

Alcohol Consumption

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Relevance to Security

Some alcohol use is normal, but excessive use can be a serious security concern. Alcohol affects the central nervous system and how the brain functions. Excessive use affects perception, thinking, and coordination. It

impairs judgment, reduces inhibitions, and increases any tendency toward aggression. Those who abuse alcohol are more likely than others to engage in high-risk, thoughtless, or violent behaviors. This increases the risk of unauthorized disclosure of classified information due to impulsive or careless behavior.

Alcoholism is a lay descriptive term. Health professionals refer to serious alcohol problems as either alcohol abuse or alcohol dependence.

- Alcohol abusers are not physically addicted to alcohol, but develop problems as a result of their poor judgment about alcohol consumption, failure to understand the risks, or lack of concern about damage to themselves or others. An alcohol abuser persists in drinking habits that are known to be causing or exacerbating a persistent or recurrent social, work, legal, psychological, or health problem -- or uses alcohol repeatedly under circumstances which are physically dangerous, such as driving while intoxicated.
- Alcohol dependence is an illness with four main features: (1) physiological tolerance, so that more and more alcohol is needed to produce the desired effects; (2) difficulty in controlling how much alcohol is consumed once drinking has begun; (3) physical dependence, with a characteristic withdrawal syndrome that is relieved by more alcohol (e.g., morning drinking) or other drugs; and (4) a craving for alcohol that can lead to relapse if one tries to abstain.

Alcohol dependence usually involves regular, daily drinking. Alcohol abuse may involve only occasional binge drinking. In evaluating drinking behavior, therefore, amount of daily consumption and amount consumed occasionally at a single sitting are both relevant. If an individual drinks to the point of physical incapacitation or unconsciousness, that is also relevant.

Alcohol abuse may be part of a pattern of impulsive, immature, sensation-seeking, hostile, or antisocial behavior that raises serious concern about a subject's reliability, trustworthiness, or judgment. Alcohol abuse may also be an acute, but extended, reaction to grief or physical pain. If the alcohol issue alone is not sufficient to justify an adverse decision, it may nevertheless contribute to a disqualifying pattern of undesirable behavior. Refer to the discussion of a Pattern of Dishonest, Unreliable, or Rule-Breaking Behavior in the [Personal Conduct](#) guideline.

Evidence of Adverse Effect on Behavior

There is much statistical evidence to document a relationship between alcohol use and fatal automobile accidents, other forms of accidental death and injury, spousal abuse, crime, and suicide. According to the National Highway Traffic Safety Administration, the risk of fatal automobile injury is at

least eight times greater for drivers with a blood alcohol level of .08 or higher than for drivers who have consumed little or no alcohol.[1](#)

Intoxicated drivers in fatal crashes are two times less likely to wear safety belts than drivers who have not been drinking. Of drivers who have accidents while driving with suspended, revoked, or no licenses, about 83% have been drinking. [2](#)

Intoxicated motorcyclists are more likely to be involved in a fatal accident than any other driver. In 2003, 30% of fatally injured motorcyclists had a Blood Alcohol Concentration (BAC) greater than .08. Additionally, intoxicated motorcyclists have been found to wear helmets only two-thirds as often as motorcyclists who are not intoxicated. [3](#)

Alcohol abuse is also a leading risk factor in accidental injury and it is the fifth leading cause of death in the U.S. In 2003, almost 50% of trauma patients in U.S. emergency rooms were alcohol-impaired.[4](#) In data on fire and burn-related incidents, individuals who had been drinking were three times more likely to die from their injuries than individuals who had not. Blood alcohol levels as low as .025 to .04 have been found to significantly affect thought processes and radio communication by pilots. Additional studies suggest that alcohol is associated with at least 34% of adult drownings. [4](#)

Alcohol Use by Convicted Spies

Evidence from past espionage cases indicates that alcohol problems are more prevalent among convicted spies than in the population as a whole. Among 24 convicted American spies who were interviewed and tested after their imprisonment, 20 had been drinkers. Eleven had been heavy drinkers. Nine reported that their alcohol consumption increased when they started to engage in espionage; the remainder reported no change in their habits. Seven had been arrested and convicted at least once for an alcohol-related vehicular offense (driving while under the influence). Sixteen of the 24 reported that during their developmental years, one or both parents had an alcohol-related problem. Psychological disorders, attempted suicide, and physical abuse were common among the families of these subjects. [5](#)

CIA operations officer Aldrich Ames, who was arrested for espionage in 1994, had a reputation for drinking too much. There are several specific instances in which his drinking led directly to actions that endangered security. Ames became seriously inebriated while playing in a CIA-FBI softball game. He had to be driven home that night and left behind at the field a jacket with his CIA badge, a wallet that included alias documentation, and cryptic notes on a classified meeting. On another occasion, at a meeting at CIA Headquarters with foreign officials, Ames became so intoxicated that he made inappropriate remarks about CIA operations and then passed out at the

table.6 For additional information on Ames' drinking problem, see [Ames Example](#).

Alcohol and Emotional/Mental Issues

Several studies have found that within the general population nearly half of all those diagnosed as [alcohol abusers or alcohol dependent](#) also have some form of psychiatric disorder. Individuals suffering from alcohol dependence are much more likely to suffer from additional psychiatric disorders, such as major depression or post-traumatic stress disorder, than alcohol abusers.7

A different study that examined people in treatment for both alcohol and other drug problems found that at least 62% had a current mental disorder or a history of some mental disorder during their lifetime.8 Both these numbers are significantly higher than the prevalence of mental disorders in the U.S. population as a whole.

