

(Report) in which she opined that the Individual met sufficient diagnostic criteria for a diagnosis of MDD, recurrent, moderate, with anxious distress under the *Diagnostic and Statistical Manual of Mental Health Disorders – Fifth Edition, Text Revision (DSM-5-TR)*. *Id.* at 26. She further opined that this condition could impair the Individual’s judgment, stability, reliability, and trustworthiness. *Id.*

The LSO issued the Individual a Notification Letter advising him that it possessed reliable information that created substantial doubt regarding his eligibility for access authorization. Ex. 1 at 6–8. In a Summary of Security Concerns (SSC) attached to the letter, the LSO explained that the derogatory information raised security concerns under Guideline I of the Adjudicative Guidelines. *Id.* at 5.

The Individual exercised his right to request an administrative review hearing pursuant to 10 C.F.R. Part 710. Ex. 2. The Director of the Office of Hearings and Appeals (OHA) appointed me as the Administrative Judge in this matter, and I conducted an administrative hearing. The LSO submitted eight exhibits (Ex. 1–8) and the Individual submitted nine exhibits (Ex. A–I). The Individual testified on his own behalf and offered the testimony of two managers in his chain of command. Transcript of Hearing, OHA Case No. PSH-25-0200 (Tr.) at 3, 97, 108. The LSO offered the testimony of the DOE Psychologist. *Id.* at 3, 119.

II. THE NOTIFICATION LETTER AND THE ASSOCIATED SECURITY CONCERNS

The LSO cited Guideline I (Psychological Conditions) of the Adjudicative Guidelines as the basis for its substantial doubt regarding the Individual’s eligibility for access authorization. Ex. 1 at 5. “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.” Adjudicative Guidelines at ¶ 27. The SSC cited the DOE Psychologist’s opinion that the Individual met sufficient criteria for a diagnosis of MDD, recurrent, moderate, with anxious distress under the *DSM-5-TR* and that this condition could impair his judgment, stability, reliability, and trustworthiness. Ex. 1 at 5. The LSO’s invocation of the DOE Psychologist’s opinion that the Individual had a condition that may impair his judgment, stability, reliability, or trustworthiness justifies its invocation of Guideline I. Adjudicative Guidelines at ¶ 28(b).

III. REGULATORY STANDARDS

A DOE administrative review proceeding under Part 710 requires me, as the Administrative Judge, to issue a Decision that reflects my comprehensive, common-sense judgment, made after consideration of all of the relevant evidence, favorable and unfavorable, as to whether the granting or continuation of a person’s access authorization will not endanger the common defense and security and is clearly consistent with the national interest. 10 C.F.R. § 710.7(a). The regulatory standard implies that there is a presumption against granting or restoring a security clearance. *See Dep’t of Navy v. Egan*, 484 U.S. 518, 531 (1988) (“clearly consistent with the national interest” standard for granting security clearances indicates “that security determinations should err, if they must, on the side of denials”); *Dorfmont v. Brown*, 913 F.2d 1399, 1403 (9th Cir. 1990) (strong presumption against the issuance of a security clearance).

An individual must come forward at the hearing with evidence to convince the DOE that granting or restoring access authorization “will not endanger the common defense and security and will be clearly consistent with the national interest.” 10 C.F.R. § 710.27(d). An individual is afforded a full opportunity to present evidence supporting his or her eligibility for an access authorization. The Part 710 regulations are drafted so as to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. *Id.* § 710.26(h). Hence, an individual is afforded the utmost latitude in the presentation of evidence to mitigate the security concerns at issue.

IV. FINDINGS OF FACT

A. Individual’s Mental Health History

The Individual began experiencing episodes of depression as a teenager. Ex. 5 at 22. During depressive episodes, the Individual experienced anxiety, panic attacks, persistent irritable mood, sleep issues, inability to enjoy things, excessive self-criticism, low energy, poor concentration, low appetite, psychomotor slowing, and suicidality. *Id.* In approximately 2006, at which time he was a minor, the Individual engaged in his first suicidal gesture by placing the barrel of an unloaded gun in his mouth during a depressive episode. *Id.*

The Individual was first diagnosed with MDD in approximately 2014, at which time he was in his twenties, after he went to a psychiatrist at the recommendation of a supervisor to whom he had shared his depressive symptoms. *Id.* at 24; Tr. at 74–75. The Individual was prescribed antidepressant medication. Tr. at 75.

