*The original of this document contains information which is subject to withholding from disclosure under 5 U.S. C. § 552. Such material has been deleted from this copy and replaced with XXXXXX's.

United States Department of Energy
Office of Hearings and Appeals

In the Matter of: Personnel Security Hearing	)	
	)	
Filing Date: July 20, 2021	)	Case No.: PSH-21-0085
	)	
	)	

Issued:

Administrative Judge Decision

Richard A. Cronin, Jr., Administrative Judge:

This Decision concerns the eligibility of XXXX XXXX (the Individual) to hold an access authorization under the United States Department of Energy's (DOE) regulations, set forth at 10 C.F.R. Part 710, "Procedures for Determining Eligibility for Access to Classified Matter and Special Nuclear Material."[1] As discussed below, after carefully considering the record before me in light of the relevant regulations and the *National Security Adjudicative Guidelines for Determining Eligibility for Access to Classified Information or Eligibility to Hold a Sensitive Position* (June 8, 2017) (Adjudicative Guidelines), I conclude that the Individual's security clearance should be granted.

I. BACKGROUND

The Individual is employed by a DOE contractor in a position that requires him to hold a security clearance. On December 9, 2019, the Individual completed a Questionnaire for National Security Positions (QNSP), in connection with seeking access authorization. Exhibit (Ex.) 7 at 43. In response to one of the questions regarding psychological and emotional health, the Individual responded that he had been hospitalized on three occasions for a mental health condition in 2013, August 2008, and May 1985. *Id.* at 28–29. The Individual later underwent a psychological evaluation by a DOE consultant psychologist (DOE Psychologist) in September 2020. Ex. 5.

Due to unresolved security concerns related to the Individual's psychological condition, the Local Security Office (LSO) informed the Individual, in a letter dated October 28, 2020 (Notification Letter), that it possessed reliable information that created substantial doubt regarding the Individual's eligibility to hold a security clearance. In an attachment to the letter (Summary of

[1] The regulations define access authorization as "an administrative determination that an individual is eligible for access to classified matter or is eligible for access to, or control over, special nuclear material." 10 C.F.R. § 710.5(a). This Decision will refer to such authorization as access authorization or security clearance.

Security Concerns), the LSO explained that the derogatory information raised security concerns under Guideline I (Psychological Conditions) of the Adjudicative Guidelines. Ex. 1.

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 subsequently conducted an administrative review hearing. The LSO submitted eight numbered exhibits (Ex. 1–8) into the record and presented the testimony of the DOE psychologist at the hearing. The Individual submitted 25 exhibits (Ex. A through X) into the record, and presented the testimony of three witnesses, including his own testimony.[2]

II. THE NOTIFICATION LETTER AND THE ASSOCIATED SECURITY CONCERNS

As indicated above, the Notification Letter informed the Individual that information in the possession of the DOE created a substantial doubt concerning his eligibility for a security clearance. The LSO cited Guideline I (Psychological Conditions) of the Adjudicative Guidelines as a basis for denying the Individual a security clearance. Ex. 1. Guideline I provides that "[c]ertain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness." Adjudicative Guidelines at ¶ 27. A formal diagnosis of a disorder is not required for there to be a concern under this guideline. *Id.* A condition that could raise a security concern is "[a]n opinion by a duly qualified mental health professional that the individual has a condition that may impair judgment, stability, reliability, or trustworthiness[.]" *Id.* at ¶ 28(b).

The LSO alleged that: 1) the Individual was involuntarily hospitalized for three days because he was delusional in 2013; 2) was involuntarily hospitalized for three days following an incident where he physically threatened another man in August 2008; 3) in May 1985, he was involuntarily hospitalized for three days with a diagnosis of Pseudobulbar Affect, followed by a transfer to a psychiatric facility where he was involuntarily admitted for three to four weeks with a diagnosis of Phencyclidine Delirium; and 4) the DOE Psychologist determined that the Individual met the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (DSM-5) criteria for Delusional Disorder, Grandiose Type, a mental condition that impairs judgement, reliability, stability, and trustworthiness. Ex. 1. The above allegations adequately justify the LSO's invocation of Guideline I.