Potentially Disqualifying Conditions

Extract from the Guideline

(a) alcohol-related incidents away from work, such as driving while under the influence, fighting, child or spouse abuse, disturbing the peace, or other incidents of concern, regardless of whether the individual is diagnosed as an alcohol abuser or alcohol dependent;

(b) alcohol-related incidents at work, such as reporting for work or duty in an intoxicated or impaired condition, or drinking on the job, regardless of whether the individual is diagnosed as an alcohol abuser or alcohol dependent;

(c) habitual or binge consumption of alcohol to the point of impaired judgment, regardless of whether the individual is diagnosed as an alcohol abuser or alcohol dependent;

(d) diagnosis by a duly qualified medical professional (e.g., physician, clinical psychologist, or psychiatrist) of alcohol abuse or alcohol dependence;

(e) evaluation of alcohol abuse or alcohol dependence by a licensed clinical social worker who is a staff member of a recognized alcohol treatment program;

(f) relapse after diagnosis of alcohol abuse or dependence and completion of an alcohol rehabilitation program;

(g) failure to follow any court order regarding alcohol education, evaluation, treatment, or abstinence.

The seven potentially disqualifying conditions listed in the Adjudicative Guidelines fall into two distinct categories: (1) behavioral issues, and (2) medical issues. Accordingly, this discussion of disqualifying conditions is divided into two major parts:

- **Behavioral Evaluation:** This looks at how the subject behaves while under the influence of alcohol. Do the subject's actions indicate poor judgment, unreliability, untrustworthiness, or carelessness? How imminent is the security risk? The behavioral evaluation is done by the adjudicator based on information developed during the investigation.
- **Medical Evaluation:** This looks at alcohol abuse or dependence as an illness. Does the subject meet the criteria for a diagnosis of alcohol abuse or dependence? Is the subject's drinking likely to continue or get worse? Is counseling or treatment likely to be effective? Has the subject had a relapse after treatment? Has the subject failed to follow a court order regarding alcohol education, treatment, or abstinence? Medical evaluation is done by a duly qualified medical professional based on information developed during the investigation.

Behavioral Evaluation

From a security perspective, the key question about alcohol use is how it affects a subject's judgment and ability to control his or her behavior. How the subject behaves under the influence of alcohol is more important than how much or how often he or she drinks and whether or not he or she is diagnosed as an alcoholic.

People differ greatly in their reaction to alcohol. Some who are dependent upon alcohol are quiet drunks who cause no trouble. Some infrequent drinkers go on occasional binges and totally lose control. Some individuals who have engaged in flagrant misconduct or poor judgment while under the influence of alcohol do not receive an adverse medical diagnosis when they should have.

An adverse adjudication decision based on an individual's behavior does not need to be supported by a medical diagnosis of alcohol abuse or dependence. Such a diagnosis may not be available even when the subject's behavior provides clear evidence of security risk. This is because medical diagnosis of alcohol abuse or dependence is heavily dependent upon information provided by the subject. This makes diagnosis difficult, as alcoholics and problem drinkers are often unwilling to admit the extent of their drinking. Moreover, an employee whose security clearance may be at stake has a strong incentive to deny symptoms of an alcohol problem when talking with a medical professional. See Ames Example.

Drinking behavior that causes or exacerbates any of the following types of problems is a security concern when:

- Work problems such as absences, reduced productivity, unreliability, carelessness, or unsafe habits;
- Social problems such as family conflict, [domestic abuse](#), loss of friends, interpersonal conflicts, abusiveness and [aggression](#), or belligerency;
- Legal problems such as [driving while intoxicated](#), public drunkenness or disorderly conduct;
- Financial problems such as neglect of bills or overspending; or
- Health problems such as liver damage or making an ulcer worse.

Work-Related Incidents

Incidents at work are generally more serious than if the same type of behavior occurs away from work. If a subject allows alcohol use to affect any aspect of work performance, it may affect other aspects of work performance including control over classified information. If the subject's supervisor or a coworker has reported alcohol on subject's breath at work, absenteeism, or that the subject's performance has been adversely affected by hangover or by drinking during lunch, this is more serious than alcohol use that affects only one's personal life.

Incidents that do or could relate directly to the protection of classified information are the most serious. Such incidents may be characterized by:

- **Excessive Talkativeness:** An individual who becomes excessively talkative while intoxicated may say things that are regretted or not remembered later. Such a person may be unable to exercise the care and discretion needed to protect classified information. The risk is greatest for personnel whose job requires meeting and discussing sensitive topics with others, often over lunch where drinks may be served, without making inappropriate revelations regarding classified information. This includes many intelligence officers, liaison officers, negotiators, purchasing agents, and senior officials.
- **Loss of Physical Control:** An individual who occasionally becomes intoxicated to the point of passing out may lose physical control over sensitive materials. This is a particular concern among personnel who must carry a weapon or classified materials outside a secure area.

