United States Department of Energy
Office of Hearings and Appeals

In the Matter of: Personnel Security Hearing	)	
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Filing Date: March 28, 2022	)	Case No.: PSH-22-0073
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	)	

Issued: August 5, 2022

Administrative Judge Decision

James P. Thompson III, Administrative Judge:

This Decision concerns the eligibility of XXXXXXXXXXXXXXX (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 should not be granted access authorization.

I. BACKGROUND

The Individual is employed by the DOE in a position that requires possession of a security clearance. The DOE Local Security Office (LSO) discovered concerning information regarding the Individual's alcohol use. The information prompted the LSO to request that the Individual be evaluated by a DOE-consultant Psychiatrist ("DOE Psychiatrist"). Afterward, the LSO informed the Individual by letter ("Notification Letter") that it possessed reliable information that created substantial doubt regarding his eligibility to possess a security clearance. In an attachment to the Notification Letter, entitled Summary of Security Concerns (SSC), the LSO explained that the derogatory information raised security concerns under Guideline G of the Adjudicative Guidelines.

The Individual exercised his right to request an administrative review hearing pursuant to 10 C.F.R. Part 710. The Director of the Office of Hearings and Appeals appointed me as the Administrative Judge in this matter, and I subsequently conducted an administrative review

[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.

hearing. At the hearing, the Individual presented the testimony of four witnesses, including a psychologist, and testified on his own behalf. The LSO presented the testimony of the DOE Psychiatrist. The Individual submitted twenty-one exhibits, marked Exhibits A1 through H.[2] The LSO submitted seven exhibits, marked Exhibits 1 through 7.[3]

II. THE NOTIFICATION LETTER AND THE ASSOCIATED SECURITY CONCERNS

As indicated above, the LSO cited Guideline G (Alcohol Consumption) of the Adjudicative Guidelines as the basis for concern regarding the Individual's eligibility to possess a security clearance. Exhibit (Ex.) 1.

Guideline G provides that "[e]xcessive 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." Adjudicative Guidelines at ¶ 21. Conditions that could raise a security concern include "[h]abitual or binge consumption of alcohol to the point of impaired judgment, regardless of whether the individual is diagnosed with alcohol use disorder[,]" and "[d]iagnosis by a duly qualified medical or mental health professional (e.g., physician, clinical psychologist, psychiatrist . . .) of alcohol use disorder[.]" *Id.* at ¶ 22(c) and (d). The SSC cited the DOE Psychiatrist's April 2021 conclusion that the Individual had habitually consumed alcohol to the point of impaired judgment and met the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), criteria for Alcohol Use Disorder (AUD), Severe, without adequate evidence of rehabilitation or reformation. Ex. 1. The cited information justifies the LSO's invocation of Guideline G.

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 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

[2] Exhibit H was received after the hearing, and it is a letter from the Individual's physician.

[3] The LSO's exhibits were combined and submitted in a single, 170-page PDF workbook. Many of the exhibits are marked with page numbering that is inconsistent with their location in the combined workbook. This Decision will cite to the LSO's exhibits by reference to the exhibit and page number within the combined workbook where the information is located as opposed to the page number that may be located on the page itself.

full opportunity to present evidence supporting his or her 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. *Id.* at § 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

In 2020, the Individual disclosed in a Questionnaire for National Security Positions (QNSP) that he completed as part of the security clearance process that he had been hospitalized in 2017 due, in part, to his alcohol use. Ex. 7 at 93. His disclosure stated that after the hospitalization, he engaged in an alcohol outpatient treatment program ("Outpatient Treatment") for approximately a month, and he then left the program against medical advice. *Id.* at 126. During a subsequent investigation conducted by the U.S. Office of Personnel Management (OPM), the Individual explained to the OPM investigator that he left Outpatient Treatment before completing it because he did not believe it was addressing his depression, the underlying cause of his alcohol consumption. *Id.* at 108. He also disclosed that "drinking . . . made his depression worse." *Id.* at 127. The record includes Outpatient Treatment information obtained by the OPM investigator that documents the Individual's reported daily alcohol consumption as eight to fifteen shots of whiskey. *Id.*