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 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 entire process

[2] The Individual's exhibits A through W were combined and submitted in a single, 487-page PDF workbook. Some of the exhibits contain page numbering that is inconsistent with their location in the combined workbook. This Decision will cite to the Individual's exhibits by reference to the exhibit and page number within the combined workbook where the information is located. The Individual submitted two exhibits that were both marked "Exhibit X." To avoid confusion, this Decision refers to the final exhibit as "Exhibit X.1.

is a conscientious scrutiny of a number of variables known as the "whole person concept." Adjudicative Guidelines ¶ 2(a). The protection of the national security is the paramount consideration. The regulatory standard implies that there is a presumption against granting or restoring a security clearance. *See Department 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).

The 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). The Individual is afforded a full opportunity to present evidence supporting his eligibility for an access authorization. The Part 710 regulations are drafted to permit the introduction of a very broad range of evidence at personnel security hearings. Even appropriate hearsay evidence may be admitted. 10 C.F.R. § 710.26(h). Hence, an individual is afforded the utmost latitude in the presentation of evidence to mitigate the security concerns at issue.

The discussion below reflects my application of these factors to the testimony and exhibits presented by both sides in this case.

IV. FINDINGS OF FACT

On September 10, 2020, the DOE Psychologist conducted a clinical interview (CI) of the Individual as part of a psychological evaluation. Ex. 5 at 1. During the CI, the Individual reported a history of his psychiatric hospitalizations and mental health treatment. His first hospitalization was in 1985, which resulted in an initial diagnosis of Pseudobulbar Affect. *Id.* at 2. He was then transferred to a state hospital and was diagnosed with Phencyclidine Delirium, although there was no evidence that the Individual had ingested hallucinogenic drugs. *Id.* at 2–3. The DOE Psychologist noted in his evaluative report (Report) regarding his examination of the Individual that the Individual remained hospitalized for three to four weeks, which suggests he was treated for psychosis. Ex. 5 at 3.

Additionally, the Individual reported that in August 2008, he was hospitalized for three days following an angry incident with another man. Ex. 5 at 3. He said that he had become "addicted" to marijuana, which he used in oil form two or three times a week for the prior two years. *Id.* He believes his anger was caused by suddenly stopping the marijuana one month prior to the August 2008 incident. *Id.* In 2009, he began seeking treatment from his current treating psychiatrist (Treating Psychiatrist) who diagnosed him with posttraumatic stress disorder (PTSD). *Id.* The treating psychiatrist has since revised the Individual's diagnosis to Attention Deficit Hyperactivity Disorder (ADHD), which is treated with prescribed medication. *Id.* at 3–4.

The Individual also told the DOE Psychologist that he had obtained a medical marijuana card (medical card)[3] in April 2011 to treat PTSD and pain symptoms but did not renew his medical card and ceased marijuana usage in 2013. *Id.* at 2, 4. Approximately one month after he ceased

[3] A medical card authorizes a person to legally use and possess marijuana medical products pursuant to state law.

marijuana use in 2013, he was arrested and charged when an altercation ensued after he attempted to take another man's wallet. *Id.* at 4. Upon his arrest, he refused to give his name, stating that he was from "the White Sands Missile Range in Area 51, and that any information on him had to go through Dick Cheney or President Barack Obama, as his information was classified." *Id.* at 5. Because he was delusional, he was hospitalized for three days. *Id.* at 4. When hospital staff asked him for his name, he provided a similar response regarding the confidentiality of his name and that only the President could require him to provide it. *Id.* at 5. He was diagnosed with bipolar disorder and marijuana abuse. *Id.* at 5. He stated that he experienced anger as a withdrawal symptom for a month after discontinuing marijuana use. *Id.* The DOE Psychologist noted that although the Individual admitted that his behavior during the 2013 incident was psychotic, he also stated that he had a reasonable explanation for his behavior. *Id.* The Individual explained that at the time of the incident, he was working on an invention for which he was applying for a grant from the Bill Gates Foundation, and he was worried that divulging his real name would connect him to his arrest and jeopardize his chances of being awarded the grant from the Gates Foundation. *Id.*

The DOE Psychologist reported that during the CI, the Individual discussed multiple inventions that he had created including the invention for the Gates Foundation which he is very "secretive" about, and he had believed that "mild voices in [his] head" were telling him that he was "special" and that his invention would "make a lot of money" so that he could stop working for his family business. *Id.* The DOE Psychologist also reported that the Individual told him about two other businesses that he had registered that were related to other inventions, however, the Psychologist stated that there was no record by the Secretary of State that he had registered one of his businesses. *Id.* at 6.

