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# Beyond Abstinence: A Clinically Informed Harm Reduction Approach to Treating Substance Use and Trauma Through Personality Assessment

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## ABSTRACT

*This article presents a detailed case study examining the psychological profile and treatment of "James," a client with co-occurring substance use disorder (SUD) and posttraumatic stress disorder (PTSD), through the lens of the Five-Factor Model (FFM) of personality. By integrating multimodal assessment data—including the SASSI-4, TSI-2, MMPI-2, and MCMI-IV—with FFM trait analysis, the case illustrates how personality factors such as high Neuroticism, low Agreeableness, and low–average Conscientiousness contribute to treatment complexity and inform targeted interventions. The article also explores the ethical and clinical implications of applying a harm-reduction approach during early recovery, offering a rare, real-world example of its implementation. Through a critical discussion of therapist decision-making, client autonomy, and treatment risks, the article provides a model for ethically navigating unconventional strategies in dual-diagnosis cases. This case contributes to emerging paradigms in trauma-informed, personality-integrated addiction treatment and invites further exploration into precision-based approaches in mental health care.*

## Keywords

Five-Factor Model, Substance use disorder, PTSD, Harm reduction, Personality assessment, Trauma-informed care.

## Introduction

As psychologists, our work often centers around the one-on-one clinical relationship, where we tailor interventions to each client's unique experiences using evidence-based practices and sound clinical judgment. This article explores a distinctive therapeutic approach for a client presenting with a complex set of challenges, including comorbid Post-Traumatic Stress Disorder (PTSD) resulting from a severe work-related machinery explosion, polysubstance addiction, financial hardship, severe depression, and anxiety. The client was also coping with the emotional aftermath of a recent breakup and was in the early stages of remission from substance use.

At the outset of therapy, the primary goal was to assess the client's psychological functioning through comprehensive testing objectively and to develop a highly individualized treatment plan. While the client showed a strong desire to maintain sobriety and devoted significant effort toward recovery, he also struggled with overwhelming emotional distress, marked by anger, anxiety, depression, and suicidal ideation, typical of individuals facing early trauma recovery and addiction remission.

Given the severity and complexity of his symptoms, our treatment strategy diverged from traditional abstinence-based models. Instead, we adopted a harm-reduction-informed approach that permitted the carefully monitored, low-dose use of certain substances as a transitional coping mechanism. Concurrently, we engaged in intensive therapeutic work targeting the client's PTSD symptoms and associated mental health concerns. This integrative method provided a more compassionate and flexible path to long-term healing, stabilization, and functional recovery.

## Theoretical and Conceptual Framework (with Critical Perspectives)

This case study draws on a critical integrative framework that interrogates the limitations of conventional treatment models for

individuals with dual diagnoses. It leverages trauma-informed care, harm reduction, person-centered therapy, and stage-based models of behavior change, while challenging rigid abstinence norms and overly pathologizing approaches. Each theoretical lens contributes to a nuanced, client-responsive model that recognizes the complexity of comorbid psychiatric and substance use disorders, particularly in individuals like James.

This study is situated within a framework of **ethical innovation**, which emphasizes the careful adaptation of nontraditional interventions, such as harm-reduction models, within ethically sound, evidence-informed, and client-centered practice [1,2]. Ethical innovation, in this context, refers to the deliberate use of flexible strategies that respect client autonomy while prioritizing safety and long-term recovery".

### Trauma-Informed Care (TIC): Challenging Pathologization

Trauma-Informed Care (TIC) emphasizes the impact of trauma on behavior and resists retraumatizing clinical practices [3]. Unlike conventional models that risk labeling trauma responses as dysfunction, TIC reframes James's hypervigilance, mistrust, and substance use as adaptive responses to overwhelming events. The therapy focused on restoring a sense of safety, predictability, and control—core elements often lost through traumatic experiences. This approach intentionally counters traditional models of therapy that may unintentionally replicate power imbalances and control dynamics, which can be retraumatizing for survivors.

Critique: Standard psychiatric frameworks often fail to center trauma history, focusing on symptom reduction over meaning-making [4]. This framework resists that reductionism.

### Dual Diagnosis and Integrated Treatment: A Rebuttal to Sequential Care

James presented with comorbid PTSD, polysubstance use, depression, and suicidality, necessitating an integrated treatment approach. Research shows that sequential models, which delay trauma work until after substance abstinence, are ineffective [5]. In contrast, this case employed concurrent treatment that addressed trauma and substance use simultaneously.

Critique: Fragmented care fails to account for the self-medicating function of addiction. Integrated approaches recognize that substance use is often a symptom, not the root problem.

### Harm Reduction: A Challenge to Abstinence Orthodoxy

Traditional abstinence-only models often marginalize clients with complex trauma histories by imposing rigid behavioral expectations. Harm reduction, as advocated by Marlatt [6], critiques moralistic and punitive frameworks, offering a flexible path to recovery that emphasizes client agency and incremental change. Allowing James to control his substance use decreased his shame and empowered him to develop insight into his behavior.

Critique: Abstinence enforcement may retraumatize clients and paradoxically increase relapse risk [6]. Harm reduction critiques this by valuing safety over purity.

### Person-Centered Therapy: Humanizing the Clinical Encounter

Drawing from Carl Rogers, this model centered unconditional positive regard, empathy, and authenticity—a direct challenge to pathologizing narratives. By co-creating the treatment plan, the therapist shifted from expert to collaborator, affirming James's autonomy and inner wisdom.

Critique: Traditional models often ignore the client's voice, reinforcing passivity. Person-centered care resists diagnostic reductionism by emphasizing the human experience behind the symptoms.

### Transtheoretical Model of Change: Critiquing Linearity

The Transtheoretical Model (TTM) [7] conceptualizes behavior change as a cyclical process rather than a linear one. Although James appeared to be in the maintenance stage, his ambivalence revealed unresolved inner conflicts. Recognizing relapse as part of the change process normalized his experiences and enhanced motivation.

Critique: The model challenges "success/failure" binaries in recovery. Rather than seeing relapse as treatment failure, it views it as feedback within a longer developmental arc.

### Cognitive-Behavioral Therapy (CBT): Structured, Yet Adapted

While CBT was not explicitly named, its principles informed strategies to help James identify cognitive distortions, regulate emotions, and restructure trauma-related thoughts [8,9]. Techniques were adapted to accommodate emotional safety, such as exposure being paced and titrated to avoid retraumatization.

