (Tr. 64) Applicant said, "I am in therapy now currently for the past couple weeks since Dr. [W's] report recommending therapy." (Tr. 31)

Applicant attended eight 50-minute psychotherapy sessions from March 13, 2026 to May 29, 2026, with Dr. W. (AE F) His next scheduled session is June 19, 2026. *Id*.

On June 13, 2026, Dr. W provided an updated diagnosis and prognosis stating:

> [Applicant] has made good progress in treatment thus far and he has used his time effectively in sessions. His diagnosed Major Depressive Disorder is in full remission. In consultation with me, [he] has decided (with my approval) that a psychiatric consultation for medication is not warranted at this time, given that his depression is in full remission. We agreed that [Applicant] will seek a psychiatric consultation should his depressive symptoms re-emerge in the future. *Id*.

Applicant's Parent's Descriptions of His Mental Health

Applicant's mother is a clinical psychologist with impressive credentials. (Tr. 84) She disagreed with the diagnosis of BPD because the testing employed was inadequate for this diagnosis. (Tr. 85-86) She did not conduct any psychological tests on Applicant. (Tr. 89) She did not believe the BPD criteria could be found during a depressive episode. She explained her disagreement with Dr. Z's diagnosis of BPD of Applicant as follows:

> Yeah, I absolutely disagree with that. Accurate assessment requires -- a personality disorder in particular requires longitudinal data across context which may not have been fully available to that evaluator, and his recent diagnosis does not align with his long-term stability and functioning which is clearly evident. Furthermore, I have looked -- I know that those reports based on information that [Applicant] has shared that one of the assessment -- the main way of determining the BPD diagnosis was based on the MMPI alone, which is not sufficient to formally diagnose a personality disorder. Formal events-based diagnosis of personality disorders generally require structured interviews or specialized inventories like the SCID-5-PD, which is a structured clinical interview for the *DSM-5* personality disorders, or the Millon Clinical Multiaxial Inventory, which is the MCMI-3 or 4, and -- or diagnostic interview for personality disorders. Without those, any conclusions about personality disorder are preliminary or incomplete, and he has never had any instances of the nine criteria that we would use to determine a determination about borderline personality disorder. **He's never exhibited any of those, outside of a major depressive disorder, so that would be -- the borderline personality disorder would be**

contraindicated in that case,[2] and also the fact that no other psychologist or evaluator has ever diagnosed him with BPD.

I mean, I have been on the front lines all his life, so I have observed him longitudinally throughout his life and across all kinds of different contexts, and these isolated instances, which -- you know? One occurred during adolescence. The most serious, you know, was -- occurred in that context of a major depressive episode, and now, given his stable functioning over many years, that is also -- the risk of relapse is very low at this point. (Tr. 85-87 (emphasis added))

Applicant's mother considered the most recent incident with a shotgun to be "a cry for help." (Tr. 87) She said:

We understand that individuals don't reach their full neurological or psychosocial maturity levels until their late 20s. It was during COVID when [the incident involving a shotgun] happened, which is another unprecedented time in this country's history and in his life. You know? He's very lonely. He has voluntarily sought help after that. (Tr. 87)

Applicant's mother also said:

I think what is most relevant to the panel is [Applicant's] sustained recovery and long-term stability. For many years, he's demonstrated sound judgment, emotional regulation, and responsible conduct. He's completed a rigorous degree in physics. He sought treatment voluntarily when needed. He's maintained stable employment. He manages his finances well. He's earning promotions at work based on merit and performance. He avoids any high-risk behaviors. He -- you know, no drinking, gambling, debt. He has -- he maintains a nice home, and he does sustain healthy social relationships. He's a business manager. Also a business manager of our private practice. (Tr. 80-81)

[2] BPD is supposed to have a "longstanding course" when a depressive disorder occurs at the same time as BPD. *DSM-5* at 666 states:

> **Differential Diagnosis**--*Depressive and bipolar disorders*. Borderline personality disorder often co-occurs with depressive or bipolar disorders, and when criteria for both are met, both may be diagnosed. Because the cross-sectional presentation of borderline personality disorder can be mimicked by an episode of depressive or bipolar disorder, the clinician should avoid giving an additional diagnosis of borderline personality disorder based only on cross-sectional presentation without having documented that the pattern of behavior had an early onset and a longstanding course.