During his 2021 evaluation with the DOE Psychiatrist, the Individual reported that his alcohol consumption increased in late 2016 due to the onset of depressive symptoms, and he acknowledged that he had been "probably drinking more than [he] should have[.]" Ex. 5 at 21. The DOE Psychiatrist reported that the Individual's medical records demonstrate that he had been diagnosed with Major Depressive Disorder, Moderate, Recurrent, in 2017 after being "hospitalized for acute cardiac problems and suicidality[.]" *Id.* at 29. Months later, the Individual was again hospitalized, this time involuntarily, after he experienced an "alcohol-induced blackout" during which he contacted his mother and "expressed that he was experiencing thoughts of ending his life." *Id.* at 30. In the months preceding his first hospitalization, he had attempted to take "gap" days from consuming alcohol, which were occasionally unsuccessful, and experienced diminished control over his drinking and associated guilt. *Id.* at 21. He reported that he had consumed alcohol to relieve his feelings of depression. Ex. 5 at 22. The DOE Psychiatrist noted that the Individual provided conflicting information regarding his alcohol consumption in 2017; for example, he reported consuming one bottle of wine per day and occasional shots of whisky instead of the eight to fifteen shots of whiskey disclosed in his medical records. *Id.* He attributed the discrepancies to a lapse in recall. *Id.*

The Individual also described his prior treatment for alcohol use during the evaluation. First, he identified how his alcohol use had impacted his life and career and how his mother and sister expressed concern and asked him to seek treatment in 2017. Ex 5 at 23-24. As result, he engaged with his employer's employee assistance program (EAP) and attended several Alcoholics

Anonymous (AA) meetings before participating in the intensive Outpatient Treatment.[4] *Id*. As part of his treatment, he was prescribed Antabuse, which deters alcohol consumption by producing a "rather severe physical reaction when alcohol is consumed[.]" *Id.* at 25. He admitted that, during Outpatient Treatment, he occasionally consumed wine at dinner by intentionally discontinuing Antabuse, which he disclosed to the treatment provider. *Id.* at 24. He did not receive any additional treatment for alcohol use after he "left the program against medical advice and declined recommendations for additional treatment." *Id.* at 25.

The Individual told the DOE Psychiatrist at the time of the evaluation that he did not need any form of treatment for his alcohol consumption. *Id.* at 24. He also stated that he had been consuming approximately one to one and a half beers once per week since 2017. *Id.* at 26. The Individual underwent a urine ethylglucuronide (EtG) and a blood phosphatidylethanol (PEth) test as part of the evaluation. *Id.* at 27. Both tests were for the purpose of detecting past consumption of alcohol, and both test results were negative and therefore consistent with the Individual's reported recent alcohol consumption. *Id*. He stated that while his family was "not thrilled" that he had continued to consume alcohol despite having a problem with it in the past, he believed his alcohol consumption was reasonable and completely controlled. *Id.* at 26.

The DOE Psychiatrist concluded that the Individual suffered from AUD, Severe, without rehabilitation or reformation because the Individual continued to "suffer from Severe Alcohol Dependence," he had consumed alcohol during his 2017 abstinent-based Outpatient Treatment, he prematurely ended the treatment program, he had not received any additional treatment or monitoring, he reported consuming alcohol to intoxication in 2017, and he continued to consume alcohol despite acknowledging his prior use was problematic and contributed to the onset of or exacerbated his "most recently experienced major depressive episode." *Id.* at 31. The DOE Psychiatrist also concluded that the Individual had, through 2017, habitually consumed alcohol to the point of impaired judgment. *Id.* The DOE Psychiatrist provided the following recommendations. The Individual should maintain sobriety for twelve months. The Individual should also participate in a substance-based aftercare program for six months; attend and fully participate in a peer-based support program, such as AA, at least twice a week for one year; and receive random EtG and two PEth tests over the same period. Ex. 5 at 31-32.