The aforementioned medication did not control the Individual’s depressive symptoms and he “attempted to strangle himself with a belt in 2017 and . . . 2018” during depressive episodes. Ex. 5 at 24; Tr. at 76 (testifying that he did not disclose this behavior to his treating psychiatrist at the time because of fear of hospitalization). In 2019, the Individual experienced such intense thoughts of suicide that he characterized the experience as “his thoughts telling him very loudly what to do.” Ex. 5 at 24. Although the Individual was in treatment with a mental health professional, he did not disclose his suicidal ideation because he “did not want to risk the stigma of being hospitalized.” *Id.* at 22.

At some point in 2019, the Individual presented at a hospital after a supervisor observed cuts on the Individual’s arm and expressed concern. *Id.*; Tr. at 22–23 (Individual testifying that the cuts were “fairly deep” into his arm); Tr. at 35 (testifying that he was not “trying to kill [him]self” but “didn’t really care if [he], let’s say, [] cut too deep”). The Individual was prescribed medication to help him sleep and address his suicidal ideation. Tr. at 25. Following this incident, the Individual’s diagnosis was modified to MDD with psychotic features, based on medical practitioners’ inference that the Individual’s intrusive thoughts of self-harm were hallucinations, and he was prescribed antipsychotic medication. Ex. 5 at 24; *but see id.* (Individual denying during the clinical interview with the DOE Psychologist that he experienced hallucinations).

In 2020, the Individual was diagnosed with and treated for Bipolar Disorder. *Id.* at 21; Ex. 8 at 96; Tr. at 77–78. Following a change in employment and a period of several months during which he did not receive mental health treatment, the Individual first met with the Psychiatrist for medication

management on May 29, 2024. Ex. 8 at 126; Ex. C at 16; Tr. at 27–28. The Psychiatrist prescribed the Individual four medications: an antidepressant, an antipsychotic, an antianxiety medication, and a mood stabilizer. Ex. C at 19. Following the May 2024 intake session, the Individual and the Psychiatrist met in June 2024 and August 2024 for medication management. *Id.* The Individual also began meeting with a psychotherapist (Psychotherapist) in June 2024 every two to three weeks. Ex. 5 at 23.

B. January 2025 Episode and Subsequent Treatment

In October or November 2024, the Individual stopped taking his medications because “[h]e felt tired, less creative, less smart, and like his mind worked more slowly when he was on medication.” *Id.* The Individual did not inform either the Psychiatrist or the Psychotherapist of his decision to discontinue medication. *Id.*; *see also id.* (Individual telling the DOE Psychologist during the clinical interview that this “was not the first time he had gone off his medications without talking to a doctor”). According to the Individual, he was “fine for two to four weeks” but then experienced racing thoughts, panic attacks, intrusive thoughts of suicide, and “a sense of pressure in his neck.” *Id.* at 21. The Individual would “relieve” the pressure by periodically cutting his neck superficially with a knife. *Id.*; *see also id.* at 22 (telling the DOE Psychologist that the cutting of his neck “was more self-harm than suicidal behavior”).

In January 2025, the Individual presented at a hospital because he realized that, if not addressed, his cutting behavior could escalate to the level it had in 2019 when he cut his wrists. *Id.* at 23; Tr. at 39–40; *see also* Tr. at 111–12 (testimony of Individual’s supervisor at that time that the Individual came to him for help regarding his mental health and that the supervisor drove the Individual to the hospital). The Individual was involuntarily admitted to the hospital for mental health treatment for three days. Ex. 5 at 21; Ex. 8 at 113. While hospitalized, the Individual was prescribed a different antidepressant and an antipsychotic medication. Ex. 5 at 21.

Following meetings with the Individual after his release from the hospital, both the Psychiatrist and the Psychotherapist modified the Individual’s diagnosis to MDD. *Id.* at 23. Both clinicians concluded that this diagnosis was more appropriate for the Individual based on the absence of manic or hypomanic episodes required for a Bipolar Disorder diagnosis. *Id.* The Psychiatrist continued prescribing the Individual the medications he received at the hospital. *Id.* However, in May 2025, the Psychiatrist prescribed the Individual the mood stabilizer she had prescribed him prior to his hospitalization. Ex. D at 19.

The Psychotherapist worked with the Individual on developing a safety plan following the Individual’s release from the hospital. Ex. 5 at 24. The safety plan called for the Individual to maintain a stable schedule with respect to eating, sleeping, socializing, and hygiene because the Individual was prone to ruminating, which contributed to his suicidal ideation, when his schedule was unstable. *Id.* The safety plan further called for the Individual to contact friends, family, or the Psychotherapist, or to go to an emergency room, if he experienced suicidal ideation. *Id.*

C. Evaluation by the DOE Psychologist

On June 18, 2025, the Individual met with the DOE Psychologist for a clinical interview. *Id.* at 20. Following the clinical interview, the DOE Psychologist contacted the Psychiatrist and Psychotherapist to collect additional information. *Id.* at 23. Based on the information in the Individual's personnel file provided by the LSO, her clinical interview of the Individual, and information from the Psychiatrist and Psychotherapist, the DOE Psychologist prepared a history of the Individual's mental health symptoms and treatment consistent with that recited above in this Decision. *See id.* at 20–25.