As part of his examination of the Individual, the DOE Psychologist ordered a drug screening test and administered a battery of psychometric tests, including the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) and the Rorschach test (Rorschach). The DOE Psychiatrist additionally conducted a mental status exam on the Individual.[4] Id. at 2, 6–8, 11–24, 27–31. The drug screen was negative for all drugs including marijuana.[5] *Id.* at 11–12. The MMPI-2-RF results suggested that he portrayed himself as unusually virtuous, although the results did not indicate any psychopathology. *Id.* at 7. In his Report, the DOE Psychologist noted the Rorschach findings relevant to his evaluation, including the Individual's weak reality adherence. The DOE Psychiatrist also noted that some of the Individual's Rorschach responses are often seen in people prone to mania and a type of thought disorder often seen in people prone to delusions. *Id.*

In the Report, the Psychologist diagnosed the Individual as suffering from Delusional Disorder, grandiose type, which is a mental condition that impairs judgment, reliability, stability, and trustworthiness. *Id.* at 8. He noted that the Individual believes he is "especially talented and gifted with an important ability to imagine inventions." *Id.* at 7–8. The DOE Psychologist recommended that the Individual be evaluated for antipsychotic mediation by a psychiatrist who is provided the

[4] The LSO subsequently submitted the Rorschach test separately from the Psychologist's report and noted that it is still part of Exhibit 5. Accordingly, this Decision cites the Rorschach test as Exhibit 5 at 27–31.

[5] According to the physician who provided the test results to the DOE Psychologist, in the case of marijuana, the test provides evidence that the Individual had not used marijuana for possible weeks before the test was conducted. *Id.* at 12.

full information about his psychotic tendencies. *Id.* at 8. The DOE Psychologist further opined that the Individual's prognosis is poor because delusional thinking is usually difficult to change with either medication or verbal therapy. *Id.* at 9.

The Individual submitted court documents for his 1985 involuntary confinement, including an Individual Treatment Plan prepared by a clinical psychologist where he was hospitalized. Ex. A. He also submitted hospital records from his 2008 and 2013 hospitalizations, as well as proof of expungement and court dismissal regarding his 2013 arrest. Exs. C–D; Ex. E. Ex. E. He also submitted a report dated March 28, 2021, from an examining psychologist who conducted a Fit for Duty psychological evaluation of the Individual. Ex. F at 278. Based on her evaluation, and a review of collateral information including the Individual's records and the DOE Psychologist's Report, the examining psychologist opined that "[b]ased on the current findings, delusional disorder was not supported." [6] *Id.* at 285. Additionally, the Individual submitted a Treatment Summary report from his psychiatrist (Treating Psychiatrist) which summarized the treatment that he has provided for the Individual since 2009. Ex. G at 289. The Treating Psychiatrist also reviewed the DOE Psychologist's Report and opined that he "completely disagreed with the diagnosis of delusional disorder[.]" *Id.* at 290.

The Individual submitted nine reference letters written by his current colleagues and managers, as well as one letter from his brother who was his former supervisor. Exs. H–O; Ex. X; Ex. X.1. All these character statements asserted that the Individual possessed sound judgment and is trustworthy and reliable. *Id.* Further, regarding his job skills, a colleague described the Individual as having "a unique ability to adapt and improvise using any machine on the floor to get the job done[.]" A performance appraisal regarding the Individual stated he has "excellent machining skills" and highlighted specific duties in which he has particularly strong abilities. Ex. M; Ex. P. [7]

V. HEARING TESTIMONY

During the hearing, the Individual sought to demonstrate that he had mitigated the security concerns. Regarding his 1985 hospitalization, he testified that he had not knowingly ingested PCP, although his diagnosis involved PCP use. Tr. at 24. He indicated that he may have unknowingly ingested PCP, because a friend with whom he had a disagreement, may have drugged him. *Id.* at 22–23.