The record includes a report provided by a psychologist ("Psychologist") who conducted an evaluation of the Individual several months after the DOE Psychiatrist. Therein, the Psychologist provided his opinion after reviewing the Individual's reported personal history and alcohol use. Ex. D. The Psychologist diagnosed the Individual with AUD, Severe, In Sustained Remission. *Id.* at 7. The Psychologist recounted that the Individual described his 2016 alcohol use to be "at least a bottle of wine per night" with the intent to become intoxicated. *Id.* at 5. The Psychologist cited favorably the fact that the Individual disclosed his alcohol use to providers while in Outpatient Treatment. *Id.* at footnote 1. He reported the Individual's statement that, after the Outpatient Treatment, he had "a very long history of having one beer at times" without any problems. *Id.* The Individual also reported abstaining from alcohol and attending weekly AA meeting by video teleconference since receiving the DOE Psychiatrist's report. *Id.*

[4] He did not obtain a sponsor in AA, nor did he work through the AA 12 Steps. Ex. 5 at 24.

The Psychologist explained in his report that consuming alcohol after a diagnosis of AUD does not necessarily indicate a relapse within the DSM-5. *Id.* at 8. Rather, a relapse occurs "only if the consumption leads the [person] to meet one of the 11 criteria of alcohol use disorder." *Id.* The Psychologist stated that the Individual "did not become psychologically addicted to alcohol," and, after Outpatient Treatment, "did not resume his regular consumption of excessive amounts of alcohol." *Id.* at 9. The Psychologist opined that, after "completing the alcohol education portion of the recovery program he attended[,]" "[a]dditional treatment would provide no further preventative benefit." *Id.* The Psychologist referenced the Individual's reported outstanding work performance, his decision to work in the office during the pandemic, and his physical training regime as factors that substantiate the Individual's claim of overcoming his alcohol problem. *Id.* at 11. The Psychologist concluded that the Individual had remained free from his alcohol problem for over four years by the date of the evaluation, but stated that a PEth test at monthly intervals would "leave no stone unturned in verifying" that the Individual is "free from any impairment" from alcohol. *Id.*

At the hearing, a work colleague of the Individual testified that, in the last year preceding the hearing, they had participated in three to four after-work social events together where the Individual did not consume alcohol while other participants consumed alcoholic beverages. Tr. 17-18. This colleague considered the Individual reliable and trustworthy. *Id.* at 15, 20-21. A friend who engages in a regular, physically demanding outdoor activity with the Individual outside of work similarly testified that he observed the Individual refrain from consuming alcohol at an event in the last year, and he considers the Individual to be reliable and trustworthy. *Id.* at 29, 35-38.

The Individual's sister testified that she and the Individual see each other twice a year, and they communicate weekly. *Id.* at 51. She testified that she was not aware of the extent of the Individual's alcohol use in 2017, but she did know that he was "using alcohol" during that period. *Id.* at 55. She testified that she visited with the Individual in-person three times in the previous year leading up to the hearing. *Id.* at 56. Two of the visits lasted for an entire week, and two of the visits were during the holiday season. *Id.* The sister testified that they shared most meals together during the visits, and she never observed the Individual consume alcohol. *Id.* at 56-57, 60-61, 62-63. She testified that the Individual told her more recently that he has been "pursuing this healthy lifestyle . . . with physical exercise[,]" which was "one of the steps that he's taking . . . to avoid" his issue with alcohol use. *Id.* at 63. She testified that she would be a support to him if she believed he was feeling depressed or struggling. *Id.* at 67-68. She was not aware that he had been participating in AA. *Id.* at 65.

The Individual testified to the following. He confirmed that he "absolutely abused alcohol" during 2016 to 2017 because he was upset about aspects of his life. *Id.* at 84-85. He also confirmed that he left Outpatient Treatment against the treatment provider's recommendations because he believed they were not treating his depression. *Id.* at 148, 167. However, he could not recall whether he was discharged or withdrew from the program. *Id.* at 168. He stated that he last consumed alcohol to intoxication in November 2018.[5] *Id.* at 97. The Individual testified that a wakeup call occurred in 2017 when he was required to take medication for high blood pressure as a result of his alcohol consumption. *Id.* at 153. He believed that his alcohol use also put him at risk