Violence, Aggression, Domestic Abuse

Alcohol consumption often precedes aggressive or violent behavior. Alcohol is a known factor in over 25% of nonhomicide violent crimes and recent studies have found that in 32-47% of homicides the offender has been drinking. The

more serious and violent the crime, the greater the likelihood that the offender was under the influence of alcohol at the time of offense. [9](#)

Alcohol use is apparent in 67% of domestic violence cases against an intimate partner. When drinking, men are more likely than women to become violent toward intimate partners, who suffer the most severe injuries as a result of alcohol-related violence. [9](#) Research at Fort Bliss supports studies of civilian populations that show alcoholism and alcohol abuse are related to 50% to 75% of spouse abuse incidents. So many spouse abusers have alcohol problems that spouse abuse may be regarded as a possible indicator of alcohol problems. The Fort Bliss study recommends that within a military community, all spouse abusers be referred for alcohol evaluation. [10](#)

Driving While Intoxicated

Frequent driving or engaging in other physically hazardous activity while intoxicated, e.g., boating, skiing, or operating machinery, is a serious concern. If this happens during duty hours, it is a very serious concern. State laws differ on the use of the terms DWI and DUI. DUI stands for driving while under the influence, and it usually refers to the influence of either alcohol or drugs. DWI usually stands for driving while intoxicated, and may refer only to alcohol. However, DWI may also stand for driving while impaired, in which case it may refer to either drugs or alcohol or may refer to a specific degree of alcoholic impairment distinct from intoxication.

Many responsible citizens occasionally drive with a blood alcohol level above the legal limit. In the 2003 National Survey on Drug Use and Health, an estimated 13% of Americans over the age of 12 has reported driving while intoxicated in the past twelve months, with 20% of 18-20 year olds and 28% of 21-25 year olds reporting drunk driving in the previous year. [11](#) In a 13-year-long study conducted on 1,380 individuals, 66% of men and 47% of women between the ages of 21 and 27 reported that they had driven drunk at least once in the three years preceding the survey.

Despite the prevalence of drinking and driving, a single arrest for driving while intoxicated (DWI or DUI) is an important indicator of alcohol abuse. Most of those who are arrested do not just happen to be caught during an unusual lapse in judgment or through an unfortunate piece of bad luck. Thirty to 70% of first-time DUI offenders are expected to have an alcohol problem significant enough to merit some form of treatment or counseling. [12](#) A different study of 4,403 persons convicted of driving under the influence in Vermont in the late 90s found that 70% were diagnosed as probable alcohol abusers or alcohol dependent. [13](#)

The probability is high that people who get so drunk that they drive unsafely and attract law enforcement attention are problem drinkers. Since problem drinkers have a greater tendency to repeatedly drive under the influence, they have a much more significant risk of being caught.

This finding has significant implications for investigators and adjudicators. A single recent DWI/DUI arrest suggests that investigators should intensify their search for other indications of alcohol-related problems or other behavioral problems. Depending upon recency of the DWI/DUI, adjudicators may wish to require an alcohol evaluation before approving eligibility for access.

Blood Alcohol Concentration

For legal purposes, degree of intoxication is often measured by blood alcohol concentration, usually abbreviated as BAC. This refers to the number of grams of pure alcohol present in 100 milliliters of blood. State laws differ in how they define the minimum level of blood alcohol concentration that constitutes legal evidence of intoxication for driving purposes. The two approaches are "illegal per se" and "presumptive" levels.

In states that use an illegal per se level, the BAC test alone may be sufficient for conviction. In the various states, the most common illegal per se level is .08, but it can be as low as .01 (for minors, certain commercial drivers, and convicted DWI/DUI offenders) or as high as .10 in some states. Presumptive levels of intoxication are generally lower than illegal per se levels and require a greater burden of proof to convict an individual of drunk driving.

BAC levels are influenced by the amount of alcohol consumed, the rate at which it is consumed, and the rate at which the alcohol is metabolized (eliminated) by the body. The adult male body is able to eliminate alcohol at the rate of almost one drink per hour. Because the average female body is smaller and weighs less, it takes the average woman about 1 hour and 15 minutes to eliminate one drink. The accepted definition of one drink is beverage alcohol that contains about one-half ounce of pure ethyl alcohol. That is one 12-ounce can of beer, a 5-ounce glass of wine, or a shot of liquor (1.5 ounces). Food in the stomach slows the absorption of alcohol into the system, but it does not speed elimination of the alcohol from the system. When alcohol is consumed faster than it can be eliminated, it accumulates in the bloodstream and the BAC goes up. Impairment begins long before the BAC reaches the legal limit. [14](#)

The National Commission Against Drunk Driving maintains an Alcohol Impairment Resource Center at www.ncadd.com/08_reso_center.cfm. This has charts showing how many drinks it takes for men and women of different body weights to reach various BAC levels and charts that show the type of impairment at different BAC levels. It states that "by the time a level of .08 is reached, virtually everyone experiences dangerous driving skill impairment, even those who are experienced or habitual drinkers." Concentration starts to become impaired at BAC .05, information processing and judgment at .06, and concentrated attention and speed control at .08.

DWI/DUI May Indicate Other Security Issues

Some researchers have suggested that driving while impaired is often part of a more general behavioral syndrome typified by high-risk behaviors and irresponsible attitudes.¹⁵ Individuals with alcohol-related offenses (such as DWI/DUI or disturbing the peace) often have derogatory information in other areas as well. This might include, for example, misdemeanor theft, spouse abuse, rule violations or other problems at work, financial problems, or withholding of information on the personnel security questionnaire.