The Individual testified regarding his involvement in a 2008 altercation which led to his psychiatric hospitalization. *Id.* at 25–30; Ex. C at 87–90. He asserted that in 2008, shortly prior to his hospitalization, he had tried to stop using marijuana. *Id.* at 28–30. At the time of the 2008 altercation, he was in withdrawal from marijuana use, which caused excessive energy and difficulty sleeping. *Id.* at 28–30. The Individual testified that he has learned from subsequent sessions with his Treating Psychologist that sleep deprivation can trigger mania, which is what the Individual believed happened prior to the altercation. *Id.* at 28–29. Hospital records from 2008

[6] The examining psychologist noted that the Rorschach results from the DOE Psychologist's report were not included, and despite requesting them, she was not able to obtain them as of the date of her report. Ex. F at 285.

[7] The Individual also submitted a response addressing the allegations in the Summary of Security Concerns and included documents related to his inventions. Exs. Q–X.

reflect that he was diagnosed with Bipolar Disorder I, manic, severe, and was hospitalized for three days. Ex. C at 87–90. He was discharged with prescription medication. *Id.* at 39.

The Individual testified that his 2013 hospitalization was a result of the combination of severe sleep deprivation coupled with heavy medical marijuana use. *Id.* at 32–33, 81. In support of his testimony, he submitted his 2013 hospital records which showed he had a positive toxicology screen for marijuana, and was diagnosed with history of bipolar disorder, most recent episode hypomanic; and marijuana abuse. Ex. D at 113–15. He explained that in May 2013, he was working on a grant proposal for one of his inventions, and due to the very tight deadline, he was working long hours which resulted in significant sleep deprivation. Tr. at 31, 82. He had also stopped using marijuana in May 2013, right before his hospitalization. *Id.* at 81–83. Moreover, he indicated that on the date of the 2013 altercation, which led to his arrest and hospitalization, he was already angry because of a previous heated argument with his brother. *Id.* at 79–80.

Additionally, he testified that while hospitalized for a psychotic episode, he was prescribed Lithium which he believes helped stabilize him. *Id.* at 96–97. He briefly complied with a referral to another treatment provider after his hospitalization but stopped because he felt he did not need further treatment since he had stabilized. *Id.* at 89–91. After his 2013 hospitalization, the Individual kept a reserve supply of prescribed antipsychotic medication and made an agreement with his family members that if he ever experienced psychotic symptoms again. *Id.* at 96–99. 162–64. However, he admitted that he did not disclose his 2013 hospitalization to his Treating Psychiatrist or inform him of his family agreement. *Id.* at 92–93, 97–98.

The Individual testified that he possessed a medical card from 2011–2013.[8] Tr. at 149–150, 158. He stated that the medical card was issued by his state's Department of Health. *Id.* at 159. He was interested in trying medical marijuana because he believed it would relieve anxiety symptoms. *Id.* at 150. At the time he requested a prescription, his Treating Psychiatrist did not feel comfortable prescribing medical marijuana to him, so he found another doctor that prescribed it for PTSD.[9] *Id.* at 149–50. He testified that before his medical card expired, he used medical marijuana a few times every week on a regular basis. *Id.* at 81. He stated that he used marijuana capsules containing tetrahydrocannabinol (THC) concentrated oils, as it was recommended for PTSD. *Id.* The Individual further asserted that during the period that he had a medical card, he never ingested nonprescribed marijuana and that his last use of nonprescribed marijuana was prior to the time he obtained his medical card. *Id.* at 158. He asserted that his last use of marijuana was in May 2013, when his medical card expired. *Id.* at 83. He recognizes the harm that marijuana has caused him, including the traumatic psychotic episodes. *Id.* at 65. Consequently, he discontinued the use of medical marijuana because he has no desire to use the substance again. *Id.* He further asserted that even if he does not obtain his security clearance, he will not return to using marijuana. *Id.* at 66–

[8] The transcript indicates the Individual testified that his medical card expired in 2018, however, this appears to be a misstatement. Tr. at 150. All other instances of the Individual's testimony state that his medical card expired in 2013, which he asserts is also his last date of marijuana use. *Id.* at 64–65, 83.

[9] The Treating Psychologist subsequently testified that he prescribes medical marijuana for people who have chronic pain and PTSD, although he is "not a big fan of it" because for some people it works well, while for others "it's a disaster." *Id.* at 56–57. He testified that at the time the Individual initially inquired about it, the Treating Psychiatrist did not believe he knew him well enough to prescribe him medical marijuana, although he acknowledged that the Individual did have PTSD, which would be a reason to use it. *Id.* at 57.