[5] This date differs from the DOE Psychiatrist's report, which listed 2017. *See supra.*

for a stroke and gave him a heart condition. *Id.* at 164. The record shows that, in approximately 2019, the Individual reduced his consumption to one beer a week.[6] *Id.* at 98-99. He then completely stopped consuming alcohol after he received the DOE Psychiatrist's report in July 2021. *Id.* at 99. Prior to the evaluation with the DOE Psychiatrist, he believed that one could be sober so long as they were not consuming alcohol to intoxication. *Id.* at 95. After receiving the DOE Psychiatrist's report, he recognized that he had misjudged the gravity of his alcohol use in the context of possessing a security clearance. *Id.* at 100. He is a lot more comfortable and in a "100 percent mentally different place." *Id.* at 86, 87. He deals with emotional setbacks by "walk[ing] it off" or turning to physical activity. *Id.* at 91. He addresses stressful situations such as experiencing grief by working his way through them and leaning on people for support. *Id.* at 110, 111- 12. He stated that he is accountable for his abstinence to his friends, his family, and his work colleagues. *Id.* at 146.

The Individual testified regarding his participation in AA. He started "calling" into AA meetings on Saturday evenings because it was "really good enforcement for not having a beer with dinner[,]" which had been his once-a-week pattern. *Id.* at 101. He confirmed that he had not attended AA twice a week, as was recommended by the DOE Psychiatrist. *Id.* at 169. He stated that "it's a failure on [his] part[,]" and that he "should have been going to the second one." *Id.* at 169. He testified that Saturdays were also a good opportunity for AA because "work is pretty busy." *Id.* However, he stated that he would not "make excuses" because "you find time for the things you need." *Id.* He explained that he called in late for AA because he is introverted and "scared to get called on in groups[,]" but he would participate if called upon. *Id.* He explained that he did not obtain an AA log-in sheet documenting his attendance because he had difficulty connecting by video. *Id.* at 143-44. He had not "worked" the AA Steps in the "official sense[,]" but he did employ the steps in his daily life. *Id.* at 142. He attempted early on in his sobriety to obtain a sponsor, but he felt that it would be disingenuous to ask for sponsorship since he did not have any trouble remaining abstinent and he was not experiencing any of the challenges "that would require a sponsor[.]" *Id.* at 120. He stated that the intended to continue attending AA "as long as needed[,]" and he is fully committed to lifelong sobriety. *Id.* at 105.

The record includes the results of five ethanol blood tests taken by the Individual between August 2021 and June 2022. Ex. C; Ex. E. All results were negative. *Id.* The Individual explained that he requested "blood alcohol tests" in an attempt to be responsive to the DOE Psychiatrist's recommendations. *Id.* at 124-25. He testified that he was unable to enroll in random testing because his health care provider did not give random tests. *Id.* at 123. He also specifically requested a PEth test ahead of the hearing, which he had to obtain from a different provider because it was not offered through his regular provider. *Id.* at 124-25. He testified that he made a good faith effort to comply with the recommendations. *Id.* at 136. He confirmed that he did not show the DOE Psychiatrist's report to his medical provider. *Id.* at 137. He also confirmed that he did not reach out to his employer's EAP in order to obtain testing that would be consistent with the DOE Psychiatrist's recommendations. *Id.* at 138.

The Individual testified that he did not follow the recommendation to attend aftercare. *Id.* at 126. He explained that he believed that it would have been challenging to enroll in the program with a

[6] This differs slightly from the reported consumption of one to one and a half beers per week documented in the DOE Psychiatrist's report. *See supra.*

"one beer a week habit[,]" and he questioned whether he would have been accepted. *Id.* He chose to not pursue an aftercare program because he believed it was not necessary given his recovery. *Id.* at 126-27, 145-46. He also stated that work was "extremely busy" at that time, although he stated that he did not want to offer that as an excuse. *Id.* at 170. He expressed that he would have done it if it had been necessary to "get well[.]" *Id.* at 171. He confirmed that he received the report from the Psychologist in November 2021. *Id.* at 175. He testified that it was "freeing" to have "it documented that [he] was in remission" and "doing the right things[.]" *Id.*

The Psychologist testified after considering the testimony of the Individual and the Individual's witnesses and stated his opinion that the Individual's AUD remained in sustained remission with an excellent prognosis. *Id.* at 187-88. He opined that the Individual's efforts demonstrated that he has "learned his lesson about alcohol" and that he would use "a more appropriate means of seeking help" if he were to become depressed in the future. *Id.* at 188. The Psychologist testified that the Individual did not need to attend AA because the Individual believed he had resolved his problem and the Psychologist did not find a basis to conclude otherwise. *Id.* at 201.