Additionally, as part of her evaluation of the Individual, the DOE Psychologist administered the Minnesota Multiphasic Personality Inventory-3 (MMPI-3). *Id.* at 25. She found that the Individual's responses to the MMPI-3 produced "a valid profile with no indications of attempts to present himself in a more favorable light than would be warranted." *Id.* The Individual's responses to the MMPI-3 produced clinically significant elevations on scales assessing "demoralization," "low positive emotions," and "emotional dysfunction." *Id.* According to the DOE Psychologist, these responses and scores showed evidence of unhappiness, lack of motivation, stress, low confidence, anxiety, and frequent rumination. *Id.*

Based on the information collected through her evaluation, the DOE Psychologist concluded that the Individual met sufficient criteria for a diagnosis of MDD, recurrent, moderate, with anxious distress, under the *DSM-5-TR*. *Id.* at 26. She opined that this condition had led the Individual to exercise impaired judgment, stability, and reliability considering his history of suicidal behavior, failure to take medication as prescribed, and involuntary hospitalization for mental health treatment. *Id.* The DOE Psychologist recommended that the Individual remain in treatment with the Psychiatrist and Psychotherapist, taking his medication as prescribed and adhering to his safety plan, for one year. *Id.*

D. Individual's Post-Hospitalization Treatment

The Individual stopped meeting with the Psychotherapist in July 2025 after the Psychotherapist transferred to another office. *Tr.* at 90. On August 11, 2025, the Individual began meeting with a marriage and family therapist (Therapist) for individual therapy. *Ex. A* at 4. The Individual met with the Therapist on August 11 and August 25, 2025, but forgot to schedule a subsequent session. *Ex. B* at 6. After the passage of a significant period without meeting with the Therapist, the Individual felt "some shame" which led him not to attempt to schedule another session. *Id.* The Individual next met with the Therapist on February 10, 2026, during which session the Individual stated that he "wanted to touch base . . . as he [wa]s pursuing a security clearance and [mental health] records [would be] reviewed." *Id.*

At the February 10, 2026, session with the Therapist, the Individual indicated that he was seeking therapy related to "symptoms involving: depression [and] anxiety." *Id.* However, he denied "feel[ing] depressed" and told the Therapist that he was managing his symptoms with medication. *Id.* He identified aspects of his anxiety, such as his "tendency to catastrophize," on which he wanted to work with the Therapist. *Id.* at 7. The Individual further expressed that he was "uncertain about therapy." *Id.* at 6–7. The Therapist recommended that the Individual return for therapy. *Id.* at 14. Based on the Individual's self-reported symptoms, the Therapist assessed the Individual's risk of danger to himself or others as "Low/Negligible." *Id.* at 13.

In his hearing testimony, the Individual stated that he found medication more helpful than therapy and expressed frustration at mental health practitioners he had met with prior to the Therapist who had devoted what he perceived as undue time to assessing him for an autism diagnosis rather than providing actionable steps to address his mental health symptoms. Tr. at 54–57. The Individual expressed the intention to attend sessions with the Therapist on at least a monthly basis. *Id.* at 58.

In addition to meeting with the Therapist, the Individual met with the Psychiatrist every one to two months for medication management following his January 2025 hospitalization. Ex. D at 19–20. During these meetings, the Psychiatrist collected information on the Individual’s symptoms and adjusted his prescribed medication to help him manage mood symptoms and anxiety. *Id.* As of the Individual’s most recent session on January 26, 2026, the Psychiatrist’s working diagnosis for the Individual was MDD, moderate, with “associated mixed features (moments of mild elevated mood with racing thoughts).” *Id.* at 23. Other than “racing thoughts,” the Psychiatrist found no symptoms consistent with a diagnosis of Bipolar Disorder. *Id.* The Psychiatrist indicated that the Individual’s compliance with his medication regimen was “improved” and that he reported no suicidality, but that he continued to present with “[p]rominent depression.” *Id.*

The Individual testified at the hearing that quality sleep is essential to maintaining his mental health because, in the past, insomnia contributed to his racing thoughts which in turn contributed to his suicidal ideation. Tr. at 33–34. His current medication has helped him to sleep and accordingly has minimized his racing thoughts. *Id.* at 33. The Individual intends to meet with the Psychiatrist as scheduled and strictly adhere to his medication regimen going forward because he recognized that the detrimental effects of his past mental health symptoms outweighed the short-term energy benefits he experienced after discontinuing his medication. *Id.* at 34–35, 70. The Individual sets daily alarms on his phone reminding him to take his medication and uses pill organizers, which he fills weekly, to support his compliance with his medication regimen. *Id.* at 36–37.