67. He is motivated to remain abstinent from drug use because he highly values and enjoys his current job, and his employer has a random drug testing program, so if he ever tested positive for drugs, he would be terminated. *Id.* at 66. He asserted that his colleagues and management are happy with his work performance and like him as a colleague. *Id.* at 67; Exs. H–O; Ex. X; Ex. X.1.

The Individual also testified about his inventions. He asserted that he has an entrepreneurial spirit because he had worked in his family business where he created products from raw materials. Tr. at 68. He testified that because he worked with his family business for 33 years, he was "naturally drawn to want[ing] to make things," and became very good at manufacturing and creating things. *Id.* at 16, 68. He acknowledged that at times, the products he created were not successful or lucrative. *Id.* at 17, 71. In support of his testimony, he submitted evidence regarding his inventions, including his application for a 2013 grant and tax forms that indicated revenue earned for the sales he made. Exs. P–T.

The Individual testified that he sought treatment with his prior treating psychiatrist from 1987 through 1999, who initially diagnosed him with bipolar disorder, but later adjusted his diagnosis to ADHD.[10] *Id.*at 86–87; *see* Ex. 8 at 87. Regarding his current mental health treatment, the Individual testified that he currently sees his Treating Psychiatrist every three months and has not missed any of his treatment appointments in the past three years. *Id.* at 155. He also testified that he planned to discuss prescription Lithium use with his Treating Psychiatrist. *Id.* at 156.

The Individual's Treating Psychiatrist testified on the Individual's behalf at the hearing. The Treating Psychiatrist has been intermittently treating the Individual since 2009. Ex. G at 1. He stated that initially, there was a gap in the Individual's treatment including when the Individual had his 2013 psychotic episode. *Id.* at 56; *see Id.* at 93 (Individual stated he did not tell his Treating Psychiatrist about the 2013 hospitalization). The Treating Psychiatrist testified that for the past three years, he has been providing the Individual with psychiatric treatment on a regular, consistent basis every two to three months. *Id.* at 55–56.

Regarding the Individual's diagnosis, the Treating Psychiatrist opined that the Individual has a history of drug-induced manic psychotic episodes. *Id.* at 41. He further opined that he does not believe that the Individual has bipolar disorder, because he has not manifested this diagnosis in any way and is not involved with marijuana or other drugs. *Id.* In addition, he opined that the Individual has a diagnosis of ADHD under the DSM-5, and although he does not quite meet the criteria for situational anxiety, he has anxiety from this process of trying to obtain his security clearance. *Id.* He testified that he previously treated the Individual for PTSD. *Id.* at 37. The Treating Psychiatrist opined that the Individual has a mild case of ADHD, which does not affect his judgment and reliability. *Id.* at 42. He further testified that he does believe that the Individual's ADHD plays a role in susceptibility to psychotic episodes. *Id.* at 57. The Treating Psychiatrist

[10] A letter written by the prior treating psychiatrist dated March 12, 1999, stated that he has known the Individual since 1990, and opined that the Individual that the Individual has been competent during that entire time, and the prior psychiatrist's professional medical opinion is that the Individual is competent as of the date of the letter. Ex. 5 at 3; Ex. 8 at 87.

prescribes the Individual a very low dose of atomoxetine, which is a drug treatment for ADHD. *Id.* at 55.

The Treating Psychiatrist also testified that having reviewed the DOE Psychologist's Report, he disagrees with the diagnosis of delusional disorder, grandiose type. *Id.* at 37 –38. He asserted that the diagnosis is an overreach of the interpretation of the information given during the CI. *Id.* at 38. He testified that he has not seen any evidence of the Individual having true delusions. *Id.* He explained that a grandiose delusion is a belief held where a person clearly believes something is not true, and any reasonable person would say is not true. *Id.* In this regard, the Individual neither believes that he is special, nor does he believe that he is waiting to be discovered for his inventions. *Id.* at 39. The Report indicated that the Individual's delusions consisted of the Individual's inventions, including one for which he was applying for an award, and the Individual's belief that he is "special" because he thinks he is capable of being an inventor since he is a good mechanic. *Id.* at 39. The Treating Psychiatrist testified of his awareness that the Individual, in fact, tried to create the inventions that he described in the CI, and when he was unsuccessful in selling one of his inventions, acknowledged that his attempt at inventing did not work. *Id.*