Critique: Standard CBT can be overly cognitive and under-emotive, minimizing the role of relationship and embodiment. In this case, it was softened and integrated within a trauma-informed lens.

### Relapse Prevention Theory: From Pathology to Process

Marlatt and Donovan [6] reconceptualize relapse not as moral failure, but as part of a broader behavioral process. For James, the lapse in drinking became a moment of insight, not shame. This model supports resilience by encouraging clients to learn from setbacks.

Critique: This model challenges the moralistic framing of relapse, promoting psychological flexibility over punitive reactions.

### Self-Medication Hypothesis: Substance Use as Emotional Survival

Khantzian [10] argues that substance use often functions as a strategy to cope with emotional pain. James's drinking was a means to manage feelings of inadequacy and suppressed rage, emotions that emerged from unresolved trauma. Therapy helped uncover and redirect these emotional energies.

Critique: This hypothesis critiques models that reduce addiction to chemical dependency, instead recognizing the psychodynamic function of substance use.

### Integrated PTSD and SUD Treatment: Prioritizing Safety Over Exposure

Najavits [11] asserts that clients with PTSD and addiction histories require concurrent treatment with emotional safety as the foundation. In this case, the therapeutic relationship itself served as a corrective emotional experience, enabling James to practice vulnerability within a context of emotional containment.

Critique: Traditional trauma therapies often demand premature exposure. Najavits's model critiques this by prioritizing emotional regulation before trauma processing.

### Motivational Interviewing (MI): Resistance as a Relational Signal

MI [12] honors client autonomy and frames resistance as an opportunity for deeper engagement. Offering James choices restored his sense of control, aligning with MI's goal of evoking—not imposing—change.

Critique: MI challenges authoritarian therapist styles, positioning resistance not as defiance, but as relational misattunement.

### Recovery Capital: Reframing Strengths as Therapeutic Currency

Recovery capital [13] refers to the internal and external assets that sustain recovery. Through therapy, James developed psychological capital—encompassing self-trust, emotional literacy, and resilience—which became a foundation for long-term change.

Critique: Deficit-based models often ignore clients' existing strengths. Recovery capital theory reframes clients as already resourceful, shifting the focus from pathology to potential.

## Case Description

### Demographics

Mr. James Doer is a 32-year-old Caucasian male who identifies as single and is the biological parent of an 8-year-old son. He has never been married. He resides in an urban U.S. setting and reports no specific cultural or religious affiliation. English is his primary language. The case has been de-identified for confidentiality purposes.

### Presenting Concerns

James requested a psychological evaluation to explore symptoms related to post-traumatic stress disorder (PTSD) following a significant workplace accident and to address patterns of substance use involving alcohol, marijuana, and cocaine. He also expressed longstanding anger issues, difficulty with emotional empathy, and concerns about his personality traits, questioning whether he may exhibit narcissistic or sociopathic tendencies. He is seeking psychotherapy focused on trauma recovery and addiction, with the additional goal of better understanding his emotional reactivity and interpersonal functioning.

### Clinical History

### Medical History

James sustained physical injuries and nerve damage in a machinery explosion at work on January 12, 2022. He experiences chronic symptoms such as nerve pain (described as a "lightning strike feeling") triggered by temperature changes and bodily functions. He reports disrupted sleep, frequent nightmares, night sweats, and persistent physical discomfort from extensive scarring on his arms, back, and face, contributing to body dysmorphia and low self-esteem.

### Psychiatric History

James has a history of anxiety and depression, though he discontinued medication due to undesirable side effects. He describes himself as emotionally numb, volatile, and prone to suicidal thoughts, particularly following the recent loss of his romantic partner, but has made efforts to ensure safety by temporarily surrendering his firearm to a friend. He denies any psychotic symptoms.

### Substance Use History

James began experimenting with substances early in life. His first use of alcohol and cigarettes occurred at age 13, followed by marijuana and other drugs by age 16. Over time, this escalated into polysubstance use, including regular alcohol consumption (4–6 days per week, often to intoxication), marijuana, and occasional cocaine use. He acknowledges using substances to suppress emotional pain, regulate anger, and cope with the distress of trauma and interpersonal conflict.

### Educational and Occupational History

James attended college but dropped out during his first year. He subsequently pursued work in a skilled trade and was employed full-time until the workplace accident that caused significant injury and psychological distress. He identifies as a diligent worker who generally complies with procedures and safety measures, and he denies any history of prior work-related accidents.

### Family History and Early Life

James described a traumatic childhood marked by emotional abuse and neglect, particularly from his father, whom he described as volatile and intimidating. He often witnessed parental conflict and continues to harbor intense resentment toward his parents. He identifies with a preoccupied attachment style and fears he may be reenacting elements of his father's abusive behavior in his romantic relationships.

### Interpersonal and Relational History

James recently ended a significant relationship after crossing emotional and verbal boundaries. He and his partner are currently maintaining no contact to focus on personal healing. He acknowledges patterns of manipulative behavior, emotional control, and difficulty empathizing with others' suffering. The breakup has surfaced existential despair and intense shame about his relational patterns.

### Therapeutic Context

James sought treatment at an outpatient clinic. Sessions were conducted in a private, weekly format over 24 months.

### Mental Status Examination

During the mental status examination, James presented as clean, well-groomed, and appropriately dressed, demonstrating cooperative behavior throughout the session. His mood appeared depressed and anxious, and his affect was emotionally blunted, though he openly reported experiencing persistent anger. Cognitively, he was alert and oriented to person, place, and time, but exhibited notable impairments in short-term memory and concentration. His speech was coherent and goal-directed, with no signs of disorganized thought processes. James's thought content was preoccupied with past trauma, issues of self-worth, and recent relational failures. He denied any delusions or hallucinations. His insight into his maladaptive behaviors is emerging, and while he shows some awareness of his difficulties, his judgment is fair but often compromised under emotional stress. He reported passive suicidal ideation, particularly following interpersonal losses, but emphasized protective factors such as his relationship with his 8-year-old son and ongoing therapeutic support. As a precautionary measure, James voluntarily surrendered his firearm to a trusted friend to reduce risk during periods of emotional instability.