As to the risk of a serious future episode, Applicant's mother said:

> [H]e demonstrated over the past six years of sustained stability without any ongoing outpatient treatment or -- and at least within the past year and a half, two years without medication, which is one of the strongest predictors of continued remission. He has long-term functional stability in work and his relationships and his daily life. Indicates a low current risk of depressive relapse. And his current level of occupational performance and high (inaudible) strongly supports his psychological stability. (Tr. 82)

Applicant's mother's written statement indicates:

> [Applicant] has demonstrated insight into his mental health history and has taken responsibility for his well-being through active engagement in consistent self-care practices. After stable functioning on Escitalopram for several years, [he] tapered the medication about a year ago with no adverse consequences. He is self-aware, responsible, and proactive about seeking help or guidance when it would be beneficial. We talk almost daily and enjoy time together as a family several times a month. For over a year, he has functioned well without medication, with no decline in occupational performance, daily functioning, or interpersonal stability; it's clear he's doing very well without the use of medication. [He is] a dependable and trustworthy individual. You should have no concerns regarding his reliability, judgment, discretion, and general suitability for maintaining his security clearance. (AE D)

Applicant's father is a psychologist. He has never treated his son. (Tr. 112) Applicant and his father are very close, and they communicate every day. (Tr. 110) After a lengthy description of Applicant's behavior, he concluded:

> [T]he few instances that would fit criteria for borderline personality disorder were tied to, you know, extreme stress when he was depressed. You know, I've worked a lot with borderline personality disorder and I have a good feel for it. I never got that feel from [Applicant]. I got the [feeling] of major depression and a kid not understanding how to deal with it. (Tr. 109)

Applicant's father said that after Applicant's mental-health inpatient treatment in 2020, he was changed. (Tr. 110) He was more hopeful, positive, and socially outgoing. (Tr. 110) He was more communicative with his father. (Tr. 110) He loves his current employment. (Tr. 110-111) His father said:

> [Applicant] learned from those experiences and developed insight into himself and his social world. Today, he's emotionally stable, kind, and wise for his age. He knows where, how, and when to get help if he needs it. He's

always valued honesty and shown integrity. He takes his job responsibilities and security clearance requirements very seriously. (AE D)

Applicant's Response to Dr. Z's Evaluation

Applicant denied that he had "unpredictable interpersonal relationships nor unstable and intense personal relationships." (HE 2) He said:

> My most recent personal relationship lasted several years, two of which we lived together before deciding to separate amicably. I have two close friends from college I have known for 8+ years, as well as friends and colleagues from [from work] I have known for several years since I started working there. I will readily provide contact information or access to medical records if that would help. Impulsivity, suicidal ideations/gestures, and feelings of emptiness have only occurred during two brief periods of my life in 2010 and 2020. . . . Inappropriate and intense anger can only describe the one incident, as documented, in 2010 when I was 16 years old during the same major depressive episode. I did not understand the significance or impact of the text messages I sent during that time. I am not sure where the mood instability comes from; I have never had an issue with mood instability or told I have an issue with it from what I can remember. I do not have interpersonal difficulties as evidenced by numerous friends and good relationships with coworkers. My reliability, judgement, stability, and trustworthiness are in no way compromised by my current psychological state. I am sure my friends, family, and coworkers will attest to this. (HE 2)

***DSM-5* and MDD**

The diagnostic criteria for MDD are as follows:

> A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
> Note: Do not include symptoms that are clearly attributable to another medical condition.
>
> 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
> 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
(Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or another medical condition.
Note: Criteria A–C represent a major depressive episode. (*DSM-5* at 160-61)

"The course of major depressive disorder is quite variable, such that some individuals rarely, if ever, experience remission (a period of 2 or more months with no symptoms, or only one or two symptoms to no more than a mild degree). (*DSM-5* at 163) As to remission of MDD, *DSM-5* states:

> The risk of recurrence becomes progressively lower over time as the duration of remission increases. The risk is higher in individuals whose preceding episode was severe, in younger individuals, and in individuals who have already experienced multiple episodes. The persistence of even mild depressive symptoms during remission is a powerful predictor of recurrence. (*DSM-5* at 165)

For BPD's prognosis, D*SM-5* states, "Follow-up studies of individuals identified through outpatient mental health clinics indicate that after about 10 years, as many as half of the individuals no longer have a pattern of behavior that meets full criteria for borderline personality disorder." (*DSM-5* at 165)

Character Evidence

Applicant has been employed for the past five years, and he received several promotions at his employment. (Tr. 67; AE B) He has excellent performance evaluations.