According to the Individual, he has not experienced a significant depressive episode since April 2025 or suicidal ideation since late-January 2025. *Id.* at 62, 85. If the Individual experienced a severe depressive episode like that which led to his hospitalization in January 2025, he would contact his family and the Psychiatrist to obtain help. *Id.* at 49. The Individual testified that, although he would not want to be hospitalized for mental health reasons again, he would not hide information for fear of being hospitalized as he had in the past and he viewed being forthcoming with his clinicians and family as an important part of intercepting a mental health episode before it became serious enough to lead to his hospitalization. *Id.* at 49–50.

E. Updated Opinion of the DOE Psychologist

In her hearing testimony, the DOE Psychologist amended her diagnosis of the Individual to either MDD with mixed features or Bipolar II Disorder and opined that “the treatment would be essentially the same” for the two conditions.³ *Id.* at 120, 134. She opined that, regardless of the

³ The DOE Psychologist explained that her modified diagnosis was based on the Individual’s testimony regarding the connection between his sleep difficulties and racing thoughts, which the DOE Psychologist deemed “features of hypomania,” and the Individual’s description of his symptoms being controlled in conjunction with the Psychiatrist

applicable diagnosis, the Individual's condition was under control. *Id.* at 139. In so concluding, the DOE Psychologist cited the Individual's "great deal of insight into the risk of stopping medication," his stated commitment to adhere to his medication regimen, his improved forthcomingness with the Psychiatrist, and his having overcome his fear of hospitalization if he reveals negative symptoms. *Id.* at 122–23.

The DOE Psychologist opined that the Individual was stable and had "a good prognosis for maintaining emotional stability going forward" with "a low probability of [] decompensation." *Id.* at 130, 132, 140. She noted that the Individual's system of using alarms and pill organizers and his improved communication with the Psychiatrist were positive factors suggesting he would control his mental health symptoms in the future. *Id.* at 124–28. Although the Individual's prognosis would be better if he adhered to her recommendation to participate in therapy, the DOE Psychologist testified that it would not be "absolutely necessary" for him to do so to control his mental health symptoms. *Id.* at 126–28.

V. ANALYSIS

Conditions that could mitigate security concerns under Guideline I include:

- (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;
- (e) There is no indication of a current problem.

Adjudicative Guidelines at ¶ 29.

The Individual received treatment from the Psychiatrist following his January 2025 hospitalization and his symptoms have significantly moderated as a result of his adherence to his medication regimen. While the Individual has only minimally participated in therapy since meeting with the DOE Psychologist, the DOE Psychologist testified that therapy was not strictly necessary for controlling his condition despite her prior recommendation that he receive it. Accordingly, I

prescribing him a mood stabilizer which would have controlled hypomania. Tr. at 120; *see also* Ex. D at 19 (reflecting the Individual's history of having been prescribed lamotrigine, a mood stabilizer).

conclude that the Individual has voluntarily participated in a treatment program suitable for his condition and that the condition is amenable to treatment. Moreover, the DOE Psychologist opined that the Individual had a good prognosis for maintaining emotional stability going forward. Accordingly, I find the second mitigating condition applicable. *Id.* at ¶ 29(b).

Additionally, the DOE Psychologist opined that the Individual's condition is under control and that he is at low risk of another episode that could impair his judgment, stability, reliability, or trustworthiness. Thus, the third mitigating condition is also applicable to the facts of this case. *Id.* at ¶ 29(c).

In light of the aforementioned considerations, I find that the Individual has resolved the security concerns asserted by the LSO under Guideline I.

VI. CONCLUSION

In the above analysis, I found that there was sufficient derogatory information in the possession of DOE to raise security concerns under Guideline I of the Adjudicative Guidelines. After considering all relevant information, favorable and unfavorable, in a comprehensive, common-sense manner, including weighing all testimony and other evidence presented at the hearing, I find that the Individual has brought forth sufficient evidence to resolve the security concerns asserted by the LSO. Accordingly, I have determined that the Individual should be granted access authorization. This Decision may be appealed in accordance with the procedures set forth at 10 C.F.R. § 710.28.

Phillip Harmonick
Administrative Judge
Office of Hearings and Appeals