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October 30, 2007

DEPARTMENT OF ENERGY
OFFICE OF HEARINGS AND APPEALS

Hearing Officer's Decision

Name of Case: Personnel Security Hearing

Date of Filing: January 30, 2007

Case Number: TSO-0466

This Decision concerns the eligibility of xxxxxxxxxxxxxxx (the individual) for an access authorization 1/ under the regulations set forth at 10 C.F.R. Part 710, entitled "Criteria for Access to Classified Matter or Special Nuclear Material." Based on the record before me, I have determined that the individual's request for an access authorization should be granted.

I. Procedural Background

The individual is an applicant for an access authorization. On November 22, 2005, the local security office (LSO) conducted a Personnel Security Interview (PSI) to discuss the individual's use of alcohol. Subsequently, the LSO referred the individual for a forensic psychiatric evaluation with a DOE consultant-psychiatrist. Soon thereafter, the DOE referred this case for administrative review because it was unable to resolve the security concerns associated with the individual's use of alcohol. It then issued a Notification Letter to the individual on December 19, 2006, in which it specified the derogatory information in its possession and how that information falls within the purview of one criterion contained in 10 C.F.R. Part 710.8(j) (Criterion J). 2/

Upon receipt of the Notification Letter, the individual filed a request for a hearing. The LSO transmitted the individual's hearing request to the Office of Hearings and Appeals (OHA), and the OHA Director appointed me as the Hearing Officer in this case.

At the hearing that I convened, the DOE Counsel called one witness, the DOE consultant-psychiatrist. The individual called two witnesses: a clinical psychologist and his wife. The

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1/ Access authorization is defined 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).

2/ /Criterion J concerns information that the individual "has been or is a user of alcohol habitually to excess, or has been diagnosed by a psychiatrist or a licensed clinical psychologist as alcohol dependent or as suffering from alcohol abuse." 10 C.F.R. § 710.8(j).

individual also testified on his own behalf. The individual and the DOE Counsel submitted a number of written exhibits prior to the hearing.

II. Standard of Review

The Hearing Officer's role in this proceeding is to evaluate the evidence presented by the agency and the individual, and to render an opinion based on that evidence. See 10 C.F.R. § 710.27(a). Part 710 generally provides that "[t]he decision as to access authorization is a comprehensive, common-sense judgment, made after consideration of all relevant information, favorable or unfavorable, as to whether the granting of access authorization would not endanger the common defense and security and would be clearly consistent with the national interest. Any doubt as to the individual's access authorization eligibility shall be resolved in favor of national security." 10 C.F.R. § 710.7(a). I have considered the following factors in rendering this decision: the nature, extent, and seriousness of the conduct; the circumstances surrounding the conduct; the individual's age and maturity at the time of the conduct; the voluntariness of the individual's participation; the absence or presence of rehabilitation or reformation and other pertinent behavioral changes; the motivation for the conduct, the potential for pressure, coercion, exploitation, or duress; the likelihood of continuation or recurrence; and other relevant and material factors. *See* 10 C.F.R. §§ 710.7(c), 710.27(a). The discussion below reflects my application of these factors to the testimony and exhibits presented by both sides in this case.

When reliable information reasonably tends to establish the validity and significance of substantially derogatory information or facts about an individual, a question is created as to the individual's eligibility for an access authorization. 10 C.F.R. § 710.9(a). The individual must then resolve that question by convincing the DOE that granting his access authorization "would not endanger the common defense and security and would be clearly consistent with the national interest." 10 C.F.R. § 710.27(d).

III. Findings of Fact

In 2004, the individual applied for a security clearance in connection with his anticipated employment with a DOE contractor. Shortly thereafter, the individual completed a Questionnaire for National Security Positions (QNSP). On the QNSP, the individual divulged that he was taking a prescribed anti-depressant. This revelation prompted the DOE to conduct a PSI with the individual on November 22, 2005, and to request a copy of his medical records. 3/ During the course of the PSI, the individual discussed his alcohol use. He stated that he typically consumes two glasses of wine on Friday evenings, having one before dinner and one during dinner. The individual also commented that his alcohol consumption "may be waltzing with the devil a little bit." PSI at 15. He further stated that he consumed two or three drinks nightly for a number of years starting in his teenage years but he has decreased his consumption over the last five to ten years. When asked whether anyone has ever told the individual that he drank too much, the individual stated that his wife "probably" has.