(AE C) A friend who has known Applicant for 10 years, three coworkers, and his parents made statements on his behalf. (Tr. 70-122; AE E) The general sense of their statements is that he is friendly, honest, diligent, and responsible. He can handle stressful situations.

Policies

The U.S. Supreme Court has recognized the substantial discretion of the Executive Branch in regulating access to information pertaining to national security emphasizing, "no one has a 'right' to a security clearance." *Department of the Navy v. Egan*, 484 U.S. 518, 528 (1988). As Commander in Chief, the President has the authority to "control access to information bearing on national security and to determine whether an individual is sufficiently trustworthy" to have access to such information. *Id*. at 527. The President has authorized the Secretary of Defense or his designee to grant applicants eligibility for access to classified information "only upon a finding that it is clearly consistent with the national interest to do so." Exec. Or. 10865, *Safeguarding Classified Information within Industry* § 2 (Feb. 20, 1960), as amended.

Eligibility for a security clearance is predicated upon the applicant meeting the criteria contained in the adjudicative guidelines. These guidelines are not inflexible rules of law. Instead, recognizing the complexities of human behavior, these guidelines are applied in conjunction with an evaluation of the whole person. An administrative judge's overarching adjudicative goal is a fair, impartial, and commonsense decision. An administrative judge must consider all available, reliable information about the person, past and present, favorable and unfavorable.

The Government reposes a high degree of trust and confidence in persons with access to classified information. This relationship transcends normal duty hours and endures throughout off-duty hours. 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 about potential, rather than actual, risk of compromise of classified information. Clearance decisions must be "in terms of the national interest and shall in no sense be a determination as to the loyalty of the applicant concerned." *See* Exec. Or. 10865 § 7. Thus, this decision should not be construed to suggest that it is based on any express or implied determination about applicant's allegiance, loyalty, or patriotism. It is merely an indication the applicant has not met the strict guidelines the President, Secretary of Defense, and Director of National Intelligence have established for issuing a clearance.

Initially, the Government must establish, by substantial evidence, conditions in the personal or professional history of the applicant that may disqualify the applicant from being eligible for access to classified information. The Government has the burden of establishing controverted facts alleged in the SOR. *See Egan*, 484 U.S. at 531. "Substantial evidence" is "more than a scintilla but less than a preponderance." *See v. Washington Metro. Area Transit Auth.*, 36 F.3d 375, 380 (4th Cir. 1994). The guidelines presume a nexus or rational connection between proven conduct under any of the criteria

listed therein and an applicant's security suitability. *See* ISCR Case No. 95-0611 at 2 (App. Bd. May 2, 1996).

Once the Government establishes a disqualifying condition by substantial evidence, the burden shifts to the applicant to rebut, explain, extenuate, or mitigate the facts. Directive ¶ E3.1.15. An applicant "has the ultimate burden of demonstrating that it is clearly consistent with the national interest to grant or continue his [or her] security clearance." ISCR Case No. 01-20700 at 3 (App. Bd. Dec. 19, 2002). The burden of disproving a mitigating condition never shifts to the Government. *See* ISCR Case No. 02-31154 at 5 (App. Bd. Sep. 22, 2005). "[S]ecurity clearance determinations should err, if they must, on the side of denials." *Egan*, 484 U.S. at 531; *see* AG ¶ 2(b).

Analysis

Personal Conduct and Psychological Conditions

AG ¶ 15 explains why personal conduct is a security concern stating:

> Conduct involving questionable judgment, lack of candor, dishonesty, or unwillingness to comply with rules and regulations can raise questions about an individual's reliability, trustworthiness and ability to protect classified information. Of special interest is any failure to provide truthful and candid answers during the security clearance process or any other failure to cooperate with the security clearance process. . . .