Further, the Treating Psychiatrist noted that the MMPI did not show any psychotic tendencies.[11] *Id.* He also noted that he is not an expert in psychological testing, however, he asserted that psychologists have different opinions regarding the accuracy of the Rorschach test. *Id.* at 40. The Report showed the Individual had abnormal Rorschach results, which indicated tendencies towards mania, and the Treating Psychiatrist stated that he is aware that the Individual has experienced mania when he has been under the influence of drugs or coming off drugs and was sleep deprived. *Id.* Neither the Individual's current nor the Individual's former Treating Psychiatrist, who treated the Individual for approximately eight or nine years, saw any evidence of mania in the Individual. *Id.*

The Treating Psychiatrist concluded that, based on his clinical experience working with patients experiencing the effect of cannabis use and withdrawal of manic symptoms, and his knowledge of the Individual, it is quite plausible that the Individual's psychotic episodes were due to a combination of reducing or abruptly stopping marijuana use and sleep deprivation. *Id.* at 40–41. He explained that cannabis (marijuana) contains both THC and cannabidiol (CBD), which possesses antipsychotic qualities. *Id.* at 45. However, THC lasts in the body's system much longer than CBD. *Id.* at 45. The Treating Psychiatrist stated that for some people who stop using marijuana, once the CBD, which is a psychotic blocker, is no longer in their system, any THC in that person's system could cause a delayed psychotic reaction. *Id.* He noted that the Individual's hospital records for his 2013 hospitalization showed he had cannabis in his system when he had his psychotic episode. *Id.* at 45; Ex. D at 115. He also noted that in addition to having cannabis in his system, the Individual also had significant sleep deprivation. Based upon on his clinical experience, the combination of sleep deprivation and sudden discontinuation of sedating substances has resulted in some of his patients having psychotic symptoms. *Id.* at 46.

[11] The Treating Psychiatrist acknowledged that the MMPI results showed the Individual "tried to look good[,]" however, he indicated that this portrayal would be consistent with someone who is taking an MMPI for the process of trying to obtain a security clearance. *Id.* at 39–40.

The Treating Psychiatrist opined on his conclusion that the Individual does not suffer from bipolar disorder. He asserted that assuming if the Individual had bipolar disorder and the marijuana was making it worse, the Individual would have continued to manifest bipolar symptoms after the marijuana left his system. *Id.* at 61. However, the Individual did not manifest any bipolar symptoms either under the care of his current Treating Psychiatrist or while under the care of his former treating psychiatrist. *Id.* at 60. The Treating Psychiatrist also asserted that while the Individual's hospital records indicated that he stabilized when he was given Lithium, it is difficult to state with certainty that he stabilized due to Lithium. *Id.* at 47–48. He asserted that for a true manic episode, it would take up to eight weeks or longer before Lithium would stabilize bipolar disorder, so if a person stabilizes in a few days, then it was probably the result of the Lithium. *Id.* The Treating Psychiatrist testified that the Individual could have stabilized spontaneously during his hospitalization, because he was getting sleep and the marijuana was further processing out of his body. *Id.* at 47.

The Treating Psychiatrist concluded that the Individual's prognosis is excellent as long as he does not use marijuana again. *Id.* at 42. Although he acknowledged that the Individual's prior history of three psychiatric hospitalizations is concerning, he believes that the Individual's last two psychotic episodes were due to the combination of substance use and sleep deprivation. *Id.* As such, he opined that he is confident that "as long as he stays away from using any substance [,] he will not have another [psychotic] episode." *Id.* at 53. Moreover, the Treating Psychiatrist asserted that the Individual has been able to withstand significant stress without developing any psychotic symptoms, so he is confident in his belief that the Individual is not "at any more risk [for future psychotic episodes] than the average person. *Id.* at 58. He further testified that the Individual has been consistently adamant in spontaneously declaring his intention to remain abstinent for marijuana and other illicit substances, as he has recognized the potential for harm. *Id.* at 62–63. The Treating Psychiatrist also stated that the Individual has indicated to him that he wants to continue treatment, which the Treating Psychiatrist is "absolutely" willing to oblige. *Id.* at 43.