3/ The DOE resolved all issues regarding the individual's mental health.

The individual's statements during his PSI prompted DOE to refer him to a DOE consultant-psychiatrist for an evaluation, which was conducted on June 23, 2006. As part of his evaluation, the DOE consultant-psychiatrist considered the fact that the individual began drinking beer in his teenage years and continued through college. The DOE consultant-psychiatrist noted that the individual began drinking wine after college, typically two glasses of wine on a Friday evening. He referred to several reports found in the individual's medical records. Specifically, the DOE consultant-psychiatrist considered a March 8, 2005, report written by the individual's primary care physician. In that report, the physician states that the individual used to abuse alcohol, gave it up, but has gradually begun to drink more alcohol to the point where, on at least one occasion, he was slurring his words. The physician gave the individual a diagnosis of "alcohol" and "not impaired" in a report of medical treatment and prescribed Antabuse to reduce the individual's desire to drink. The DOE consultant-psychiatrist further noted that the individual sought medical advice on several occasions because of complaints of chest pain. He referred to another physician's report which noted that the individual had consumed alcohol on one occasion and the next morning he had chest pain. He noted that the individual decided to abstain from drinking at this time, but later resumed drinking. The DOE consultant-psychiatrist did not diagnose the individual as suffering from alcohol abuse or dependence, or opine that the individual habitually used alcohol at any time. He found nonetheless that the individual's alcohol use "poses a risk of a lapse in his judgment and reliability."

IV. Analysis

A. Security Concerns Cited Under 10 C.F.R. § 710.8(j)

The Notification Letter cites Criterion J as the sole basis for the security concerns in this case. To support the Criterion J concerns, the Notification Letter refers to the individual's discussion of his alcohol use in a 2005 PSI in which the individual stated that he currently consumes two glasses of wine on Friday evenings and revealed that he once drank an unspecified amount of alcohol on a daily basis. In addition, the Notification Letter relies on the report of a DOE consultant-psychiatrist who concluded that the individual's alcohol use "poses a risk of a lapse in his judgment and reliability." *See* Notification Letter.

In this case, there is no formal diagnosis of alcohol abuse, alcohol dependence or concrete evidence that the individual used alcohol habitually to excess. Nevertheless, I received evidence and testimony at the hearing to allow the DOE to provide additional support for its concerns about the individual's alcohol use. Excessive alcohol consumption often leads to the exercise of questionable judgment or the failure to control impulses, and can raise questions about an individual's reliability and trustworthiness. *See Adjudicative Guidelines for Determining Eligibility for Access to Classified Information* (December 29, 2005 Memorandum for William Leonard, Director, Information Security Oversight Office).

B. Testimony of DOE Consultant-Psychiatrist

The DOE consultant-psychiatrist testified that he evaluated the individual in July 2006 and that there were a couple of issues that concerned him during the course of his evaluation. First, the DOE

consultant-psychiatrist stated that the individual did not readily mention his alcohol use when questioned why he was sent for an evaluation. Transcript of Hearing (Tr.) at 11. Rather, the DOE consultant-psychiatrist stated that he had to prompt him to discuss his alcohol usage. He testified that he thought this was very unusual. *Id.* Second, the DOE consultant-psychiatrist testified that he reviewed "extensive reports" of physical examinations dating back to 1994. *Id.* at 12. He testified that he was concerned with a progress note written from the individual's March 2005 visit with his physician, particularly that the individual drank alcohol to the point where he was slurring his words. *Id.* He also noted that this progress note stated that the individual "used to abuse alcohol." *Id.* The DOE consultant-psychiatrist testified that he questioned why the individual would continue to drink if he had chest pains. *Id.* He referred to one doctor's note which stated that "[the individual] had alcohol on one occasion and surprisingly the next morning he had a recurrence of chest pain. . . . At that time he started abstaining from alcohol and he had no recurrence of his symptoms. He is, therefore, now convinced that the alcohol is a problem with his chest pain syndrome." *Id.* The DOE consultant-psychiatrist testified that he is always concerned when someone stops drinking for a reason and then resumes drinking. According to the DOE consultant-psychiatrist, "it is not diagnostically specific but it certainly raises your suspicion." *Id.* at 13. Based on the foregoing, the DOE consultant-psychiatrist concluded that the individual faces a risk of a lapse in judgment and reliability. *Id.*