Although each derogatory item may be minor by itself, the information as a whole may add up to a pattern of impulsive, irresponsible, or sociopathic behavior. Such cases may be adjudicated under the [Alcohol](#) or the [Personal Conduct](#) guideline. The adjudicator makes a whole-person judgment on whether the individual has the "strength of character, trustworthiness, honesty, reliability, discretion, and sound judgment" required by Section 3.1.(b) of Executive Order 12968.

A study of 132 college students showed that individuals with DUI arrest records had more reports of motor vehicle accidents, were more likely to drive after drinking repeatedly, had a higher number of reported traffic violations, and scored higher on self-ratings of risk-taking behaviors.¹⁶ Another study has shown that drivers who report driving drunk are more likely to ride with drunk drivers.¹⁷ These behaviors indicate a general lack of judgment and irresponsible behavior that must be considered when evaluating the whole person.

A study of over 4000 DUI offenders in Vermont found that 32% had prior criminal charges and 20% had prior alcohol-related criminal charges.¹³ Another study found that impaired drivers arrested after an accident or moving violation scored significantly higher on tests of hostility, sensation-seeking, psychopathic deviance, and mania than impaired drivers caught in roadblocks or impaired drivers who have never been caught. ¹⁸

Other Indicators of Serious Problem

Failure to Recognize that One Has a Problem: Recognition that one has an alcohol problem is the first step toward recovery. Refusal or failure to accept counseling or to follow medical advice relating to alcohol abuse or dependence is a serious concern. Refusal or failure to comply with a supervisor's advice to significantly decrease alcohol consumption or to change lifestyle and habits which contributed to past alcohol-related problems is a serious concern. Failure to cooperate in or to complete successfully a court-ordered alcohol education program or a prescribed alcohol rehabilitation program is a very serious concern.

Part of Broader Pattern of Behavior: An alcohol problem that is part of a broader pattern of undesirable behavior is more serious and more likely to cause trouble than an alcohol problem that exists in isolation. When alcohol

problems appear together with any other issue, the combination adds up to more than the sum of its parts. See the [Personal Conduct](#) module.

History of Alcohol Use: If recent evidence of a drinking problem is present, medical professionals will need a subject's entire history of alcohol use back to childhood in order to assess the seriousness of this issue. On the other hand, [remission of drinking problems without treatment](#) is common as younger drinkers mature or as the lifestyle, stress, or other circumstances that prompted the drinking change. Therefore, incidents more than three to five years old may no longer be relevant if there are no more recent indications of an alcohol problem. [19](#)

High School and College Drinking Practices

Every year since 1975, the Institute for Social Research at the University of Michigan has conducted a nationwide survey of about 17,000 high school seniors on drug and alcohol use and related questions. This survey includes annual follow-up questionnaires mailed to a sample of previous participants from each high school graduating class since 1976. This survey confirms significant reductions in frequency and amount of alcohol consumption by high school students since the mid 1980s, but the level remains very high. The figures on binge drinking are particularly significant. The survey asks about alcohol use during the past 30 days and the past year.

In 2005, 47% of high school seniors reported current drinking, meaning they consumed alcohol during the previous 30 days. Thirty percent reported being "drunk" during the previous 30 days, and 28% reported binge drinking (5 or more drinks in a row) during the previous two weeks. Sixty-nine percent of the seniors reported consuming alcohol during the previous year, and 48% reported having become drunk during the previous year. The breakdown of these figures between males and females was not available at the time this was written. [23](#)

Among college students surveyed in 2004, alcohol use during the previous 30 days was 73% for males and 65% for females, while 47% of males and 28% of females reported having five or more drinks at a time at least once during the previous two weeks. This type of heavy drinking at one sitting peaks among 21-22 year-olds. It diminishes from 42% of 21-22 year-olds (males and females combined) to 27% by ages 29 to 30. [24](#)

Ames Example

The case of Aldrich Ames holds a number of lessons related to alcohol abuse. Ames is the CIA officer arrested in 1994 after nine years of espionage during which he compromised many CIA operations in the former Soviet Union.

When Ames was reassigned from Mexico City to Washington in 1983, his supervisor recommended that he be counseled for alcohol abuse due to several incidents that occurred during his Mexico City assignment. The counseling he received amounted to one conversation with a counselor who, according to Ames, told him that his case was not serious when compared to many others. The fallacy here was that the counselor depended on what Ames told him, and we can assume that Ames almost certainly did not give him the full story.

The following is a list of alcohol abuse incidents involving Aldrich Ames. It is significant not so much for what it tells about Ames' alcohol use, as for what it tells about Ames as a person -- his irresponsibility and lack of self-control. This record indicates that Ames lacked the "strength of character, trustworthiness, honesty, reliability, discretion, and sound judgment" required by Section 1.3.(b) of Executive Order 12968. Whether a doctor who interviews Ames finds that his alcohol use meets the formal medical definition of abuse or dependence was essentially irrelevant under these circumstances. His behavior alone indicated he was a security risk.

In his entrance-on-duty polygraph examination in March 1962, Ames admitted that in November 1961 he and a friend, while inebriated, had "borrowed" a delivery bicycle from a local liquor store, were picked up by the police, and subsequently released with a reprimand. In April 1962, he was arrested for intoxication in the District of Columbia. He was arrested for speeding in 1963 and for reckless driving in 1965; Ames later stated that at least one of these incidents was alcohol-related.

At a Christmas party at CIA Headquarters in 1973, Ames became so drunk that he had to be helped to his home by employees from the Office of Security. At an office Christmas party in 1974, he became intoxicated and was discovered by an Agency security officer in a compromising position with a female CIA employee.