AG ¶ 27 articulates the security concern for psychological conditions:

> 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 ¶ 16 lists personal conduct disqualifying conditions that are potentially relevant in this case as follows:

> (c) credible adverse information in several adjudicative issue areas that is not sufficient for an adverse determination under any other single guideline, but which, when considered as a whole, supports a whole-person assessment of questionable judgment, untrustworthiness, unreliability, lack of candor, unwillingness to comply with rules and regulations, or other

characteristics indicating that the individual may not properly safeguard classified or sensitive information;

(d) credible adverse information that is not explicitly covered under any other guideline and may not be sufficient by itself for an adverse determination, but which, when combined with all available information, supports a whole-person assessment of questionable judgment, untrustworthiness, unreliability, lack of candor, unwillingness to comply with rules and regulations, or other characteristics indicating that the individual may not properly safeguard classified or sensitive information. This includes, but is not limited to, consideration of:

(1) untrustworthy or unreliable behavior to include breach of client confidentiality, release of proprietary information, unauthorized release of sensitive corporate or government protected information;

(2) any disruptive, violent, or other inappropriate behavior;

(3) a pattern of dishonesty or rule violations; and

(4) evidence of significant misuse of Government or other employer's time or resources; and

(e) personal conduct, or concealment of information about one's conduct, that creates a vulnerability to exploitation, manipulation, or duress by a foreign intelligence entity or other individual or group. Such conduct includes: (1) engaging in activities which, if known, could affect the person's personal, professional, or community standing.

AG ¶ 28 provides psychological conditions that could raise a security concern and may be disqualifying in this case:

(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.

The record establishes AG ¶¶ 16(c), 16(d), 16(e), 28(a), 28(b), 28(c), and 28(d). Further details will be discussed in the mitigation analysis, *infra*.

AG ¶ 17 lists personal conduct mitigating conditions which are potentially applicable:

(a) the individual made prompt, good-faith efforts to correct the omission, concealment, or falsification before being confronted with the facts;

(b) the refusal or failure to cooperate, omission, or concealment was caused or significantly contributed to by advice of legal counsel or of a person with professional responsibilities for advising or instructing the individual specifically concerning security processes. Upon being made aware of the requirement to cooperate or provide the information, the individual cooperated fully and truthfully;

(c) the offense is so minor, or so much time has passed, or the behavior is so infrequent, or it happened under such unique circumstances that it is unlikely to recur and does not cast doubt on the individual's reliability, trustworthiness, or good judgment;

(d) the individual has acknowledged the behavior and obtained counseling to change the behavior or taken other positive steps to alleviate the stressors, circumstances, or factors that contributed to untrustworthy, unreliable, or other inappropriate behavior, and such behavior is unlikely to recur;

(e) the individual has taken positive steps to reduce or eliminate vulnerability to exploitation, manipulation, or duress; and

(f) the information was unsubstantiated or from a source of questionable reliability.

AG ¶ 29 lists psychological conditions mitigating conditions which 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.

Discussion of Disqualifying and Mitigating Conditions

In ISCR Case No. 10-04641 at 4 (App. Bd. Sept. 24, 2013), the DOHA Appeal Board concisely explained Applicant's responsibility for proving the applicability of mitigating conditions as follows:

> Once a concern arises regarding an Applicant's security clearance eligibility, there is a strong presumption against the grant or maintenance of a security clearance. *See Dorfmont v. Brown*, 913 F. 2d 1399, 1401 (9th Cir. 1990), *cert. denied*, 499 U.S. 905 (1991). After the Government presents evidence raising security concerns, the burden shifts to the applicant to rebut or mitigate those concerns. *See* Directive ¶ E3.1.15. The standard applicable in security clearance decisions is that articulated in *Egan*, *supra*. "Any doubt concerning personnel being considered for access to classified information will be resolved in favor of the national security." Directive, Enclosure 2, [App. A] ¶ 2(b).