The Examining Psychologist testified regarding the Fit for Duty psychological evaluation of the Individual. *See* Ex. F. She stated that she administered a battery of clinical tests, including the MMPI and a test based on DSM criteria. *Id.* at 102–108. She testified that the Individual's MMPI results showed elevated underreporting consistent with the MMPI results from the DOE Psychologist's Report, which is common in these types of evaluations. *Id.* at 104. Moreover, she testified that when the MMPI scales accounted for this underreporting, the Individual did not have elevations in any other scales including scales for delusional disorder. *Id.* at 104. The Examining Psychologist stated that the Individual had no elevations and that his results in normal range following all other clinical testing. *Id.* at 105–108. She opined that the Individual does not meet the criteria for delusional disorder, grandiose type, as the diagnosis involves types of beliefs that cannot be verified by independent sources. *Id.* at 115–16, 119–20. By contrast, she testified that the Individual's desire to create and garner grants for inventions are not delusions. *Id.* Further, unlike delusions that cannot be verified, the inventions and projects that the Individual stated he worked on were verified by independent sources which she also confirmed. *Id.* at 116–17; Ex. F at 280–81; Exs. P–T. The Examining Psychologist also asserted that people with grandiosity do not admit to a lot of fault, as "it can never be that person's fault" when it comes to matters like their ideas. *Id.* at 117. By contrast, she stated that that the Individual did not attribute fault to others when his inventions were not successful, and rather, "he took responsibility, which also shows a

lack of grandiosity." *Id.* at 117–18. The examining psychologist also testified that based on testing results and a review of his treatment records, there is no diagnosis under the DSM-5 for the Individual.[12] *Id.* at 108–09; 130. Regarding the Individual's prognosis, she opined that if he remains sober, then he has a good prognosis and is not expected to have further psychotic episodes. *Id.* at 109, 131.

The DOE Psychologist confirmed that he had diagnosed the Individual with Delusional disorder and stated that he based the diagnosis primarily on the fact that "[t]he nature of [the Individual's] psychotic episodes always had a grandiose component to it, which the hospitals noted." *Id.* at 174-75. He provided the example of the Individual's 2013 hospitalization, during which the Individual had a delusion that his name was classified so he could not reveal it to hospital staff. *Id.* at 175. The DOE Psychologist testified that he now recognizes the significance of the fact that the Individual's grandiose delusions had only appeared during the times that he had been hospitalized for psychotic episodes. *Id.* at 177–78.

After issuing his Report, the DOE Psychologist reviewed the Individual's hospitalization records, and based on the information contained therein, he changed his opinion regarding the possibility of the Individual suffering from bipolar disorder as an underlying condition. *Id.* at 180–81. He stated that the hospital records showed that the Individual had "blatant manic episodes." *Id.* at 181. The DOE Psychologist noted that although he cannot conclude whether the Individual's marijuana use really caused the Individual's manic episodes, he is aware that there is a lot of variation regarding how individuals metabolize THC. *Id.* at 181. He testified that research findings by the Mayo Clinic suggest that if a person uses marijuana daily, the half-life of it can be as long as 15 to 20 days, which is contrasted by a much shorter half-life for a person who only uses marijuana once or twice per month. *Id.* Thus, the DOE Psychologist concluded that if the Individual had stopped using marijuana approximately one month before a manic episode, then this prior use could have a manic episode.[13] *Id.* at 182.

The DOE Psychologist also concluded that given that the Individual has not had any additional hospitalizations in the last eight years, the Individual may have an underlying condition that is triggered with the use of marijuana. *Id.* at 183. The lack of manic episodes within the last eight years is a positive prognostic note for the Individual. *Id.* at 183. He further concluded that he agrees with the Individual's treating psychiatrist's opinion, in that if the Individual refrains from using marijuana, he is "probably… going to be okay." *Id.* at 42, 183–184. Moreover, he asserted that if he had received all the Individual's medical records at the time of his evaluation, he would not have diagnosed him with delusional disorder. *Id.* at 187. He testified that he would have said the Individual "had delusions, …and it probably was in the context of bipolar disorder," although

[12] The examining psychologist stated that she did not test for ADHD because that was not part of the referral question when the Individual was referred to her for an evaluation. Tr. at 109.

[13] The DOE Psychologist explained that in his professional experience and based on the literature he has reviewed, the current strength of marijuana is far greater than 30 years ago. *Id.* at 179. He indicated that the Individual had the choice of a wide range of marijuana products, which have varying degrees of potency. *Id.* The DOE Psychologist asserted that if a person has an underlying psychological condition, and if he uses marijuana or any disinhibiting drug, it tends to release that underlying condition and bring it to the forefront. *Id.* at 179–80.

he could not diagnose him with bipolar disorder for a lack of some symptomatic characteristics. *Id.* at 186–87.