## Methodology

### Assessment Tools and Procedure

James D. underwent a comprehensive **psychological assessment** to evaluate his emotional, behavioral, and personality functioning, with a focus on trauma-related symptoms and substance use. The evaluation included clinical interviews and standardized psychometric instruments. Posttraumatic stress symptoms were assessed using the Trauma Symptom Inventory, Second Edition (TSI-2), which James completed on 05/15/2022 and again on 06/05/2022. His personality and emotional profile were evaluated through the Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2), the Millon Clinical Multiaxial Inventory, Fourth Edition (MCMI-IV), and the NEO Personality Inventory-3 (NEO-PI-3), all administered on 05/15/2022. In addition, the Substance Abuse Subtle Screening Inventory, Third Edition (SASSI-4), was used on the same date to assess substance use patterns. These results informed diagnosis and guided the development of an individualized treatment plan.

### Ethical Considerations

The ethical use of client data in this case adhered to established standards of informed consent, autonomy, and institutional oversight. The client, an adult receiving psychotherapy, was first approached during a therapy session and asked whether he would be open to having aspects of his treatment process used for scientific publication, particularly due to the uniqueness of the therapeutic approach employed. Upon expressing interest and giving verbal agreement, a formal letter was sent to the client by the therapist outlining the nature and purpose of the proposed research use.

Subsequently, the client received a written request from the institution where he was receiving care, formally asking for his permission to allow his therapist to use anonymized clinical data for research and publication purposes. After reviewing the details, the client voluntarily agreed and was provided with a comprehensive informed consent form, in line with ethical research standards. This form detailed the scope, purpose, confidentiality safeguards, and his right to withdraw consent at any time without affecting his treatment. The client signed this document, thereby granting written permission.

This three-step process—therapist inquiry, institutional request, and formal consent—ensured that the client's autonomy was respected and that ethical guidelines for clinical research were fully upheld in accordance with the Declaration of Helsinki and relevant institutional review standards.

## Evaluation and Results

### Evaluation of PTSD

James completed the following trauma test, both at the beginning of therapy and again a few weeks later.

#### *Trauma Symptom Inventory, Second Edition (TSI-2)*

The Trauma Symptom Inventory, Second Edition (TSI-2) assesses trauma-related symptoms across various contexts such as assault, violence, accidents, and abuse. T-scores between 60-64 indicate problematic symptoms, while scores of 65 or higher are clinically elevated.

James completed the TSI-2 twice, on March 15, 2022, and May 15, 2022, to monitor changes related to psychotherapy or other factors. Scores from the two dates are presented as "T-score 1" and "T-score 2." Only differences with a significance level of .05 or less are considered clinically meaningful; values marked "NS" indicate no significant change.

#### *T-Score 1 (5/15/22 administration)*

James responded to the TSI-2 openly and honestly, endorsing numerous trauma-related symptoms, which supports the validity of the results. His profile indicates significant trauma-related difficulties that align with his current experiences.

Two key factors were notably elevated. The first, Posttraumatic Stress, includes symptoms such as flashbacks, nightmares, intrusive memories, cognitive and behavioral avoidance of trauma reminders, hyperarousal (like irritability and sleep disturbances), and dissociation. The second, Externalization, involves problematic behaviors such as anger, tension-reduction activities, sexual disturbances, and suicidal thoughts or behaviors. These behaviors often reflect attempts to cope with overwhelming trauma-related feelings or poor emotional regulation, sometimes manifesting as self-destructive or aggressive actions.

James showed clinically elevated symptoms of anxious arousal, suggesting he experiences anxiety, panic, hyperalertness, and related physiological symptoms. His depression score indicates persistent feelings of sadness, worthlessness, hopelessness, and

possible social withdrawal, with an increased risk for suicidality. He also has high intrusive experiences marked by nightmares, flashbacks, and upsetting triggered memories, which cause significant distress.

**Table 1:** Comparison of TSI-2 on March 15, 2022, and May 15, 2022.

| Scale/Subscale/Factor | T-score 1 | T- score 2 | Change Score | Level of Significance |
|---|---|---|---|---|
| Validity Scales | | | | |
| Response Level | 44 | 44 | 0 | NS |
| Atypical Response | 74 | 66 | -8 | NS |
| Factor | | | | |
| Self-Disturbance | 67 | 59 | -8 | 0.1 |
| Posttraumatic Stress | 71 | 65 | -6 | 0.1 |
| Externalization | 79 | 71 | -8 | 0.15 |
| Somatization | 59 | 54 | -5 | NS |
| Clinical Scale/Subscale | | | | |
| Anxious Arousal | 75 | 71 | -4 | NS |
| Anxiety | 72 | 72 | 0 | NS |
| Hyperarousal | 76 | 67 | -9 | 0.15 |
| Depression | 73 | 67 | -6 | 0.05 |
| Anger | 71 | 65 | -6 | 0.1 |
| Intrusive Experience | 79 | 72 | -7 | 0.1 |
| Defensive Avoidance | 65 | 62 | -3 | NS |
| Dissociation | 56 | 46 | -10 | 0.05 |
| Somatic Preoccupation | 59 | 54 | -5 | NS |
| Pain | 59 | 55 | -4 | NS |
| General | 58 | 52 | -6 | NS |
| Sexual Disturbance | 61 | 67 | 6 | NS |
| Sexual Concerns | 60 | 67 | 7 | NS |
| Dysfunctional Sexual Behavior | 60 | 63 | 3 | NS |
| Suicidality | 74 | 63 | -11 | 0.05 |
| Ideation | 83 | 68 | -15 | 0.01 |
| Behavior | 47 | 47 | 0 | NS |
| Insecure Attachment | 62 | 58 | -4 | NS |
| Relational Avoidance | 58 | 58 | 0 | NS |
| Rejection Sensitivity | 63 | 55 | -8 | 0.15 |
| Impaired Self-Reference | 61 | 48 | -13 | 0.01 |
| Reduced Self-Awareness | 66 | 48 | -18 | 0.01 |
| Other-Directedness | 55 | 48 | -7 | NS |
| Tension Reduction Behavior | 92 | 74 | -18 | 0.01 |

His defensive avoidance score reflects ongoing efforts to suppress painful memories and avoid triggers, which can limit emotional processing of trauma. Sexual disturbance scores point to distress, anxiety, and dysfunction related to sexual activity, including feelings of shame and difficulties in intimate relationships. Elevated suicidality scores raise concerns about potential self-harm or suicidal behavior and warrant careful monitoring.

Additionally, James's elevated insecure attachment scores suggest fears and avoidance in close relationships, often rooted in early experiences of loss, neglect, or maltreatment. Finally, his impaired self-reference scores indicate difficulties with self-awareness and identity, including reliance on others for validation, boundary issues, and an unstable or fragile sense of self. These issues may stem from early trauma and have led to challenges in emotional regulation and personal stability.