The DOE consultant-psychiatrist further testified that if he were asked to give a diagnosis, he would diagnose him with alcohol abuse. 4/ Tr. at 13. When questioned about why he would be concerned that the individual consumes two glasses of wine on Friday, the DOE consultant-psychiatrist explained that "it is not the two glasses of wine I'm talking about. It is his [the individual's] perception, as told by the doctor, that wine will cause you pain; and then to continue or to resume drinking wine would fit the criterion of abuse. Apparently, as it turns out, I gather wine did not cause the pain. . . . I'm not talking about the pain, I'm talking about the way he handles things, . . . that is what gives rise to the diagnosis of abuse." *Id.* at 21.

After listening to the DOE consultant-psychiatrist's testimony, I found that he provided weak support for the Criterion J allegation in this case. I turn now to the mitigating evidence provided by the individual.

C. Mitigation

a. The Individual

The individual testified that he began drinking beer in college, usually a six-pack of beer on Saturday associated with a fraternity party. Tr. at 45. He got married and often shared a six-pack of beer on Friday and Saturday nights with his wife. *Id.* He states that in 1974, when his first child was born, he did not go to many parties but still had a drink or two of wine every night with his wife. *Id.* at 46. According to the individual, his drinking habits changed in 1983 with the birth of his second child.

4/ The DOE consultant-psychiatrist did not explain how and if the individual met the criteria for alcohol abuse as set forth in the *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV TR.*.

He stated that he often drank one glass of wine at night with his wife and maybe a glass or two of beer over the weekend with a pizza dinner. Sometime in 1994, the individual began taking Prozac to treat his depression. *Id.* at 48. At this time, the individual stated that he decided to reduce his drinking to a minimum. *Id.* He stated that his drinking consisted of two glasses of wine on a Friday or Saturday night, one glass before dinner and one glass with dinner. *Id.* The individual further stated that at this time his wife decided to discontinue her drinking because she felt it was inconsistent with the teachings of her Bible fellowship group. *Id.*

The individual explained the context of a March 2005 visit with his primary care physician. He stated that while working in his yard or exercising, he experienced a shortness of breath and chest pain and began to have headaches. These symptoms prompted a visit to his physician. During the course of this office visit, the individual told the physician what he had been drinking, something he stated that he typically does during office visits. Tr. at 51. He stated that he told the physician, " I still drink my couple of glasses of wine a week, and . . . by the way, I had, I may have had two and a half or three [the] night before last. And that's when [my wife] said, well, and you were slurring your words." *Id.* at 53. The individual asserted that the office visit then took a very unexpected turn and that he had a heated exchange with his physician because the physician wanted to change the subject to the individual's inability to control his alcohol use instead of advising him about his shortness of breath. *Id.* He further stated that the physician suggested that the individual take a medication to control his alcohol use. The individual stated that he ended the visit and changed his physician after that encounter. *Id.*

After the March 2005 office visit, the individual testified that he met with two cardiologists to address his chest discomfort. During this time period, he testified that he tried discontinuing his alcohol use to determine whether that affected his symptoms. Tr. at 53. After going several weeks without alcohol and not noticing a change in his symptoms, the individual returned to his normal drinking habits. He stated that the second cardiologist diagnosed him with labile high blood pressure and prescribed a blood pressure medication. 5/ *Id.* The individual stated this cardiologist did not see a problem with his drinking wine on the weekends. *Id.*

The individual reiterated that he currently consumes only two glasses of wine on the weekend, typically a glass of wine before dinner and one during dinner on a Friday or Saturday. When asked about his intentions regarding his future alcohol usage, the individual stated that he would like to continue what he is doing. He stated that "I don't see anything wrong in my drinking a couple of glasses of wine on Friday and until I'm convinced of that, I would not like to change. If my wife were to lay down the law, I would not lose my wife over my two glasses of wine." Tr. at 56. The individual further testified that he has never experienced any medical, legal or employment problems as a result of his alcohol consumption. *Id.* at 55.