Basis for Disqualifying Conditions

In about June of 2010, Applicant was involuntarily hospitalized for one week after a suicide attempt by overdosing on medication. In about September of 2010, he again overdosed, and he was involuntarily hospitalized for suicidal ideation for another week. In about September or October of 2010, Applicant sent harassing and threatening texts to an ex-girlfriend. He was charged with felony criminal threat, and he was court-ordered to complete three months of inpatient mental-health treatment. From October 2010 to about January 2011, he received treatment in a residential facility for depression and anxiety, and he was placed on probation for one year. In about 2011, he received a peace order restraining him from contacting a girl. Upon discharge from inpatient treatment, he received a recommendation to continue outpatient treatment.

When Applicant was 18 years old, he and his parents were overseas on a tour. He was drinking heavily and thinking about suicide. He cut himself with some glass. The hospital labeled the incident as a suicide attempt. Applicant said, "it wasn't really like an attempt. It was more just like self-harm. I had friends that would cut themselves and I wanted to kind of see what that was like, I guess." (Tr. 44)

In December of 2019, Applicant told his therapist that he discussed a plan to commit suicide with a friend in November of 2019. He said, "I was having suicidal thoughts and was actively kind of wanting to do it." (Tr. 50) At that time he was unemployed, and he was not able to interact in person with friends due to the COVID-19 pandemic.

In June of 2020, Applicant took concrete steps toward committing suicide, including offering his bank account to a friend. Applicant did not believe he was improving and described himself as depressed and in crisis. However, at the time he did not recognize that he was in a crisis. He did not commit suicide because his therapist called Applicant's parents and asked them not to leave town.

From about October 2019 to about July 2020, Applicant received treatment for MDD, recurrent, severe. He received referrals to a doctor who could prescribe medication, but the provider noted that he was not interested in medication to assist with his mood. He eventually ceased treatment against treatment recommendations. An evaluator stated that if left untreated, his condition could result in enduring instability and impulsivity.

In about August 2020, Applicant became extremely depressed when a love-interest did not reciprocate his romantic feelings for her, and he sent her a text message that included a picture of him with a loaded shotgun in his mouth. The police took him to the hospital, and he was treated for MDD, recurrent, severe, with anxious distress. He was transferred into the PHP at the hospital, where he received inpatient hospitalization for four days.

In sum, Applicant had suicidal ideations, planned to commit suicide, attempted to commit suicide, or made a "cries for help" on about six occasions between 2010 and 2020. These occasions involved cutting himself, two medication overdoses, use of a loaded shotgun, and other actions. These occasions were disclosed to others, and he was hospitalized for mental-health treatments. He received a recommendation from Dr. T.B. that he continue treatment in 2019 to 2020, and he did not conform with her recommendation.

Discussion of Expert Opinions

On June 28, 2024, Dr. Z provided the following diagnosis and prognosis:

> The diagnoses below are not full psychological diagnoses. They represent the conditions that **could potentially affect** the subject's reliability, judgment, stability, and trustworthiness. Collateral records, the subjects

> self-report, and this clinical interview [show] that he meets the criteria for borderline personality disorder. **The subject currently appears stable, given that he has not had additional (known or detected) incidents of suicidal gestures.** However, it is likely that his personality continues to result in unpredictable interpersonal relationships. The subject's self-reported history indicates that since age 16 he has experienced a pattern of unstable and intense personal relationships, impulsivity, recurrent suicidal gestures, chronic feelings of emptiness, inappropriate and intense anger, and mood instability. (GE 5 at 5 (emphasis added))

I find that Dr. Z's diagnosis of MDD is well supported in the record. However, BPD was not a "full" diagnosis. This may mean that further testing and evaluation was necessary to diagnose BPD. Applicant received multiple inpatient mental-health treatments, and the record reflects that he was not previously diagnosed with BPD. Applicant father said BPD may have been appropriate when Applicant was 16; however, he did not feel that the BPD diagnosis was currently appropriate.

In ISCR 24-00641 (App. Bd. Feb. 12, 2026), the dissenting Appeal Board Chair criticized a diagnosis of alcohol use disorder (AUD) under *DSM-5*, and noted:

> In her conclusion, [the psychologist in that case] stated that Applicant "continues to meet criteria for alcohol use disorder, severe," 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, [the psychologist] 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*. *Id*. at 6.