### *T-score 2 (5/15/22 administration)*

James responded openly to the TSI-2, endorsing trauma-related symptoms, making the results a valid reflection of his current experiences. His scores showed elevated levels on the Posttraumatic Stress and Externalization factors.

The Posttraumatic Stress factor includes symptoms such as flashbacks, nightmares, avoidance of trauma reminders, hyperarousal (e.g., irritability, jumpiness), and dissociation. The Externalization factor reflects problematic behaviors like anger, tension reduction activities, sexual disturbances, and suicidal thoughts or behaviors, often used to manage overwhelming trauma-related emotions through acting out or distraction.

Clinically elevated scores were found on Anxious Arousal (anxiety, panic, hyperalertness), Depression (persistent sadness, hopelessness, possible social isolation), Intrusive Experiences (unexpected intrusive memories and flashbacks), Defensive Avoidance (efforts to avoid painful memories and triggers), Sexual Disturbance (sexual anxiety and dysfunction), and Suicidality (suicidal thoughts and risk).

Additionally, James's Insecure Attachment scores suggest fears and avoidance in close relationships rooted in early relational losses or maltreatment. After three weeks of therapy, a follow-up TSI-2 showed improvements, especially in Depression, Dissociation, Suicidality (Ideation), Impaired Self-Reference, Reduced Self-Awareness, and Tension Reduction Behaviors.

## Personality and Emotional Functioning

James completed several objective self-report measures designed to assess his personality and emotional functioning.

### *Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2)*

James completed the *Minnesota Multiphasic Personality Inventory–2*, an objective self-report measure assessing social and emotional functioning.

James's MMPI-2 results show he struggles with chronic psychological issues, including impulsivity and repeated socially inappropriate behavior followed by superficial guilt. He experiences low mood, anxiety, hopelessness, low self-esteem, and physical complaints. Suicidal thoughts are present, warranting immediate assessment.

He has anger problems with potential for explosive behavior, antisocial tendencies, and delusional beliefs about having special powers, which may increase risk of aggression. He is fearful, hypersensitive, and struggles to control anger.

James has a negative, pessimistic worldview, worries excessively, and finds little pleasure in life. Socially, he is insecure, manipulative, resentful, and critical, feeling trapped in a hostile home environment.

### *Millon Clinical Multiaxial Inventory, Fourth Edition (MCMI-IV)*

*Based on Millon, Grossman, & Millon (2015).*

#### Response Tendencies

James may exaggerate symptoms due to a tendency toward self-pity or emotional turmoil. His scores were adjusted for potential overreporting, especially on Clinical Syndrome scales (e.g., Melancholic, Masochistic, Borderline, Avoidant, Schizotypal).

#### Personality Patterns

James shows moderate personality pathology marked by emotional lability, distorted interpersonal perceptions, and a tendency toward self-defeating behaviors. His profile reflects inflated but insecure self-worth, defensiveness, hostility, and antisocial tendencies. He resists authority, justifies misconduct, and may engage in manipulative or deceptive behavior. Suspicious and envious, he sees others as malevolent and often retaliates. His relationships are characterized by provocation, resentment, and a desire for dominance.

#### Grossman Facet Scales

Notable features include dishonesty, pleasure in violating norms, impulsivity, lack of guilt, and externalization of blame. He sees himself as a victim, justifying aggressive or vindictive behavior. Mood instability and irritability are frequent, with a low frustration tolerance and chronic resentment.

#### Clinical Syndromes

James exhibits signs of Major Depression, Generalized Anxiety, PTSD, Alcohol and Drug Use Disorders, Somatic Complaints, and Hypomania. These reflect both longstanding personality traits and acute distress. His substance use appears driven by anger, self-disillusionment, and a desire to escape inner conflict. Somatic concerns may be used to manipulate others.

#### Treatment Implications

Early treatment should focus on regulating emotions, controlling impulses, and restructuring maladaptive interpersonal beliefs and behaviors.

### *NEO Personality Inventory-3 (NEO-PI-3)*

The NEO Inventories provide a comprehensive and detailed assessment of personality that is well-established and respected. The NEO-PI-3 [14] measures all five dimensions of personality: Agreeableness (A), Conscientiousness (C), Neuroticism (N), Extraversion (E), and Openness to Experience (O).

It is suitable for clients ages 12 and over, including middle school-aged children and adolescents, as well as adults with lower educational levels. Administered in under 40 minutes.

The NEO-PI-3 is a modification of the NEO PI-R in which 37 of the 240 items have been replaced. The new items are easier to understand and have better psychometric properties.

#### *Validity Indices*

Validity indices (i.e., A and C questions, the total number of items missing, and responses) are within normal limits.

#### *Global Description of Personality: The Five Factors*

The most distinctive feature of this individual's personality is his standing on the factor of Neuroticism. Individuals scoring in this range are prone to experience a high level of negative emotion and frequent episodes of psychological distress. They are moody, overly sensitive, and dissatisfied with many aspects of their lives. They are generally low in self-esteem and may have unrealistic ideas and expectations. They are worriers who typically feel insecure about themselves and their plans. Friends and neighbors of such individuals might characterize them as nervous, self-conscious, high-strung, and vulnerable in comparison with the average person. (It is important to recall that Neuroticism is a general personality dimension, and high Neuroticism scores in themselves do not imply that the individual is suffering from any psychological disorder.)

James is low in Agreeableness. Individuals who score in this range tend to be relatively unconcerned with the needs of others. They can often be brusque or thoughtless in their interactions. They tend to view other people and ideas from a critical standpoint. Their attitudes tend to be tough-minded in most situations. They are competitive and quite able to express hostile feelings directly. People might describe them as relatively stubborn or selfish. Although antagonistic people such as these are generally not well-liked by others, they are often respected for their critical independence. Their emotional toughness and competitiveness can be assets in many social and business roles).

Next, consider James's level of Conscientiousness. Men who score in this range have a normal level of need for achievement. They can set work/school aside in pursuit of pleasure or recreation. They are moderately well-organized and relatively reliable, with an average amount of self-discipline. This person is average in Extraversion. Such people enjoy being around others, but also have periods when they prefer to be alone. They are average in terms of energy and activity, and experience a normal amount of pleasant and cheerful feelings. Finally, the individual scores in the average range in Openness. Average scorers like him value both the new and the familiar and have an average degree of sensitivity to inner feelings. They are willing to consider new ideas on occasion, but they do not seek out novelty for its own sake.