5/ During the hearing, the individual submitted the deposition of his most recent physician. This physician noted that the individual was most recently diagnosed with neuro-cardiogenic syncope, an abnormality in the electrical system of the heart, a condition that is unrelated to alcohol use. *See* Individual's Exhibit A.

b. The Wife

The wife testified that the individual's drinking habits first changed after the birth of their children and later when the individual experienced some depression. She testified that he currently consumes two glasses of wine over a weekend. Tr. at 88. The wife also testified about the individual's March 2005 visit with his physician in which she was present. According to the wife, the individual had been experiencing shortness of breath and discomfort over the last several years since he began exercising. At one point, the wife stated that she rushed him to an emergency room because she believed her husband was having a heart attack. She stated that all of his tests came back negative. *Id.* at 89. The wife stated that they met with the physician in March 2005 because she wanted a second opinion concerning her husband's physical symptoms. *Id.*

The wife testified that, in an effort to get to the root of her husband's physical symptoms, she mentioned to the physician that on one occasion she observed her husband slurring his words. She testified convincingly that she never intended to imply that her husband's slurring of his words on one occasion was connected to excessive alcohol use. Tr. at 91. She further testified that she was shocked by the physician's suggestion that he place the individual on medication, Antabuse, to prevent him from drinking. The wife stated that her husband was never placed on any medication and she never witnessed him slurring his words after that time. *Id.*

c. The Clinical Psychologist

The clinical psychologist (psychologist) met with the individual on two occasions, one time in April 2007 and a second time in May 2007. As a result of his evaluation of the individual, which included psychological testing, interviews with the individual's wife and a review of the individual's medical records and DOE file, the psychologist concluded that there is no diagnosable condition, specifically that there are no findings of alcohol abuse or alcohol dependence. Tr. at 68.

During the hearing, the psychologist testified about the progress notes written during the individual's March 2005 doctor's visit stating that the individual was "slurring his words." After evaluating the individual and interviewing the individual's wife, he opined that there was no real evidence of "gross impairment" and found the offer of Antabuse (a drug used to stop individuals from drinking) by this physician to be very unusual for the individual's level of alcohol consumption. *Id.* at 71. The psychologist further testified that he questioned how "in the context of a fifteen-minute doctor visit he [the physician] focused on the drinking as an issue when they had gone seeking consultation for the dizziness and shortness of breath. And this has been eventually tracked down by a cardiologist and it has got no relation to [the individual's] drinking by the medical record, that I can see." *Id.* at 72. He reiterated that as a clinical psychologist who regularly treats and diagnoses substance abuse problems, he could not make any diagnosis of substance abuse or dependence in the individual's entire history.

The psychologist further testified how the individual's statements about his drinking pattern could possibly be misconstrued by the DOE consultant-psychiatrist. He described the individual as "somewhat concrete." *Id.* The psychologist testified to the following:

> I think I was trying to understand how . . . an experienced psychiatrist would be suspicious of [the individual] because there is nothing in the record . . . . And in my interviews when [the individual] answers questions, he will answer them just as they are asked without anticipating why they were asked, as most people would anticipate and then, . . . not only answer the explicit question but answer the implicit question. And people do this. And sometimes they do this to excess and you are suspicious about their glibness and you are suspicious about their spin. But [the individual] utterly lacks any spin and will answer a question in a very concrete way. So if you say, well, the example I used, you know, when there was a discussion about crossing a line, you know, he did cross a line. He had three glasses of wine rather than two glasses of wine. That is, for [the individual], he crossed the line. I think anyone else would have been thinking, well, what is conventional drinking and what do most people anticipate the line being, but that is not what he did.

Id. at 74.