In the instant case, Dr. *Z* said, "The subject's self-reported history indicates that since age 16 he has experienced a pattern of unstable and intense personal relationships, impulsivity, recurrent suicidal gestures, chronic feelings of emptiness, inappropriate and intense anger, and mood instability." (GE 5 at 5) He evidently found the following five criteria from *DSM-5* applied to establish BPD:

> 2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. . . . 5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). 7. Chronic feelings of emptiness. 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

For criteria 2, it is unclear if two relationships in 2016 and 2020 are sufficient for a "pattern." For criteria 7 and 8, Dr. Z did not provide the basis for his opinion that Applicant had symptoms of "chronic feelings of emptiness" and whether multiple instances of inappropriate anger must be found. At the hearing, Applicant conceded he had inappropriate anger related to the incident when he was 16 and sent threatening texts to a girlfriend. He did not relate other instances in which he had inappropriate anger. The excerpt from *DSM-5* does not indicate whether BPD or any personality disorder can be in remission or otherwise under control for five years. Dr. Z said the record he considered indicated Applicant was "stable." It is unclear whether a personality disorder must continue to be manifested in the previous five years to remain a relevant security concern.

Dr. Z also questioned whether Applicant was a credible historian in that he did not volunteer negative information or details about the incidents involving law enforcement or hospitalizations. Dr. Z said Applicant was unclear about treatment and medication history, and he could not remember details, such as the name of his current treating physician. Applicant attempted to blame his Accutane use in 2010 for his depression and suicidal action. Accutane did not contribute to his severe depressive episodes in 2019 and 2020 because he stopped taking Accutane in 2010, and the effects of Accutane would have dissipated. Dr. Z believed the BPD was a continuing potential risk to national security. Dr. Z's observation that Applicant provided a "mix of inconsistency and minimization" of his symptoms was not supported by enough specific examples to establish that he was deliberately minimizing his symptoms. Applicant's contentions about the effects of Accutane or that he had suicidal ideations and did not actually intend to commit suicide may have been his sincere beliefs and not lies or intentional minimizations. At his hearing, Department Counsel thoroughly and carefully reviewed Applicant's medical records and investigative records with Applicant, and Applicant agreed with those records and credibly elaborated on them upon request.

On February 13, 2026, Dr. W said:

> Diagnostically, Applicant meets the criteria for Major Depressive Disorder (in remission). In addition, he meets the criteria for Borderline Personality Disorder (BPD), given his history of emotional instability, self-injury, and suicide attempts. These diagnoses are consistent with a psychological evaluation [he] received in 2024. It should be noted, however, that **[Applicant] has been emotionally stable for the past six years, which bodes well for his prognosis**, especially if he establishes relationships with treatment providers in the future. It is recommended that [he] re-establish relationships with treatment providers in order to maximize the likelihood that he will remain emotionally stable moving forward. (AE A at 5 (emphasis added))

Applicant attended eight 50-minute psychotherapy sessions from March 13, 2026 to May 29, 2026, with Dr. W. (AE F) The next scheduled session is June 19, 2026. *Id*.

On June 13, 2026, Dr. W provided an updated diagnosis and prognosis stating:

> [Applicant] has made good progress in treatment thus far and he has used his time effectively in sessions. His diagnosed Major Depressive Disorder is in full remission. In consultation with me, [he] has decided (with my approval) that a psychiatric consultation for medication is not warranted at this time, given that his depression is in full remission. We agreed that [Applicant] will seek a psychiatric consultation should his depressive symptoms re-emerge in the future. *Id*.