#### *Detailed Interpretation: Facets of N, E, O, A, and C*

Each of the five factors encompasses several more specific traits, or facets. The NEO-PI-3 measures six facets in each of the five factors. An examination of the factors provides a more detailed picture of the distinctive way that these factors are seen in James.

### Neuroticism

James is anxious, generally apprehensive, and prone to worry. He often feels frustrated, irritable, and angry at others, and he is prone to feeling sad, lonely, and dejected. Embarrassment or shyness when dealing with people, especially strangers, is often a problem for him. He reports being poor at controlling his impulses and desires and unable to handle them well.

### Extraversion

James is average in his warmth toward others, but he rarely enjoys large and noisy crowds or parties. He is reluctant to assert himself and prefers to stay in the background in meetings and group discussions. The individual has a low level of energy and prefers a slow and steady pace. Excitement, stimulation, and thrills have little appeal to him, and he is less prone to experience feelings of joy and happiness than most men.

### Openness

In experiential style, James is somewhat open. He has a vivid imagination and an active fantasy life. Like most people, he appreciates beauty in music, art, poetry, and nature, and his feelings and emotional reactions are varied and important to him. He seldom enjoys new and different activities and has a low need for variety in his life. He has only a moderate level of intellectual curiosity, and he generally has liberal social, political, and moral beliefs.

### Agreeableness

James tends to be cynical, skeptical, and suspicious, and has a low opinion of human nature. He is willing, at times, to flatter or trick people into doing what he wants, but he is reasonably considerate of others and responsive to requests for help. This individual can be very competitive and is prepared to defend his views if necessary. He views himself as an average person, neither better nor worse than others. Compared to other people, he is average in his concern for those in need, and his social and political attitudes strike a balance between compassion and realism.

### Conscientiousness

James is sometimes inefficient or unprepared and has not fully developed his skills and talents. He is very neat, punctual, and well-organized, but he is sometimes less dependable, reliable, and more likely to bend the rules than he should be. He has a moderately high need for achievement, but can also set aside work and school for recreation. He sometimes finds it difficult to motivate himself to do what he should and tends to quit when tasks become too challenging. He is occasionally hasty or impetuous and sometimes acts without considering all the consequences.

### *Personality Correlates: Some Possible Implications*

Research has shown that the scales of the NEO-PI-3 are related to a wide variety of psychosocial variables. These correlates suggest possible implications of the personality profile because individuals who score high on a trait are also likely to score high on measures of the trait's correlates. The following information is intended to give a sense of how this individual might function in a number of areas. It is not, however, a substitute for direct measurement. If, for example, there is a primary interest in medical complaints, an inventory of medical complaints should be administered in addition to the NEO-PI-3.

### Coping and Defenses

In coping with the stresses of everyday life, James is likely to react with ineffective responses, such as hostile reactions toward others, self-blame, or escapist fantasies. He is likely to use both faith and humor in responding to threats, losses, and challenges. His ability to use positive thinking and direct action in dealing with problems is normal in comparison to most men. He is more likely to present a defensive facade of superiority than to be self-sacrificing. He may use such defense mechanisms as acting out and projection.

### Somatic Complaints

James may be overly sensitive in monitoring and responding to physical problems and illnesses. In medical evaluations, it may be particularly important to seek objective confirmation of symptom reports where possible

### Psychological Well-being

Although his mood and satisfaction with various aspects of his life will vary with the circumstances, in the long run, James will be marginally satisfied with life.

### Cognitive Processes

James is likely to be about average in the complexity and differentiation of his thoughts, values, and moral judgments compared to others of his level of intelligence and education. He would also probably score in the average range on measures of ego development.

### Interpersonal Characteristics

Many theories propose a circular arrangement of interpersonal traits around the axes of Love and Status. James would likely be described within such systems as cold, unfeeling, dominant, assured, and especially arrogant and calculating. His traits are associated with a high standing on the interpersonal dimension of Status and a low standing on the dimension of Love.

### Needs and Motives

Research in personality has identified a widely used list of psychological needs. Individuals differ in the degree to which these needs are reflected in their motivational structure. The respondent is likely to exhibit high levels of the following needs: aggression, harm avoidance (avoidance of danger), order, sentience (enjoyment of sensuous and aesthetic experiences), and succorance (support and sympathy). The respondent is likely to have low levels of the following needs: change, cognitive structure, dominance, endurance (persistence), and play.

### *Substance Abuse Subtle Screening Inventory, Third Edition (SASSI-4)*

The Substance Abuse Subtle Screening Inventory, Fourth Edition (SASSI-4) is a screening measure that could identify individuals with a high probability of having a substance dependence disorder,

even if those individuals do not acknowledge substance misuse or symptoms associated with it. The SASSI-4 [12] consists of a True/False side asking questions that appear to be unrelated to substance abuse, as well as a face-valid side asking how frequently the examinee has had certain experiences directly related to alcohol and other drugs. Finally, both sides of the test are used to evaluate ten decision rules. If any one of these ten rules is answered "Yes," there is a High Probability of having a substance dependence disorder. If the rules are all answered "No," there is a low Probability of having a substance use disorder.

All the rules are answered "Yes," there is a High Probability of having a substance dependence disorder.

## DSM-5 Diagnosis

James was diagnosed according to the criteria outlined in the *DSM-5-TR* [15].
F33.2 Major Depression (recurrent, severe)
F43.10 Posttraumatic Stress Disorder
F10.10 Alcohol Use Disorder
F60.2 Antisocial Personality Disorder with Unspecified Personality Disorder (Sadistic) Type, Unspecified Personality Disorder (Negativistic) Type, and Borderline Personality Style

## Intervention and Treatment Course

## Personality Traits Most Impacting James's Substance Use Patterns

James's substance use patterns appear to be significantly shaped by core personality traits, as identified through psychological assessment and supported by empirical research based on the Five-Factor Model (FFM) of personality (as measured by the NEO-PI-3). These traits include high neuroticism, low agreeableness, and average to low conscientiousness—each associated with increased vulnerability to substance use and relapse.

### High Neuroticism

- **Description:** James exhibits elevated levels of neuroticism, marked by mood instability, frequent negative emotional states, anxiety, irritability, and low self-esteem.
- **Impact:** High neuroticism is strongly linked to increased susceptibility to substance use, particularly as a maladaptive coping strategy for emotional distress. Individuals with this trait may use alcohol, cannabis, or other substances to manage psychological discomfort and emotional instability [16,17].
- **Clinical Evidence:** This trait is associated with escape-avoidant coping strategies, lower confidence in resisting substance use, and heightened sensitivity to relapse triggers such as interpersonal conflict or emotional upheaval [18].