The psychologist reiterated that he could not see any possible way of making a diagnosis of alcohol abuse, alcohol dependence or the use of alcohol habitually to excess in the individual's case. *Id.* He also disagreed with the DOE consultant-psychiatrist's opinion that the individual "drinks in spite of consequences," noting that one cardiologist may have expressed concern about the individual's drinking and his heart condition, but that two subsequent cardiologists believed the individual's drinking was unrelated to his chest pains. *Id.*

Finally, the psychologist testified that he believes the individual's alcohol consumption is "social" and normal and that there are "no consequences that are attendant with his drinking." Tr. at 79. He further opined that the individual's drinking "is absolutely within conventional bounds of . . . it is even called healthy drinking." *Id.* According to the psychologist, the individual has not developed a tolerance to alcohol. *Id.* at 80.

D. Hearing Office Evaluation of Evidence

In the administrative process, it is the Hearing Officer who has the responsibility for assessing whether an individual with possible alcohol problems has presented sufficient evidence of rehabilitation or reformation. *See* 10 C.F.R. § 710.27. Hearing Officers properly give a great deal of deference to the expert opinions of psychiatrists and other mental health professionals regarding rehabilitation and reformation. Moreover, it is my responsibility as Hearing Officer to ascertain whether the factual basis underlying the psychiatric findings is accurate, and whether the findings provide sufficient grounds, given all the other information in the record, for the denial of a security clearance. *See, e.g., Personnel Security Hearing* (Case No. VSO-0068), 25 DOE ¶ 82,804 (1996). On the basis of that evaluation, I find that the individual does not have an alcohol problem that would pose a risk of a lapse in his judgment and reliability.

After listening to all of the testimony and assessing the credibility of the witnesses during the hearing, I do not believe the individual suffers from alcohol abuse or has any other alcohol condition that would affect his judgment and reliability. The individual has convinced me that his normal drinking

pattern is to consume two glasses of wine associated with a meal over the weekend. There is no evidence in the record that the individual has been grossly impaired by his alcohol consumption. The only evidence that questions whether the individual has been impaired due to alcohol is a clinical note written from the individual's March 2005 doctor's visit. During this visit, the individual's wife mentions that he was "slurring his words." However, after listening to the testimony of both the individual and the individual's wife, I am convinced that the physician exaggerated the individual's alcohol use and therefore I will accord little weight to this evidence. I further note that the evidence in the record has shown that the individual's heart condition is unrelated to his drinking.

Moreover, I found the testimony of the psychologist to be more persuasive than that of the DOE consultant-psychiatrist. The DOE consultant-psychiatrist based most of his opinion on clinical notes written by physicians at some of the individual's past doctor visits. Again, however, it is clear from the testimony in the record that, with respect to the March 2005 visit, the individual's alcohol use was exaggerated. In addition, I did not find the DOE consultant-psychiatrist's opinion or concerns regarding the individual's alcohol use to be credible. For example, the DOE consultant-psychiatrist maintained that he was concerned that the individual ceased his alcohol consumption when he was investigating the cause of his chest pain but later resumed drinking. In light of the fact that the individual was consuming at most two glasses of wine, I am not persuaded that the individual's decision to resume his drinking poses a risk of a lapse in judgment and reliability. I agree with the psychologist that the individual's alcohol consumption of two glasses of wine once per week is nothing more than a normal, healthy drinking pattern. I have also accorded weight to the sworn deposition of the individual's current physician who opined that the individual does not have an alcohol condition. Based on the foregoing, I find that the individual has mitigated the security concerns associated with his use of alcohol.

V. Conclusion

As explained in this Decision, I find that the local DOE security office properly invoked 10 C.F.R. § 710.8(j) in denying the individual's access authorization. However, for the reasons described above, I find that the individual has sufficiently mitigated the security concerns associated with his use of alcohol. I therefore find that granting the individual's access authorization would not endanger the common defense and security and would be consistent with the national interest. Accordingly, I find that the individual's access authorization should be granted. The parties may seek review of this Decision by an Appeal Panel under the regulations set forth at 10 C.F.R. § 710.28.

Kimberly Jenkins-Chapman
Hearing Officer
Office of Hearings and Appeals

Date: October 30, 2007