The DOE Psychiatrist's testimony differed from the Psychologist in concluding that the Individual had not demonstrated rehabilitation or reformation of the condition. The DOE Psychiatrist gave the Individual a "fair to decent" prognosis after first stating that the prognosis was unclear. *Id.* at 230-31. The DOE Psychiatrist explained that Individual's AUD had not been in remission under the DSM-5 criteria at the time of the initial evaluation because the Individual continued to consume alcohol despite his diagnosis of "recurrent major depression." *Id.* at 213-14, 2015. The DOE Psychiatrist further noted that the Individual continued his alcohol consumption even though his AUD "caused significant personal distress, health consequences necessitating a hospitalization[,] . . . . [and] caused all sorts of chaos in his life[.]" *Id.* at 215-216. Finally, the DOE Psychiatrist concluded that the Individual had not complied fully with any of his recommendations. *Id.* at 220. The DOE Psychiatrist explained that the Individual did not demonstrate that he had participated in any "methodical, structured way working through the [AA] Twelve Steps." *Id.* at 220. The Individual did not enroll in random EtG testing, nor had he obtained two PEth test results. *Id.* at 222-23. The DOE Psychiatrist explained that the submitted ethanol blood test results could only detect consumption that occurred within a four-to-six-hour period. *Id.* at 221-22. Furthermore, the DOE Psychiatrist opined that, even if the Individual has been "fully sober" for "11 or 12 months time" and meaningfully participating in weekly AA, the recommendation would still be to increase AA participation to two times per week and to participate in PEth testing and random EtG testing for at least another six to twelve months. *Id.* at 226. He stated that the Individual "has not embraced the fact that he has a chronic condition and that he needs support to help maintain sobriety." *Id.* at 232. The DOE Psychiatrist also opined, assuming the Individual's report of almost a year of abstinence is true, that his risk of relapse is "low to moderate."[7] *Id.* at 232.

[7] The DOE Psychiatrist also noted that the Individual's history of depression, given that it exacerbated his alcohol consumption, placed "him at heightened risk for [consuming alcohol] again." *Id.* at 233.

V. ANALYSIS

A. Guideline G Considerations

Conditions that can mitigate security concerns based on alcohol consumption include the following:

(a) So much time has passed, or the behavior was so infrequent, or it happened under such unusual circumstances that it is unlikely to recur or does not cast doubt on the individual's current reliability, trustworthiness, or judgment;

(b) The individual acknowledges his or her pattern of maladaptive alcohol use, provides evidence of actions taken to overcome this problem, and has demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations;

(c) The individual is participating in counseling or a treatment program, has no previous history of treatment and relapse, and is making satisfactory progress in a treatment program; and

(d) The individual has successfully completed a treatment program along with any required aftercare, and has demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations.

Adjudicative Guidelines at ¶ 23.

First, I conclude that ¶ 23(c) and (d) do not apply to resolve the concern. Regarding ¶ 23(c), the Individual has not been participating in a counseling or treatment program other than attending AA once week, and he previously failed to complete an abstinent-based treatment program in 2017 after he consumed alcohol during the program and disregarded the advice of treatment providers. Furthermore, ¶ 23(d) is inapplicable because the Individual has never successfully completed a treatment program or attended aftercare.

I further conclude that the Individual failed to bring forth sufficient evidence to apply ¶ 23(a) and (b) to resolve the Guideline G security concerns. Because I rely upon much of the same evidence in analyzing these two mitigating factors, the following analysis addresses them together. The Individual admitted his pattern of maladaptive alcohol use by confirming that he used to have a problem with alcohol, and it is clear that he regrets using alcohol in order to address his depression back in 2017. He also provided evidence that he has since turned to regular, intense physical activity as a means to deal with feelings that previously contributed to his alcohol consumption, and he stopped consuming alcohol and began attending weekly AA sessions almost one year before the hearing. He also put forth evidence that he manages negative feelings by working through them or reaching out to friends and family for support. While this evidence weighs in favor of mitigation, it does not overcome the following evidence in the record that leaves me concerned about his current reliability, trustworthiness, or judgment.