### Low Agreeableness

- **Description:** James's profile indicates low agreeableness, characterized by a tendency toward distrust, oppositional behavior, and interpersonal antagonism.
- **Impact:** Low agreeableness is associated with a greater likelihood of engaging in antisocial or confrontational behaviors, including substance misuse. These individuals may be less responsive to social norms and more likely to engage in illicit or risky substance use [16,19].
- **Clinical Evidence:** Low agreeableness is often linked to confrontive coping, interpersonal conflict, and reduced motivation to adhere to recovery efforts, especially in social contexts [14,18].

### Average to Low Conscientiousness

- **Description:** James demonstrates an average level of conscientiousness with periodic lapses in organization, goal-setting, and impulse control.
- **Impact:** Lower conscientiousness is a well-documented risk factor for substance use due to its association with impulsivity, disinhibition, and poor long-term planning. These traits interfere with recovery-oriented behaviors such as maintaining sobriety, attending treatment, and adhering to structure [16,17].
- **Clinical Evidence:** Individuals low in conscientiousness are more prone to relapse and tend to use less effective coping strategies when faced with stress or temptation.

### Other Relevant Traits

- **Impulsivity and Sensation-Seeking:** James shows traits of impulsivity and acting-out behavior, often seen in individuals with stimulant or polysubstance use. These tendencies can override logical decision-making and increase the likelihood of immediate gratification through substance use [20].
- **Low Extraversion and Average Openness:** James's moderate scores in these domains suggest limited risk. While lower extraversion may inhibit access to or utilization of social recovery supports, average openness may reduce excessive novelty-seeking, slightly buffering against certain types of substance experimentation [14].

Recent studies consistently identify the following personality traits as most strongly linked to substance use risk:
**High neuroticism:** Individuals prone to negative emotions and distress are more likely to use substances to cope with these feelings.

**Low conscientiousness:** Associated with impulsivity, poor self-control, and increased likelihood of engaging in risky behaviors, including substance use.

**Low agreeableness:** Linked to lower concern for social approval and higher likelihood of antisocial or confrontational behaviors, which can manifest as substance misuse.

**High openness to experience:** Sometimes associated with specific substance use, such as cannabis, but not as strong a general risk factor as the above traits.

**Low extraversion:** Associated with substance use risk in some contexts, particularly among those with low positive emotionality.

These findings are robust across multiple large-scale and meta-

analytic studies, and are observed for both illicit and legal substances, as well as across diverse populations.

**Table 2:** Summary Personality Traits and Substance Use Risk.

| Trait | James's Profile | Impact on Substance Use Patterns |
|---|---|---|
| Neuroticism | High | Heightens emotional distress; increases reliance on substances for relief |
| Agreeableness | Low | Linked to antisocial coping and reduced motivation for recovery |
| Conscientiousness | Average/ Low | Associated with impulsivity, poor planning, and relapse risk |
| Extraversion | Average | May limit support-seeking behaviors if lower[4] |
| Openness | Average | Modest influence; may buffer or moderate novelty-seeking tendencies[4] |

Overall, James's substance use patterns are most significantly influenced by high neuroticism, low agreeableness, and average-to-low conscientiousness. These traits contribute to emotional instability, impulsivity, avoidance-based coping, and challenges in adhering to recovery routines. Understanding these personality factors is crucial for tailoring interventions that promote emotional regulation, foster adaptive coping mechanisms, and support sustained sobriety. Recent studies consistently identify the following personality traits as most strongly linked to substance use risk:

## Intervention and Treatment

James's treatment began with a comprehensive evaluation of his Post-Traumatic Stress Disorder (PTSD) symptoms, substance use patterns, and personality functioning. This assessment phase laid the groundwork for a nuanced therapeutic approach tailored to his needs.

At the outset, James presented as intensely anxious and fearful of relapse, despite being three months sober. He placed considerable emphasis on maintaining abstinence, frequently citing the damage his addiction had inflicted on his romantic relationship. He acknowledged a history of angry outbursts, low frustration tolerance, and verbal aggression linked to his substance use. His motivation was clear—he was "willing to do whatever it takes" to sustain sobriety and repair his personal life.

Initially, James approached recovery with rigid, perfectionistic thinking. His preoccupation with abstinence, though well-intentioned, heightened his anxiety and emotional reactivity. This created a pattern of agitation and frustration that sometimes erupted into verbal hostility during sessions. It became evident that his all-or-nothing mindset was reinforcing a cycle of self-sabotage and emotional dysregulation.

Given James's elevated neuroticism, low agreeableness, and low conscientiousness (as identified through NEO-PI-3 and clinical observation), the therapist implemented an active treatment plan combining Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), and relapse prevention techniques. These interventions were selected to target James's emotional volatility, interpersonal conflict, and impulsivity—all known risk factors for relapse.

In response, the therapist shifted to a harm-reduction and autonomy-supportive model during the second phase of treatment, spanning six sessions. Recognizing that James's rigid perfectionism and fear of relapse were reinforcing emotional instability, the therapist invited him to reconsider his strict abstinence stance. He was assured that exploring moderate drinking would not result in judgment or therapeutic rejection. This intervention aimed to reduce compulsive, fear-driven dynamics around substance use and promote greater self-agency and emotional regulation.

James initially responded with hesitation and anxiety, seeking reassurance: "If it were only up to me, I would not drink, but I trust my therapist has 25 years of experience. Moreover, per the doctor's order, I will take a few drinks before our next session". This marked a therapeutic turning point. In the sessions that followed, James described a feeling of psychological liberation. He told family and friends, "My doctor allowed me to drink, and I am going to enjoy the weekend with you. I feel alive again".

As part of the structured behavioral strategy, James was asked to engage in a 5-minute morning grounding routine, gradually extended to 20 minutes daily, during which he practiced calming breathing, reflection, and goal-setting. He was instructed to identify and write down three specific actions each morning that would help keep himself safe—examples included limiting alcohol, avoiding high-risk triggers, or reaching out to a support person. The overarching goal was harm reduction through intentional behavior planning.

In-session, James was asked to reflect on what he had done well the day before or during the past week, and to identify behaviors worth reinforcing in service of his "big picture" goals—such as restoring trust in his relationship, gaining emotional control, and maintaining employment stability.