Ultimately, the DOE Psychologist opined that the Individual has a "very serious underlying propensity for manic behavior and loss of control…[a]nd it is a fact [that is] tied to his use of marijuana." *Id.* at 184. His conclusion is that the Individual is prone to "manic psychotic episodes." *Id.* at 186. He further opined that if the Individual does not use marijuana, then his prognosis is very good and that the condition the Individual has is not going to be activated. *Id.* at 184, 188.

VI. ANALYSIS

A. Guideline I Considerations

The Individual's prior involuntary hospitalizations and the DOE Psychologist's diagnosis of the Individual with Delusional Disorder, Grandiose Type, raise security concerns under Guideline I of the Adjudicative Guidelines. Adjudicative Guidelines at ¶ 28(b)–(c). An individual may mitigate security concerns, in relevant part, under Guideline I if:

(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.

Adjudicative Guidelines at ¶ 29 (a)–(c).[14]

I find that the Individual has put forth sufficient evidence to apply the mitigating condition described under ¶ 29(a). First, the evidence demonstrates that his condition is readily controllable with treatment and the Individual has not had any psychotic episodes or psychiatric hospitalizations since 2013. He credibly testified that during his two most recent hospitalizations, he was withdrawing from marijuana and was significantly sleep deprived. Having engaged in regular treatment with his Treating Psychiatrist, he learned that the combination of sleep deprivation and marijuana use triggered his prior psychotic episodes. The Individual has also demonstrated his ongoing and consistent compliance with a treatment plan. He intentionally did not renew his medical card and has not used marijuana since 2013, which was the date of his last hospitalization. Moreover, he participates in regular treatment with his Treating Psychiatrist every three months and has not missed any of his treatment appointments in the past three years. Finally, he takes his medication as prescribed, and has asserted his willingness to undergo a change in medications if his Treating Psychiatrist recommends it in the future.

[14] The additional mitigating factors for Guideline I are not applicable to these facts.

I further find that the Individual has established the mitigating condition described under ¶ 29(b). In this regard, the Treating Psychiatrist's testimony that it is unlikely that the Individual is going to have psychotic episodes in the future and his prognosis is excellent as long as he does not use marijuana again, is persuasive. Further, the Treating Psychiatrist's basis for his opinion is supported by the evidence in the record. The Treating Psychiatrist has treated the Individual continually for the past three years and has not observed any delusional symptoms. The letter submitted by the Individual's former treating psychiatrist also contained no indications of the presence of delusions. Since the Individual has stopped using marijuana in 2013, he has not experienced psychotic episodes, thus supporting the Treating Psychiatrist's opinion that the Individual's psychotic episodes were caused by the combination of THC and a severe lack of sleep.

I also note that the Treating Psychiatrist persuasively testified that the Individual is willing to continue psychiatric treatment. Finally, the clinical findings support the opinion offered by the Examining Psychologist and Treating Psychiatrist, who both indicated a lack of delusional disorder and a favorable prognosis so long as the Individual remains abstinent from marijuana.

I also find that the Individual has established the mitigating condition described under ¶ 29(c). The evidence in the record supports the conclusion that while the Individual is prone to manic episodes as indicated by the DOE Psychologist, as long as he remains abstinent from marijuana, his prognosis remains good. Moreover, I note that the Individual has not suffered any psychotic episodes since he ceased marijuana use in 2013. Accordingly, I find that the evidence before me demonstrates that the Individual's condition is readily controllable with treatment and has a low probably of recurrence. Given the applicability of these mitigating factors, I therefore find that the Individual has resolved the Guideline I security concerns.

VII. Conclusion

In the above analysis, I found that there was sufficient derogatory information in the possession of the DOE that raised security concerns under Guideline I of the Adjudicative Guidelines. After considering all the relevant information, favorable and unfavorable, in a comprehensive, common-sense manner, including weighing all the testimony and other evidence presented at the hearing, I find that the Individual has brought forth sufficient evidence to resolve the security concerns set forth in the Summary of Security Concerns. Accordingly, I have determined that the Individual's access authorization should be granted.

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Administrative Judge
Office of Hearings and Appeals