In Mexico City during 1981-1983, Ames had a reputation of regularly having too much to drink during long lunches. Upon returning to the office, his speech was often slurred and he was unable to do much work. On one occasion when Ames was involved in a traffic accident in Mexico City, he was so drunk that he could not answer police questions nor recognize the U.S. Embassy officer sent to help him. At a diplomatic reception where he drank too much, he became involved in a loud and boisterous argument with a Cuban official. This alarmed his supervisors and prompted the message to CIA Headquarters recommending that he be counseled for alcohol abuse when he returned to the United States. (Routine periodic background investigation in 1983 noted only that Ames was inclined to become a bit enthusiastic when he overindulged in alcohol. It failed to find a serious alcohol problem.)

In Washington in 1984 or 1985, after consuming several drinks at a meeting with an approved Soviet contact, Ames continued to drink at a CIA-FBI softball game until he became seriously inebriated. He had to be driven home that night and left behind at the field his CIA badge, cryptic notes, a wallet which included alias identification documents, and his jacket.

One of Ames' supervisors recalled that he was drunk about three times a week during his tour in Rome from 1986 to 1989. He would go out for long lunches and return to the office too drunk to work. On one occasion in particular, he returned from a meeting with an agent too drunk to write a cable to Washington as directed by his supervisors. At an embassy reception in 1987, he got into a loud argument with a guest, left the reception, passed out on the street, and woke up the next day in a local hospital. One colleague said Ames began to drink more heavily in 1987 after he failed to get promoted. The station security officer brought Ames' drinking habits to the attention of the Chief of Station. After Ames' arrest, his wife told FBI debriefers that alcohol was partly to blame for their marriage falling to pieces during their Rome tour, and for their having numerous fights.

While assigned to CIA Headquarters during 1990 to 1994, Ames was noted for his proclivity to sleep at his desk after a long lunch. In 1992, Ames became so intoxicated during a liaison meeting with foreign officials that he made inappropriate remarks about CIA operations and personnel and then passed out at the table. [6](#)

Of course, all of this information was never pulled together in one place until after Ames' arrest. If even a fraction of the information had been known, however, it should have been sufficient at least to initiate a counseling or monitoring program.

Medical Evaluation

A medical diagnosis of alcohol abuse or dependence by a duly qualified medical professional may be a basis for adverse adjudicative action. Medical evaluation may also assist the adjudicator in determining the seriousness of an alcohol problem, whether it is likely to persist or get worse in the future, and the prospects for successful treatment.

Accurate medical evaluation is difficult when a subject conceals information from the medical professional. Alcoholics are likely to deny they have a problem. Medical evaluation is likely to be accurate and useful only if the medical professional is provided with all relevant information concerning a subject's background and behavior. This obviously did not happen in the Ames case discussed above. A medical evaluation is desirable whenever sufficient information is available for an accurate medical diagnosis, but adjudicators may make a negative decision based solely on a subject's

behavior while under the influence of alcohol, without a supporting medical evaluation of abuse or dependence.

For further information, see:

- [Definitions of Alcohol Abuse and Dependence](#)
- [Indicators of Current or Potential Future Abuse or Dependence](#)

Definitions of Alcohol Abuse & Dependence

Alcoholism is a lay descriptive term. Health professionals refer to alcohol abuse or dependence.

Alcohol abusers are not physically addicted to alcohol, but develop problems as a result of their alcohol consumption and poor judgment, failure to understand the risks, or lack of concern about damage to themselves or others. Alcohol abusers who are not addicted remain in control of their behavior and can change their drinking patterns in response to explanations and warnings. An alcohol abuser will have a pattern of drinking that has led to one or more of the following in the last 12 months:

- Has been unable to fulfill major responsibilities at school, work, or home;
- Uses alcohol repeatedly under circumstances which are physically dangerous, such as driving while intoxicated;
- Continues drinking even when personal relationships are consistently and negatively affected by the drinking;
- Has been unable to meet financial obligations because of drinking;
- Has had recurrent alcohol-related legal problems, such as alcohol-related abuse and violence or DUI/DWI arrests; or
- Continues to drink even when drinking exacerbates existing health problems.

Some alcohol abusers also become physically dependent upon alcohol. Alcohol dependence is an illness with four main features:

- Physiological tolerance, so that more and more alcohol is needed to produce the desired effects;
- Difficulty in controlling how much alcohol is consumed once drinking has begun;
- Physical dependence, with a characteristic withdrawal syndrome that is relieved by more alcohol (e.g., morning drinking) or other drugs;
- A craving for alcohol that can lead to relapse if one tries to abstain.

For additional detail, see [Medical Criteria for Diagnosis of Abuse or Dependence](#) as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.

Indicators of Current or Potential Future Abuse or Dependence

Some elements of past behavior can serve as particularly useful guides to what one might expect in the future. The presence of any of the following indicators suggests that an individual may already have a serious alcohol problem or be at high risk for developing one. Any one indicator is not conclusive evidence of a serious alcohol problem, but it is relevant circumstantial evidence and should be reported.