First, the record establishes that the Individual does not accept that he has a problem with alcohol. He testified to this fact, and his actions before and after receiving the DOE Psychiatrist's report demonstrate the same. For example, he continued to consume alcohol against the advice of the Outpatient Treatment providers, and he refused the recommendation that he continue treatment in aftercare, again substituting his judgment for that of the treatment providers. Even after receiving the DOE Psychiatrist report, he refused to enroll in the recommended aftercare, attend the recommended number of AA meetings, or seek an AA sponsor. Although the Individual obliquely offered his busy schedule as an excuse, the record is clear that he did not prioritize following the DOE Psychiatrist's recommendations. At least with respect to the AA participation, he admitted that his failure was a mistake.

Despite the Individual's belief that his problem with alcohol had long since been resolved at the time he was evaluated by the DOE Psychiatrist, the DOE Psychiatrist credibly established that the Individual's AUD was not in remission until the Individual reportedly became completely abstinent because the Individual had continued to consume alcohol, even to the point of intoxication, knowing that his depression and physical health had been seriously impacted by his alcohol use. The DOE Psychiatrist established that the Individual's continued consumption perpetuated the diagnosis of AUD, Severe, and I accept the DOE Psychiatrist's conclusion on this point over that of the Psychologist.[8]

Furthermore, the actions the Individual took over the last year, including his reported abstinence, were not in accordance with the treatment recommendations provided by the DOE Psychiatrist. The Individual refused to attend aftercare, which I find concerning because it demonstrates a failure to prioritize addressing his AUD given the severity of the diagnosis. Furthermore, it reflects negatively on his judgment that he decided to avoid attempting to enroll in aftercare, despite his previous experiences with Outpatient Treatment and EAP, because he felt it would be disingenuous. I also find it concerning that his judgment led him to conclude that he would be unable to enroll despite his diagnosis and a recommendation from a clinical psychiatrist.

I also find concerning that, not only did the Individual decline to attend two AA sessions per week as recommended by the DOE Psychiatrist, but he intentionally appeared late to the one weekly session he did attend, specifically to avoid fully participating. I remain doubtful regarding his explanation that his failure to formally document his attendance was due to his inability to figure out, over approximately a year's time, how to participate remotely by video.[9] And I do not find that his introversion is an excuse to avoid following treatment recommendations.[10] His conduct is not reflective of good judgment or a "good faith effort."

[8] In making my decision, I note that the Psychologist did not adequately explain why the Individual's continued alcohol use despite the diagnosis of depression and the apparent link to consumption did not invoke the related DSM-5 criteria. *See* Tr. at 146.

[9] Even the Psychologist expressed surprise that the Individual had participated merely by telephone instead of video by stating "I didn't know that was possible." Tr. at 192.

[10] I also note that the record is devoid of evidence of any effort on the Individual's part to determine alternative treatment option that would accommodate his introversion.

Lastly, I find concerning that the Individual was apparently incapable of obtaining the random EtG testing or PEth testing recommended by the DOE Psychiatrist. There is no question that the Individual read the DOE Psychiatrist's report and recommendations. Furthermore, the Individual had the additional benefit of the Psychologist's explanation of the value of PEth testing. However, despite the information in both evaluative reports and his prior experience with EAP and Outpatient Treatment, he testified that he believes his conduct represents a good faith effort to comply with the recommendations. Not only do I question the candidness of his testimony on this point, but it represents one more instance of behavior consistent with his pattern of partial compliance or rejection of treatment recommendations. The DOE Psychiatrist concluded at the hearing that the Individual was at the point of sustained remission, but with a low to moderate chance of relapse. For all of the reasons stated above, I conclude that the Individual has not put forth sufficient evidence to resolve the Guideline G security concerns.

VI. 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 G of the Adjudicative Guidelines. After considering all of the relevant information, favorable and unfavorable, in a comprehensive, common-sense manner, including weighing all of the testimony and other evidence presented at the hearing, I find that the Individual has not brought forth sufficient evidence to resolve the security concerns set forth in the SSC. Accordingly, I have determined that the Individual should not be granted access authorization.

This Decision may be appealed in accordance with the procedures set forth at 10 C.F.R. § 710.28.

James P. Thompson III
Administrative Judge
Office of Hearings and Appeals