To monitor his alcohol use, James was given a drinking self-monitoring protocol. He agreed to log his alcohol consumption every three days and conduct a personal evaluation every Sunday night. Since his highest-risk period spanned from Thursday to Sunday, the collaborative goal was set to not exceed 12 drinks total within that timeframe. If he anticipated going over the limit, James was encouraged to "push the extra drinks to the next shift"—a cognitive-behavioral tactic designed to delay impulsivity and reduce immediate gratification. This gave him a sense of control and choice rather than shame or defeat.

James later reported that this structure helped him "stay honest with myself," adding, "No one is there to track me—this is between me and me." He described feeling more mature and accountable. One key motivator was his pending work compensation case, which he identified as a concrete external reinforcer.

The first six sessions focused on building this behavioral foundation with a high degree of tolerance for setbacks or missed goals. During this time, the therapist provided frequent verbal reinforcement, affirming small steps and emphasizing psychological safety. As James demonstrated increased stability and consistency, the treatment model transitioned into a thinning phase. From session 7 onward, positive reinforcement was gradually reduced—verbal praise became more selective, and the symbolic reinforcement (e.g., references to "a $2,000 weekly psychological investment") was intentionally scaled down to promote intrinsic motivation and self-sustained behavior change.

This process allowed James to build momentum early in treatment while shifting over time toward greater internal responsibility, enhanced self-efficacy, and measurable reductions in alcohol consumption. By session 10, he was abstinent for multiple consecutive days each week, reported using DBT skills during craving episodes, and described feeling more "adult" in his approach to relapse prevention and emotional self-regulation.

To address James's impulsivity and deficits in planning (related to low conscientiousness), the therapist introduced executive functioning strategies that focused on building structure, increasing self-awareness, and promoting delayed responses. These included daily goal-setting, behavioral self-monitoring, and the use of calendar-based reminders to support consistent therapy attendance and enhance accountability. Each session began with a brief check-in on whether James had completed his three daily behavioral goals (e.g., staying calm during a conflict, limiting drinking, or using a grounding technique), which were written in a personal log and rated on a 1–5 scale for effort and success.

Emotion regulation techniques from Dialectical Behavior Therapy (DBT)—such as self-soothing, cognitive reframing, and distress tolerance—were actively taught, modeled, and practiced during high-craving moments. For example, during sessions, James role-played stressful social scenarios (such as receiving criticism or feeling rejected) and practiced grounding himself by taking deep breaths, repeating calming affirmations, and visualizing alternative responses.

Crucial to this progress was the therapeutic environment of trust and safety. A pivotal moment occurred when the therapist told James: "You are in therapy now. Do not worry—we will handle whatever arises. Do not be afraid to fail or relapse. Relapse is part of the healing process. We will address any situation, as long as it does not lead to jail, prison, or involve law enforcement." This message allowed James to explore behavior change without fear of punitive consequences and created the space needed for honest reflection and experimentation.

As part of building insight into his impulsive behaviors, James was asked to identify, in detail, past situations where he acted impulsively and lacked self-soothing. He described multiple instances, particularly involving verbal aggression and acting without thinking. "I usually act before analyzing," he reported. "Then I realize I should have been more patient." He noted his tendency to think, "I want it now, and I'll deal with the consequences later." James openly reflected on how this pattern contributed to losing relationships, including his most recent breakup. He shared that although he had provided for his partner materially, his lack of emotional control—especially his short temper and impatience—ultimately drove her away. He described this loss as an emotional wake-up call.

In response, the therapist and James co-developed a five-step behavioral regulation plan designed to slow his reaction process and increase emotional control:

1. Observe the situation (visually and emotionally)
2. Pause for five seconds to prevent immediate reaction
3. Remind yourself: "It's too early to react"
4. Reassess—ask: "Does my second impression match my first?"
5. Take action deliberately and own it

James initially found this process extremely difficult, stating, "This is the hardest thing I've ever had to do." However, the steps were rehearsed regularly in session through imaginal exposure, role-playing, and guided visualization, with the therapist prompting and reinforcing each stage. When successful, James was asked to journal about how the new behavior felt and what outcome it produced.

To challenge internalized beliefs that impulsivity was a sign of strength or masculinity, James was also asked to reflect cognitively: "Am I less of a man for not reacting right away?" He was encouraged to reframe self-control as a strength, visualizing that "a real man is someone who chooses his response carefully to avoid unnecessary conflict." Over time, James began to appreciate thoughtful decision-making as a sign of maturity. He reported feeling proud of instances where he paused, reassessed, and responded with intention rather than reflex.

By the end of this phase, James could recount multiple examples of situations where he successfully used the five-step plan, including moments with coworkers, family members, and in his own internal self-talk. The therapist documented weekly increases in James's ability to delay reaction, as reported by James and corroborated through role-play scenarios. The shift from impulsivity to intentionality became a central theme in his recovery narrative, reinforcing his emerging identity as someone who can regulate himself, think ahead, and preserve what he values.

Group therapy was later introduced to help mitigate James's lower extraversion and promote adaptive social interactions. He was initially resistant due to low agreeableness, but gradual exposure in a nonjudgmental group environment helped build empathy and improve interpersonal skills. Psychoeducation was also key—James learned how his personality traits interacted with addiction and how to use this knowledge to make empowered, informed decisions.

## Rationale for the Intervention

Clients with co-occurring PTSD and Substance Use Disorders

(SUD) often face heightened emotional volatility and a significant risk of relapse, especially during early remission. Traditional abstinence-focused models, while effective for some, may inadvertently retraumatize individuals with control-related trauma histories by mirroring experiences of coercion or helplessness [11].

James's case illustrates the need for therapeutic approaches that prioritize autonomy, agency, and safety. While initially committed to sobriety, his motivation was rooted more in guilt and relational pressure than self-directed intention. The therapist's harm-reduction strategy disrupted this pattern by granting James permission to make choices about drinking, thereby reframing relapse not as failure, but as a learning opportunity.

This shift facilitated psychological empowerment. Freed from binary thinking about success and failure, James became more reflective and less reactive. His substance use declined organically, not through external enforcement, but through internal growth and increased emotional regulation.

## Discussion: Gains and Critical Perspectives

Mainstream addiction treatment models have traditionally emphasized strict abstinence, symptom suppression, and therapist-driven change [6]. While these approaches can be effective, they may inadvertently replicate dynamics of powerlessness, especially harmful for trauma survivors, by imposing external control rather than fostering internal growth [11]. This article's framework challenges these conventions by foregrounding client autonomy, relational healing, and emotional safety, reflecting evolving paradigms in trauma-informed addiction care.