- Subject's drinking is causing or exacerbating a persistent or recurring social, work, school, financial, legal, or health problem. This is the heart of the alcohol issue.
- Subject has tried unsuccessfully to cut down the extent of alcohol use. Or, once subject starts drinking, he/she sometimes loses control over the amount drunk. Both are indicators of alcohol dependence.
- Subject drinks extensively while alone. Regular solitary drinking, as compared with social drinking, indicates potential current or future alcohol dependence.
- Subject drinks prior to social events (to relax), as compared with using alcohol at social events. Drinking prior to social events indicates potential current or future alcohol problems.
- Subject drinks first thing in the morning as an "eye-opener," to get rid of a hangover, or when generally not feeling well. This is a strong indicator of dependence.
- Subject claims a high tolerance for alcohol, e.g., makes statements such as: "I can drink a lot without it having any effect on me, so I don't have to worry." High tolerance is an indicator of alcohol dependence -- it takes more and more to have the same effect on the body.
- Subject uses alcohol as a means of coping with life's problems. This indicates possible psychological or emotional problems and greatly increases the likelihood that alcohol already is or will become a problem. On the other hand, if motivation is experimentation, peer pressure, or adolescent rebelliousness, this does not necessarily predict future abuse.
- There has been a recent increase in subject's drinking. A change for the worse in subject's drinking pattern may signal the existence of other relevant issues.

- Subject becomes annoyed or angry when criticized about his or her drinking. This is related to denial that the problem exists.
- Subject feels guilty about drinking and how it affects other aspects of life.

Age of onset of drinking and a family history of alcohol abuse or dependence both affect the risk that one will develop a drinking problem later in life. One survey of 42,862 individuals revealed that at least 40% of persons who begin drinking alcohol between the ages of 13-15 will have an alcohol problem at some point in their lives. However, as the age of drinking onset increases, the likelihood that a drinking problem will arise is diminished. Only 20% of drinkers who have their first drink at age 18 develop an alcohol problem at some time in their lives, and only 10% of those who begin drinking at or past age 21 will develop an alcohol problem.²⁰ Family history of alcohol abuse or dependence combined with age of onset for drinking provides a significant predictor of likely alcohol problems later in life. For teens who begin drinking at age 13, 57% who have a family history of alcohol abuse are likely to develop an alcohol problem, compared to 26% who have no family history. At age 21, those with family alcohol history and those without, 16% and 7%, respectively, will develop alcohol-related problems in the future. ²¹

Prevalence of Drinking Problems

Drinking is a problem only if it leads to adverse consequences. Younger drinkers are more likely than older drinkers to show symptoms of alcohol dependence, according to a survey conducted during 1997-2000 by the National Center for Health Statistics. This survey also found that older heavier drinkers are less likely than younger heavy drinkers to have problems as a consequence of their drinking. Specifically, this survey found that:

- Eight percent of all drinkers had experienced moderate levels of dependence symptoms (such as morning drinking and increased tolerance) during the preceding year. Twelve to 13% percent had experienced moderate levels of drinking-related consequences (such as problems with spouse, job, police, or health) during the preceding year.
- Among all survey respondents, the proportion reporting at least a moderate level of problems was highest in the 18-to-29 age category for both dependence symptoms (15%) and drinking-related consequences (26%). The proportions dropped with increasing age, reaching respective lows of 2.0% and 1.9% among respondents aged 60 and older.
- Problem levels were higher among men than among women. Among male respondents, 10% reported at least moderate levels of dependence symptoms and 16% reported negative social

consequences from drinking. Among female drinkers, 5.1% reported at least a moderate level of dependence symptoms, while 9.2% experienced negative social consequences. [22](#)

Mitigating Conditions

Extract from the Guideline

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 good judgment;

(b) the individual acknowledges his or her alcoholism or issues of alcohol abuse, provides evidence of actions taken to overcome this problem, and has established a pattern of abstinence (if alcohol dependent) or responsible use (if an alcohol abuser);

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

(d) the individual has successfully completed inpatient or outpatient counseling or rehabilitation along with any required aftercare, has demonstrated a clear and established pattern of modified consumption or abstinence in accordance with treatment recommendations, such as participation in meetings of Alcoholics Anonymous or a similar organization and has received a favorable prognosis by a duly qualified medical professional or a licensed clinical social worker who is a staff member of a recognized alcohol treatment program.

Conditions that may mitigate security concerns are discussed below. In case of uncertainty whether alcohol incidents have been mitigated, the adjudicator should make a whole-person judgment. The adjudicator should ask: Does the subject's behavior demonstrate reliability, trustworthiness, good judgment, and discretion? If the subject meets that test, access is "clearly consistent with the interests of national security." If not, access may be denied. In making such judgments, the adjudicator may wish to consult a duly qualified medical professional when available.

- [Problem is Not Serious Enough for Adverse Action](#)
- [Problem is Not Recent](#)
- [Positive Changes in Behavior](#)
- [Education, Treatment, and Rehabilitation](#)

Problem Is Not Serious Enough For Adverse Action

After considering the nature and sources of all available information, the adjudicator may determine that a subject's drinking is not serious enough to warrant recommending disapproval or revocation of clearance. It may be appropriate to recommend approval with a warning that future incidents involving alcohol will cause a review of access eligibility. The adjudicator may also recommend approval under condition that the subject agrees to evaluation by a duly qualified medical professional and complies with recommendations regarding treatment or counseling.