Applicant's parents were credible witnesses. His mother said:

> [Applicant] is self-aware, responsible, and proactive about seeking help or guidance when it would be beneficial. We talk almost daily and enjoy time together as a family several times a month. For over a year, he has functioned well without medication, with no decline in occupational performance, daily functioning, or interpersonal stability; it's clear he's doing very well without the use of medication. (AE D)

As to remission of MDD, *DSM-5* states:

> The risk of recurrence becomes progressively lower over time as the duration of remission increases. The risk is higher in individuals whose preceding episode was severe, in younger individuals, and in individuals who have already experienced multiple episodes. The persistence of even mild depressive symptoms during remission is a powerful predictor of recurrence. (*DSM-5* at 165)

In ISCR Case No. 19-00151 at 8 (App. Bd. Dec. 10, 2019), the Appeal Board sustained the administrative judge's Guideline I favorable decision. The Appeal Board discussed the administrative judge's assessment of the weight to be given to conflicting expert opinions as follows:

> A Judge is required to weigh conflicting evidence and to resolve such conflicts based upon a careful evaluation of factors such as the comparative reliability, plausibility, and ultimate truthfulness of conflicting pieces of evidence. A Judge is neither compelled to accept a DoD-required psychologist's diagnosis of an applicant nor bound by any expert's testimony or report. Rather, the Judge has to consider the record evidence as a whole in deciding what weight to give conflicting expert opinions. In this case, the Judge's conclusion that the magnitude and recency of Dr. Y's contacts with Applicant in combination with other corroborating evidence merited more weight than the uncorroborated opinions of Dr. K and Dr. B is sustainable. (internal citations omitted)

Dr. Z and Dr. W's diagnoses were essentially the same. Dr. Z made a negative credibility assessment of Applicant and expressed a security concern in his prognosis. Dr. W said, "[Applicant] has been emotionally stable for the past six years, which bodes well for his prognosis, especially if he establishes relationships with treatment providers in the future." (AE A at 5). He also said:

> 2. [Applicant's] symptoms of MDD and BPD appear well-managed following appropriate treatment and concerted efforts on his part to manage his emotions and behavior appropriately. He appears at low risk of the emotional and behavioral instability that is traditionally associated with these diagnoses, given his stability over the past six years.
>
> 3. [Applicant's] appears to clearly understand what would be expected of him should his appeal be granted. He appears fully willing and able to abide by all rules necessary to achieve this professional goal and, should he succeed in this goal, to maintain his position via appropriate behavior in the future. (AE A at 5)

I give greater weight to Dr. W's prognosis because he had an opportunity to consider Dr. Z's assessment, conduct new tests, and interview Applicant based on the additional evidence. Dr. W had eight 50-minute sessions with Applicant so far in 2026.

In ISCR Case No. 23-00706 (App. Bd. July 16, 2024), the administrative judge granted a security clearance to an applicant with a history of depressive disorder with suicidal ideation and a lengthy hospitalization at age 12, suicide attempts in high school, and a partial mental-health hospitalization in 2019. *Id*. at 2. The applicant was participating in weekly therapy sessions at the time of her hearing. *Id*. at 3. Her mental-health provider said applicant was compliant with treatment recommendations, and the current diagnosis was MDD, in full remission. *Id*. at 6. The Appeal Board noted "that Applicant's current diagnosis of major depressive disorder is not one that raises a *per se* security concern.[3]" *Id*. The Appeal Board concluded, "[a]pplicant has been medication-free for over a year with no full depressive episodes, that [applicant is] fully compliant with treatment, and that the major depressive disorder is in remission, the [administrative judge] could reasonably conclude that Applicant's condition was mitigated under MC ¶ 29(a) or MC ¶ 29(b)." *Id*. at 7. The Appeal Board affirmed the grant of the security clearance. *Id*.

[3] In November 2016, the Director of National Intelligence (DNI) issued a memorandum revising the mental health questions in Section 21 of Standard Form 86, the security clearance application (SCA). DNI Memorandum on Revisions to the Psychological and Emotional Health Questions on the Standard Form 86, Questionnaire for National Security Positions, dated November 16, 2016. See also ISCR Case No 20-01838 at 6, n. 3 (App. Bd. Dec. 29, 2022). As revised, the SCA lists the psychological disorders that are considered by their very nature to raise security concerns: Psychotic Disorder, Schizophrenia, Schizoaffective Disorder, Delusional Disorder, Bipolar Disorder, **Borderline Personality Disorder**, and Antisocial Personality Disorder. (emphasis added).