James's treatment trajectory exemplifies key principles of Self-Determination Theory [21], which posits that enduring change is most likely when autonomy, competence, and relatedness are fulfilled. Notably, when James was freed from coercive monitoring and allowed more personal agency, he internalized behavioral regulation, developed self-trust, and reduced compulsive drinking. This outcome suggests that connection and autonomy can paradoxically serve as stronger motivators for change than external control or abstinence mandates.

However, conventional relapse prevention strategies that prioritize abstinence and strict avoidance of triggers remain widespread because they can offer necessary structure and safety for many clients [6]. However, for individuals like James, with trauma histories characterized by coercion and emotional neglect, such rigid models risk retraumatization and resistance [11]. The harm-reduction approach employed here—permitting controlled alcohol use within a secure therapeutic context—illustrates a flexible, trauma-informed alternative aligned with recent literature emphasizing emotional safety and client empowerment [12,13].

James's psychological profile, interpreted through the Five-Factor Model (FFM), reveals both risk factors and therapeutic opportunities. His high Neuroticism underscores vulnerability to emotional dysregulation and impulsive substance use [17]. Low Agreeableness indicates potential interpersonal challenges, while low-average Conscientiousness suggests difficulties with organization and impulse control—all of which can hinder treatment adherence [18,22]. Nevertheless, these traits also highlight targeted entry points for intervention, such as relational therapy to foster trust, cognitive-behavioral strategies to enhance self-regulation, and skills training to improve assertiveness and boundary-setting.

Supporting assessment tools (SASSI-4, TSI-2, MMPI-2, MCMI-IV) corroborate these findings and reinforce the need for an integrated treatment approach that blends trauma-informed care with motivational interviewing, cognitive restructuring, and dialectical behavior therapy.

Despite these promising elements, James's harm-reduction model raises several important clinical and ethical concerns:

1. **Risk of Reintroducing Substances in Early Recovery:** Allowing alcohol use in early recovery, especially for clients with PTSD and emotional instability, is clinically controversial. Empirical evidence suggests such re-exposure may trigger relapse or destabilize fragile recovery processes [11]. While James showed progress, this approach risks undermining emotional and behavioral stability if applied prematurely or without adequate safeguards.
2. **Potential Reinforcement of Maladaptive Coping:** Harm reduction can inadvertently endorse substance use if not carefully managed. James's remark— "My doctor allowed me to drink"—signals potential boundary blurring and externalization of responsibility, raising concerns about whether controlled use might strengthen maladaptive coping rather than dismantle it [23].
3. **Misalignment Between Motivation and Readiness:** James's motivation appeared driven more by guilt and relational pressure than by intrinsic commitment, suggesting a possible mismatch with his actual stage of change [7]. Reframing relapse as growth, while compassionate, may risk overestimating readiness for autonomy, potentially jeopardizing long-term recovery.
4. **Ethical and Legal Considerations:** Explicitly permitting substance use introduces liability risks for clinicians. Abstinence-based cognitive-behavioral methods remain the gold standard for safety and efficacy with moderate to severe SUDs [24]. Thus, more permissive approaches warrant caution and precise documentation.
5. **Dependence on Therapist Skill and Alliance:** The success of this innovative model hinges on high therapist competence and a strong therapeutic alliance—conditions that may not be replicable across typical clinical settings. Without such support, similar interventions could lead to increased client resistance, emotional dysregulation, or premature treatment dropout [2].

In summary, James's case highlights the substantial benefits achievable through a nuanced, autonomy-supportive, and trauma-informed harm reduction approach. This model challenges

conventional, rigid abstinence frameworks by demonstrating that fostering internal motivation and creating a relational safe environment can drive meaningful and sustainable change. However, the approach also carries inherent risks and ethical complexities, necessitating careful clinical judgment, individualized application, and cautious interpretation. Future research and practice should strive to strike a balance between innovation and prudence, developing harm reduction strategies that respect client autonomy while ensuring safety and upholding therapeutic integrity. Consequently, despite its promise, this approach may not be broadly generalizable or appropriate for all clinical contexts.

### Limitations of the Study

While this case study offers valuable insights into the ethical and clinical applications of a harm reduction approach informed by personality assessment and trauma theory, several limitations must be acknowledged:

### Single-Case Design

The findings are based on a single client's experience, which limits generalizability. Outcomes may be specific to James's personality profile, therapeutic alliance, and psychosocial context, and may not apply to diverse clinical populations or settings.

### Subjectivity in Interpretation

Although the case incorporates validated assessment tools and theoretical models, the clinical decisions and interpretations are ultimately shaped by the therapist's judgment, which introduces potential bias. Replicability and consistency across different providers remain uncertain.

### Short-Term Observation

The study focuses primarily on immediate and short-term changes in behavior and emotional regulation. Long-term outcomes—such as sustained sobriety, relational health, or relapse patterns—were not tracked, which limited conclusions about the enduring efficacy.

### High Dependence on Therapeutic Alliance

The success of the approach relied heavily on a strong therapeutic alliance and the client's capacity for reflection. These conditions may not be present in all therapeutic relationships, raising questions about the approach's scalability or appropriateness for clients with low insight or engagement.

### Ethical Ambiguity and Legal Risk

While harm reduction was employed with clinical intent, the ethical permissibility and potential liability of sanctioning controlled substance use during treatment remain debated and context-dependent. This limits the approach's practical applicability in risk-averse or highly regulated clinical environments.

### Lack of Comparative Data

Without a comparison group or alternative treatment model, it is difficult to determine whether the observed improvements were specifically attributable to the harm reduction strategy or to other factors such as time, personality development, or concurrent supports.

## Conclusion

James's case illustrates the intricate interplay between early trauma, personality functioning, and dual diagnoses of PTSD and substance use. His presentation challenges traditional models of treatment by highlighting the need for an integrated, trauma-informed, and autonomy-supportive approach. Through comprehensive evaluation and therapeutic engagement, this case underscores the importance of tailoring interventions to the individual's lived experiences, relational history, and internal motivations. While James's progress reflects the potential of personalized care, his ongoing risk factors and psychological vulnerabilities also emphasize the need for vigilant, ethically grounded clinical judgment. Ultimately, this case serves as a compelling example of how flexible, precision-based psychological care can navigate the tensions between risk and recovery in complex clinical presentations.

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