In making this determination, the adjudicator considers the subject's behavior while intoxicated and medical evaluation of his or her dependence upon alcohol and the likelihood that the subject's condition may worsen. The adjudicator also makes a whole-person determination that the subject probably will or will not keep future drinking under control to ensure that it does not present a security risk. In making this judgment, the adjudicator considers everything that is known about subject's maturity, sense of responsibility, self-control, honesty, willingness to follow the rules, and commitment to the organization. See *Pattern of Dishonest, Unreliable, or Rule-Breaking Behavior* under [Personal Conduct](#).

Problem Is Not Recent

If the drinking problem occurred a number of years ago and there is no evidence of a recent problem, alcohol may no longer be an issue even if the subject received no counseling or treatment. Remission of alcohol problems without treatment or counseling is not unusual; it is usually related to a change in personal circumstances or lifestyle. It is particularly common as young drinkers mature and the lifestyle, stress, or other circumstances that prompted the drinking change. The likelihood of spontaneous remission without treatment is relatively high among young men in their 20s, but relatively low among men in their 40s or older. Controlling one's own drinking problem without treatment is far more common in women than among men. One survey rechecked the same respondents nine years later. It found that of those reporting drinking problems during the first questioning, fewer than half reported still having problems at the time of the follow-up questioning. [19](#)

The amount of time which must elapse since the last report of alcohol abuse is a judgment call. Typically, two to five years may be required, depending upon the seriousness of past alcohol incidents, changes in a subject's personal circumstances or lifestyle, the degree to which investigation finds improved drinking habits since the last incident, the whole-person evaluation, and medical evaluation. If there is strong, positive evidence of abstinence or other significant change in lifestyle, or if the subject has successfully

completed a treatment program of at least three months duration and stayed with the aftercare program without relapse, one year may be sufficient.

Pattern of Abstinence or Responsible Use

Positive changes in lifestyle or drinking habits for at least six months after subject has been warned, counseled, or has completed an alcohol awareness program may mitigate one or two recent alcohol incidents. Persuasive evidence that the subject recognizes his/her problem and is strongly motivated to overcome it is an important consideration. On the other hand, denial or grudging recognition of the problem indicates the problem is likely to persist.

Positive changes in lifestyle may be associated with moving from school into the workforce, changing jobs, getting married, having children, or getting involved with healthy hobbies, recreational activities, volunteer work, or social organizations. A positive change in lifestyle may also be a decision to avoid certain friends, or to avoid situations that support or enable irresponsible drinking, e.g., changing one's route home to avoid going by a neighborhood bar.

Education, Treatment, and Rehabilitation

This section discusses various aspects of education treatment and rehabilitation, including new approaches to treatment, predictors of successful treatment, comparison of inpatient versus outpatient treatment, aftercare requirements, and relapse rates. It also discusses circumstances under which adverse adjudicative action might be deferred pending satisfactory completion of a treatment program.

New Approaches to Treatment

A major shift is under way in the treatment of alcohol dependence, and this may soon have an impact on the mitigation of alcohol dependence as a security issue. Scientists have been decoding the brain's addiction pathways, paving the way for new, targeted medications that act on brain receptors to blunt cravings, ease withdrawal symptoms, or dull the euphoric effects of alcohol. The National Institute on Alcohol Abuse and Alcoholism, a division of the National Institutes of Health, is running more than 50 trials involving drugs and plant extracts for treating alcohol dependence. In July 2005, it issued new guidelines for treatment, encouraging doctors to consider drugs in addition to traditional therapies for alcohol-dependent patients. Some promising drugs are already available, but they do not work for all patients or they have undesirable side effects. [25](#)

When more effective drugs become available, they will make alcohol dependence a mainstream medical problem that family practitioners can deal

with. People who are not now willing to go to a clinic for behavioral therapy, or seek help in a group setting such as Alcoholics Anonymous, will be able to seek help in the privacy of their family doctor's office. Treatment will be more effective, and the risk of relapse after treatment will be significantly reduced.

[25](#)

Mandatory Education

First-time DUI/DWI offenders are often ordered by the court to attend an alcohol education program. Within the military, many alcohol incidents are also commonly addressed with alcohol education. The presumption is that with most first-time offenders education, rather than counseling or treatment, is all that is required unless there is reason to believe otherwise. Educational programs are often sufficient to make the point that an individual must drink responsibly.

Participation in Treatment

For an individual who already has a clearance, participation in a counseling or treatment program may be sufficient for mitigation **if** there is no history of previous treatment and relapse, and the individual is making satisfactory progress. The goal is to allow many individuals to continue working while undergoing treatment. This does not apply to applicants for an initial clearance. The rationale is that an organization has an obligation to help, and a self-interest in helping, many individuals who develop or manifest a drinking problem while employed. There is no similar obligation or self-interest with an applicant. This policy will also make it easier for personnel who develop an alcohol problem to seek treatment for it, rather than feel compelled to hide the problem in order to protect their security clearance. Administrative action concerning security clearance can be deferred pending satisfactory outcome of treatment.

If an existing employee's problem surfaces solely as a result of self-referral to counseling or a treatment program, there were no major precipitating factors such as alcohol-related arrests, and the employee is making satisfactory progress, the case should normally be handled as an employee assistance issue.

Successful Completion of Treatment Program

Alcohol dependence and abuse are both treatable, but [relapse](#) is not unusual. Completion of [inpatient or outpatient treatment](#) along with an aftercare program mitigates security concerns if subject has abstained from alcohol or greatly reduced alcohol consumption for a period of at least 12 months after treatment and has received a favorable prognosis by a duly qualified medical professional.