Conclusions on Mitigating Conditions

AG ¶ 29(a) does not fully apply because Applicant failed to "demonstrate ongoing and consistent compliance with the treatment plan" in 2019 to 2020. He is compliant with the current treatment plan. AG ¶ 29(c) does not apply because there is no evidence that Dr. W and Applicant's parents are "acceptable to and approved by, the U.S. Government." AG ¶¶ 29(d) and 29(e) do not apply because his MDD is not temporary and continues to be a potential mental-health problem. His MDD is a permanent diagnosis.

AG ¶¶ 17(c), 17(d), and 29(b) apply. The incidents, such as communication of threats in texts, overdosing on medications, and putting the barrel of a shotgun in his mouth are all connected to Applicant's MDD. His current circumstances are different from when those events occurred. His employment provides significant social contacts and satisfaction. He is receiving therapy. He frequently communicates with his parents. As psychologists, his parents have special insight into Applicant's psychological wellbeing. He has an exceptionally strong support system. Dr. W opined Applicant has been stable for almost six years without evidence of mental-health incidents. His impulsive suicidal actions and criminal conduct "happened under such unique circumstances that it is unlikely to recur and does not cast doubt on the [his] reliability, trustworthiness, or good judgment." Security concerns under Guidelines I and E are mitigated.

Whole-Person Concept

Under the whole-person concept, the administrative judge must evaluate an applicant's eligibility for a security clearance by considering the totality of the applicant's conduct and all the circumstances. The administrative judge should consider the nine adjudicative process factors listed at AG ¶ 2(d):

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

Under AG ¶ 2(c), "[t]he ultimate determination" of whether to grant a security clearance "must be an overall commonsense judgment based upon careful consideration of the guidelines" and the whole-person concept. My comments under Guidelines E and I are incorporated in my whole-person analysis. Some of the factors in AG ¶ 2(d) were addressed under those guidelines but some warrant additional comment.

Applicant is a 32-year-old, manager of a team of seven people. In 2018, he received a bachelor's degree in physics, and in 2023, he received an MBA. His parents

are both psychologists, and Applicant assists with the business and financial management part of their practice. He has never been investigated for a security incident.

Applicant has been employed for the past five years, and he received several promotions at his employment. He has excellent performance evaluations. A friend who has known Applicant for 10 years, three coworkers, and his parents made statements on his behalf. The general sense of their statements is that he is friendly, honest, diligent, and responsible. He can handle stressful situations.

The disqualifying and mitigating information is discussed in the psychological conditions and personal conduct analysis sections, *supra*. The reasons for granting Applicant access to classified information are more persuasive. Assuming the security concerns were not mitigated under AG ¶¶ 17 and 29, they are mitigated under the whole-person concept.

It is well settled that once a concern arises regarding an applicant's security clearance eligibility, there is a strong presumption against granting a security clearance. *See Dorfmont*, 913 F. 2d at 1401. "[A] favorable clearance decision means that the record discloses no basis for doubt about an applicant's eligibility for access to classified information." ISCR Case No. 18-02085 at 7 (App. Bd. Jan. 3, 2020) (citing ISCR Case No. 12-00270 at 3 (App. Bd. Jan. 17, 2014)).

I have carefully applied the law, as set forth in *Egan*, Exec. Or. 10865, the Directive, the AGs, and the Appeal Board's jurisprudence to the facts and circumstances in the context of the whole person. Applicant mitigated personal conduct and psychological conditions security concerns.

Security officials may obtain updated mental-health treatment records and conduct investigative activity at any time. Applicant is warned that a "failure to follow a prescribed treatment plan related to a diagnosed psychological/psychiatric condition . . . [including] failure to take prescribed medication or failure to attend required counseling sessions" may result in revocation of his access to classified information. *See* AG ¶ 29(d).

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:	FOR APPLICANT
Subparagraphs 1.a through 1.g:	For Applicant
Paragraph 2, Guideline E:	FOR APPLICANT
Subparagraphs 2.a through 2.d:	For Applicant

Conclusion

Considering all of the circumstances presented by the record in this case, it is clearly consistent with the interests of national security to grant Applicant eligibility for access to classified information. Eligibility for access to classified information is granted.

_____
Mark Harvey
Administrative Judge