Treatment programs differ on their goals. In the traditional approach, the goal is abstinence, based on the assumption that the alcohol problem is a progressive illness that can never be cured, only brought under controlled by cessation of all drinking of alcoholic beverages. The 12-Step treatment program popularized by Alcoholics Anonymous is typical of this approach.

Alternative approaches that emphasize controlled or moderate drinking have been slowly gaining support for many years. This class of treatments or interventions goes by a host of names including controlled drinking, reduced-risk drinking, moderated drinking, and asymptomatic drinking.²⁶ Specific intervention approaches go by names such as Behavioral Self-Control Training (BSCT) and Moderation Management (MM). The goal is to reduce alcohol consumption and minimize or eliminate the risks associated with one's past drinking habits. It is attractive to those who would never participate in a 12-step program.

Relapse Rates

For the adjudicator evaluating the significance of alcoholism treatment as a mitigating factor, the most significant indicators that an individual will remain abstinent are successful completion of the treatment program, strict adherence to the full aftercare program, and any other evidence that the individual recognizes his or her problem and is highly motivated to overcome it.

Since most individuals who have an alcohol problem deny they have a problem, recognition of the problem and motivation to overcome it is the key to successful treatment. Relapse is a common occurrence after all addiction treatment programs, but the risk of relapse diminishes as time passes. In alcohol as well as drug and smoking addiction programs, the first relapse occurs most commonly during the first three to six months after completion of treatment

One interesting study of treatment outcomes for military personnel was conducted by the Tri-Service Alcoholism Recovery Department (TRISARD) at the Bethesda Naval Hospital. It showed that if one gets through the first three months without relapse, the chances for long-term abstinence improve dramatically, and the chance of a relapse that affects work performance is small. It is noteworthy that failure to achieve complete abstinence did not, in most cases, lead to objectionable behavior or affect work performance. In fact, this study showed that when a patient who completed the program got through three months without a relapse, the chance that any subsequent relapse from abstinence would affect job performance was almost negligible for at least two years. ²⁷

Success of military treatment programs is measured by subsequent job performance as well as by subsequent abstinence. Studies of these programs have found that at least two-thirds of those who completed a program were

abstinent or virtually abstinent one year later. Another 19% were drinking occasionally but had substantially reduced their alcohol consumption. That leaves about 15% for whom the treatment was unsuccessful. Nearly 83% had received a satisfactory or highly satisfactory performance rating. [28](#)

Proponents of treatment that aims to help drinkers learn to drink more responsibly, without total abstinence, also cite impressive success rates. One long-term study showed that of patients followed for three to eight years following treatment, about 15% had maintained moderate drinking patterns and had no ongoing problems caused by their drinking, another 15% showed distinct reductions in the volume of alcohol consumption, but still reported some problems associated with drinking, while another 33% reported that their moderation training had helped them decide that abstaining was their best option. It was not very helpful for 26%. [29](#)

Inpatient vs. Outpatient Care

There is great variety in the length and types of treatments used in civilian alcoholism treatment programs, and the length of aftercare programs varies from one to three months up to two years. The scientific evidence of the effectiveness of many treatments is questionable, but all programs have many graduates who report successful outcomes. The evidence indicates that expensive, inpatient treatment programs offer no notable advantages in overall effectiveness as compared with outpatient treatment. [30](#) The effectiveness of treatment may be determined more by individual needs, personal attributes, and motivation of the participant to break the habit than by the specifics of the treatment program.

Reference Materials

Criteria for Medical Diagnosis of Abuse or Dependence

A diagnosis of alcohol abuse or dependence should be made by a duly qualified medical professional. Medical criteria for a formal diagnosis of any substance abuse or dependence, including alcohol abuse or dependence, are defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. The criteria are as follows:

Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:

- (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- (b) markedly diminished effect with continued use of the same amount of the substance
- (2) withdrawal, as manifested by either of the following:
 - (a) the characteristic withdrawal syndrome for the substance
 - (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- (3) the substance is often taken in larger amounts or over a longer period than was intended
- (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
- (5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple sources or driving long distances), using the substance (e.g., chain-smoking), or recovering from its effects
- (6) important social, occupational, or recreational activities are given up or reduced because of substance use
- (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

- (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
- (2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., argument with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Additional Sources of Information

The National Clearing House for Alcohol and Drug Information is the central point for ordering all information published by the U.S. Government on alcohol and drug abuse. The prevalence of all forms of substance abuse is monitored annually by two major national surveys. Both surveys are sponsored by the National Institute on Drug Abuse. Results may be obtained without charge from the National Clearinghouse for Alcohol and Drug Information at <http://ncadi.samhsa.gov>, phone 1-800-729-6686.

- *Monitoring the Future* (MTF) is an annual study of the drug- and alcohol-related behaviors and attitudes of American high school students, college students, and young adults. It includes annual follow-up questionnaires mailed to a sample of previous participants from each high school graduating class since 1976. The Internet site for MTF is <http://www.monitoringthefuture.org/>. The most recent study is available at this site.
- The *National Household Survey on Drug Abuse* is based on a national probability sample of persons age 12 and older living in U.S. households.

The Worldwide Survey on Substance Abuse and Health Behaviors Among Military Personnel has been conducted five times since 1980, the last in 2002. It is conducted for the Assistant Secretary of Defense (Health Affairs) and the Department of Defense Coordinator for Drug Enforcement Policy and Support.

Footnotes

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